Reports and Research

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Robert Wood Johnson Foundation

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ACAView

Tracking the Impact of Health Care Reform

Observations on the Affordable Care Act: 2014

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ACAView's Second Report on the Affordable Care Act

The year 2014 brought great changes to American health care as implementation of the Affordable Care Act continued and its central provisions on coverage expansion took effect. Millions of people have gained coverage through the new health care marketplaces and through the expansion of Medicaid eligibility in many states. The impact and complexity of the ACA make it essential to monitor its effects on care delivery. The need to track the effects of the ACA becomes even greater as Americans debate potential changes to the law and its implementation that could result from different state approaches to Medicaid expansion, court challenges, and legislative measures from Congress.

> The impact and complexity of the ACA make it essential to monitor its effects on care delivery.

ACAView is a joint effort between the Robert Wood Johnson Foundation and athenahealth, a cloud-based health care technology and services company. Because athenahealth is cloud-based, we can analyze and report rapidly on how the ACA is affecting physician practices. For this report, we looked at the following questions:

1. With roughly 10 million newly insured individuals in 2014, are physicians seeing more new patients in their practices?
2. Did new patients have greater health needs in 2014 than in the past?
3. What percentage of patients who were uninsured in 2013 obtained insurance in 2014?
4. To what extent did the ACA bring new coverage to patients of different ages?
5. How did the ACA change the insurance coverage of patients seen in providers' practices in 2014?

Summary of Findings

The following is a summary of our findings based on analysis of the ACAView sample of nearly 16,000 health care providers.

New-patient volumes

1. Concerns that physicians would be overwhelmed by new patients have not been borne out.

Prior to health care reform, some commentators expressed concern that physicians and other providers might be overwhelmed by new patients. This has not occurred. The proportion of new-patient visits to primary-care providers increased very slightly, from 22.6 percent in 2013 to 22.9 percent in 2014.[1] (See page 7.)

2. Although the proportion of visits from new patients increased only slightly, providers are conducting a higher proportion of more comprehensive patient evaluations.

Although providers are not seeing a materially higher proportion of new patients, they are more likely to conduct comprehensive new-patient assessments. The proportion of visits for comprehensive evaluation and management of new patients, including taking a patient history, conducting a physical exam and making medical decisions, increased from 6.7 percent in 2013 to 7.0 percent in 2014, a relative increase of 4.5 percent. (See page 7.)

3. New patients visiting physician offices in 2014 were not sicker or more complex than in 2013.

We found no evidence that patient complexity increased in 2014: physician work intensity per visit remained flat, diagnoses per visit increased slightly, and the percentage of visits with high-complexity evaluation and management codes actually decreased slightly. Primary care providers are seeing a higher proportion of patients with diagnosed mental disorders, but this appears to reflect a continuing trend that predated coverage expansion. (See pages 7-8.)

[1] New-patient visits are defined as those where an individual has not seen a given provider in at least two years.

Increased Insurance Coverage

4. From the physician perspective, the proportion of patient visits by uninsured individuals has fallen much more in expansion states than in non-expansion states.

As a result of the 2012 Supreme Court decision on the constitutionality of the ACA, states may elect whether or not to increase the number of individuals who qualify for Medicaid. About half the states elected to do so, while the others generally maintained their approaches to Medicaid eligibility. The numbers of uninsured patients have fallen much more precipitously in expansion states than in non-expansion states. From 2013 to 2014, the proportion of visits by uninsured patients in Medicaid expansion states fell from 4.6 percent to 2.8 percent, a relative decrease of 39 percent. In the non-expansion states, the proportion of visits by uninsured patients fell from 7.0 percent to 6.2 percent, a decrease of only 11 percent. (See page 9.)

5. The ACA has dramatically benefited uninsured individuals with stable provider relationships, particularly in expansion states.

We analyzed data for 100,000 patients with stable physician relationships who were uninsured for at least part of 2012-2014. The proportion of these individuals who obtained insurance after ACA implementation increased dramatically and much more in the expansion states (from 34.8 percent to 57 percent) than in non-expansion states (from 27.8 percent to 36.5 percent). (See page 9.)

6. Prior to coverage expansion, fewer uninsured adults in older age brackets obtained insurance; the ACA has all but eliminated these age disparities.

In 2013, adult patients between 35 and 64 were significantly less likely to obtain insurance compared with those between 18 and 34. With coverage expansion, these age differences have largely disappeared, particularly in the Medicaid-expansion states. (See page 10.)

Changing Payer Mix

7. Coverage expansion has changed the payer mix in physician practices, boosting the proportion of Medicaid patients in the Medicaid-expansion states and increasing the share of commercially insured patients in the non-expansion states.

The ACA has changed physician payer mix substantially. In non-expansion states, the proportion of visits from commercially insured patients increased from 72.0 percent to 74.0 percent. In expansion states, the proportion of visits from Medicaid patients rose from 12.8 percent to 15.6 percent. (See page 11.)

8. Although Medicaid enrollment increased in non-expansion states, Medicaid patient volumes in these states are actually declining.

Under the ACA, the number of individuals enrolled in Medicaid increased by1.5 million in non-expansion states despite the fact that eligibility criteria remained relatively constant.[2] This is likely due to the fact that publicity around the ACA encouraged qualified individuals to obtain Medicaid coverage they had not previously applied for. Despite this increased Medicaid coverage, the number of Medicaid enrollees seen in physician offices in non-expansion states actually decreased by 10.8 percent. (See page 11.)

9. The increase in Medicaid utilization in expansion states occurred very quickly, with a substantial uptick occurring within three months of ACA implementation.

Physician payer mix[3] tends to be extremely stable over time. In expansion states, however, the proportion of visits with Medicaid patients spiked quickly, from 12.2 percent in December 2013 to 15 percent in March 2014. Medicaid mix peaked at 16.7 percent of all visits in September. (See page 11.)

10. A small but increasing number of patients switched from commercial insurance coverage to Medicaid.

In the Medicaid expansion states, 1.1 percent of individuals with commercial coverage switched to Medicaid from 2012 to 2013. This number increased to 1.8 percent between 2013 and 2014, a significant increase in relative terms. This increase in switching from commercial to Medicaid coverage could reflect both individuals who lost their jobs and low-income workers who chose Medicaid to avoid premium contributions and to reduce their out-of-pocket costs. (See page 12.)

[2] Kaiser Family Foundation, Total Monthly Medicaid and CHIP Enrollment, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/#, accessed 9 February 2015.
[3] Physician payer mix refers to the proportion of patients with particular types of insurance coverage as a percentage of all visits.

About ACAView

ACAView is a joint initiative of the Robert Wood Johnson Foundation (RWJF) and athenaResearch, a department of athenahealth. RWJF is the nation's largest foundation focused solely on improving health and health care. athenahealth is a health care information technology and services company serving more than 62,000 providers in approximately 100 specialties across the country.

The ACAView initiative provides researchers, policymakers, and the public with regular updates on how the Affordable Care Act (ACA) is affecting provider practices. We focus on the ACA's goal of increasing insurance coverage through expanding Medicaid eligibility and providing affordable commercial insurance through federal subsidies on new health insurance marketplaces. ACAView uses data aggregated from athenahealth's ambulatory-care software platform, a cloud-based system for managing patient health records, billing and communication. athenahealth data offers near real time visibility into patient demographics, clinical services and practice economics. athenahealth's data represents actual patient-provider encounters, and therefore provides greater precision and a larger range of metrics than self-reported surveys permit.

Our first report, which was published in July 2014, provided an early description of changes in insurance and health status following implementation of the ACA.[4] This second report covers data through 2014. We will continue to publish regular reports as changes in the health care system become more apparent. athenahealth is also providing monthly updates to RWJF, and additional information is available on the RWJF website and on CloudView, an athenahealth blog.[5]

Sample Overview

ACAView tracks provider activity among practice locations that have used athenahealth's cloud-based software continuously since at least December 31, 2010. Comparing data over time within a single practice cohort allows us to capture shifts in patient demographics, practice patterns and payer policies.

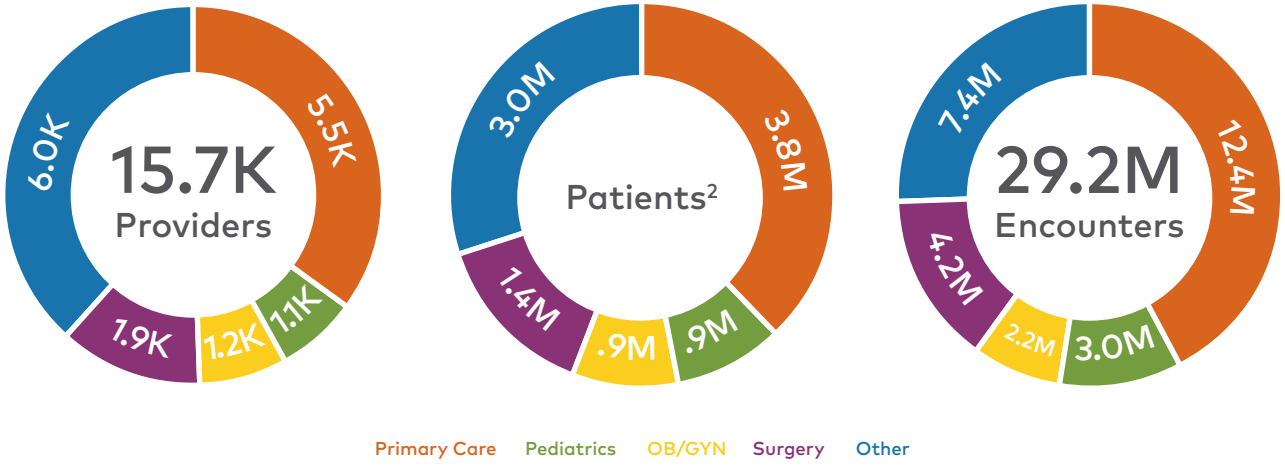
The practices reported in the ACAView metrics, a subset of all practices in athenahealth's database, include roughly 15,000 providers. Approximately 35 percent are primary-care providers, 7 percent are pediatricians, 7 percent are obstetricians or gynecologists, with the remainder distributed across various specialties. (See Figure 1 for more detailed data on the providers, patients and encounters in the research sample.)

Relative to the nation's practitioners as a whole, the ACAView cohort has fewer solo practices and more practices with 10 or more physicians, as well as a higher proportion in the South and a smaller proportion in the West. Most of the physicians in the sample are community practitioners, rather than affiliates of academic medical centers. Our sample does not include visits to emergency departments or inpatient settings. The appendix to this report includes a more detailed comparison of the ACAView sample to selected national benchmarks.

[4] Available for download at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414550.
[5] Reports and blog posts online at http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/athenahealth.html and at http://www.athenahealth.com/blog/.

Figure 1. Research Sample[1]

Average Annual Number of Providers, Patients and Encounters for the Period 2013-2014



[1] Practices active before 2011

[2] Unique patients cannot be summed across specialties, since patients may see providers in multiple specialties

New-Patient Volumes

1. Concerns that physicians would be overwhelmed by new patients have not been borne out.

The ACA was intended to dramatically reduce the number of individuals without health insurance so as to improve their health outcomes. In the run-up to coverage expansion, some commentators expressed concern that physicians' offices would be overwhelmed by the demand for visits by newly insured patients.[6] As we explore below, these concerns did not materialize in the first year of coverage expansion. In fact, the number of new patients that doctors are seeing has increased only slightly.

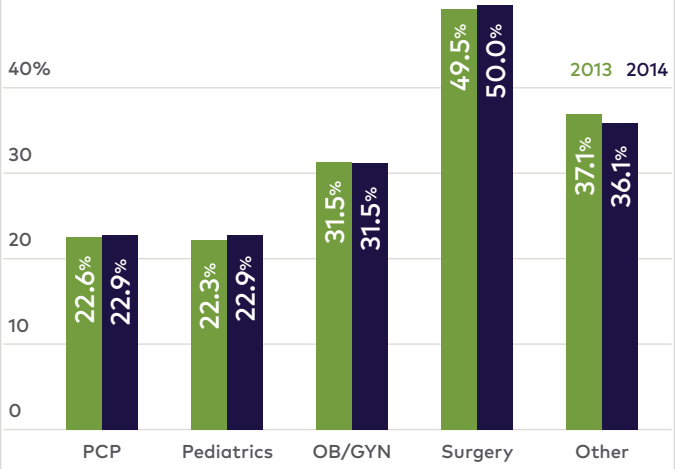
We analyzed two measures of patient access to physician services. The first is the proportion of all patient visits accounted for by new patients. We define a new patient as one who has not seen a given provider in at least two years. We carry the new-patient designation through the year; a patient who satisfied our new-patient criteria in January 2013, for example, is considered new through all of 2013. This definition allows us to measure the proportion of total physician work devoted to new patients over the course of the year.

Although millions of people have gained insurance, providers have not seen an overwhelming influx of new patients. Figure 2 shows that the proportions of visits from new patients for five physician categories did not change appreciably from 2013 to 2014. For example, PCPs had 22.6 percent of their visits from new patients in 2013 and 22.9 percent in 2014. Similarly, small increases were evident for pediatricians and surgeons, while the proportion of new-patient visits was flat for OB/GYNS and declined slightly for other medical specialists.

There are several possible explanations for this small increase in the proportion of visits by new patients. Approximately 10 million individuals gained coverage in 2014, representing about 3 percent of the U.S. population. Some of these newly insured individuals already had established provider relationships, even without insurance, so would not be counted as new patients. Many others might not have needed to visit a physician after getting coverage or might have sought care in an emergency department. As a result, the overall proportion of new patients visiting PCPs in 2014 might be expected to be modest. In addition, the small increase in new-patient visits could be partly explained by some practices not accepting new patients or not belonging to networks affiliated with plans offered through the exchanges.

[6] See, for example, a study from the Kaiser Family Foundation stating that pent-up demand would strain the primary care health system (https://kaiserfamilyfoundation.files.wordpress com/2013/01/8161.pdf) and from the U.S. Health Resources and Services Administration, warning that shortages of PCPs would be aggravated by new ACA coverage (http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf).

Figure 2. Proportion of Visits From New Patients, by Specialty Category



Sample: Over 58 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

2. Although the proportion of visits from new patients increased only slightly, providers are conducting a higher proportion of more comprehensive patient evaluations.

While physicians are not seeing much greater numbers of new patients, there is some indication they are conducting more comprehensive assessments for the new patients they do see. Our second measure of new-patient volumes uses billing codes for evaluation and management (E&M) services. For this more stringent definition of new patients, we counted patients as new if their visit was recorded with the procedure codes indicating a new-patient E&M visit. [7] These new-patient procedure codes are recorded for patients who have not seen a given provider or a provider with the same specialty in a particular practice in at least three years. The visit must also include a patient history, a physical exam, and medical decision-making. This definition of new-patient visits is more likely to indicate visits in which physicians are beginning a new patient relationship rather than merely treating symptoms for patients they have not seen before.

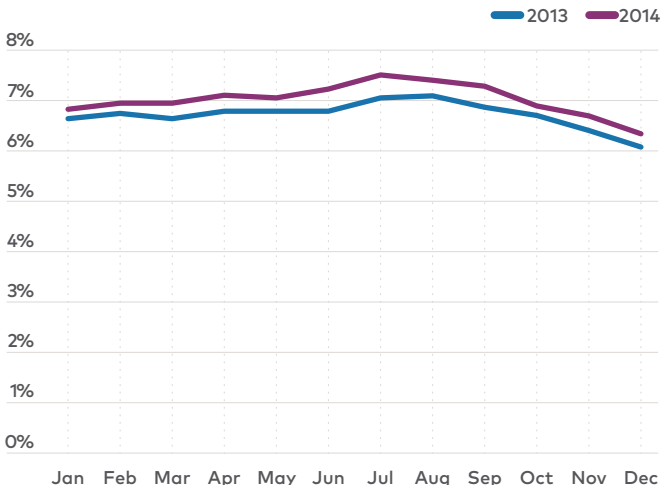
For these reasons, the numbers of these new-patient E&M visits are much smaller than the numbers of new-patient visits under our first definition. Figure 3 shows physicians using new-patient E&M codes at a higher rate in 2014 compared to 2013. In 2014, new patient E&M codes were used in 7.0 percent of all visits, compared to 6.7 percent in 2013, a relative increase of 4.5 percent. A potential implication is that the ACA may have increased the rate at which physicians are establishing new relationships with patients.

3. New patients visiting physician offices in 2014 were not sicker or more complex than in 2013.

On a variety of measures, new patients visiting physician offices in 2014 do not appear to be sicker or more complex than new patients in 2013. Results on patient complexity and required work effort appear in Figure 4 below. Work RVUs per patient visit (a measure of provider effort that takes into account the time, skill and intensity required in different procedures) remained constant; diagnoses per visit increased from 2.0 to 2.1; and the number of "high complexity" evaluation and management codes actually declined from 8.0 percent to 7.5 percent for all visits. [8]

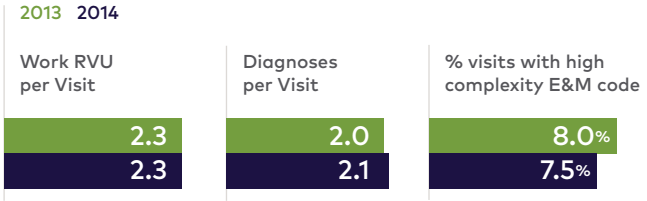
Figure 3. Proportion of Visits with New-Patient E&M Code

2013 vs. 2014



Sample: Over 58 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

Figure 4. Work Intensity Metrics for New Patients 2013 vs. 2014



Sample: Over 17 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

[7] Under this definition, new-patient visits were those with CPT codes of 92002, 92004, 99201-99205, 99321-99328, 99331-99345, or 99381-99387.
[8] We define high-complexity E&M encounters as those with claims billing for CPT codes that are valued more highly within a cluster of E&M codes. For example, within the group of E&M codes 99211-99215, we classify the codes 99214 and 99215 as high complexity.

The data also shows no consistent evidence of an increase in the proportion of patients with chronic disease treated by providers. Figure 5 shows rates of chronic illness recorded in visits to primary care providers among adults (ages18-64) – the group most likely to be affected by the ACA. The changes in chronic disease rates have been modest and inconsistent over the three-year period, 2012-2014. An exception is mental disorders, which increased between 2013 and 2014, and are discussed below.

Figure 5. Proportion of Adult (18-64) PCP Visits with Chronic Disease Diagnoses*

	2012	2013	2014
Diabetes	9.2%	9.3%	9.1%
High Blood Pressure	17.5%	17.5%	17.5%
High Cholesterol	12.3%	12.3%	11.7%
Mental Disorders	11.2%	11.9%	12.4%

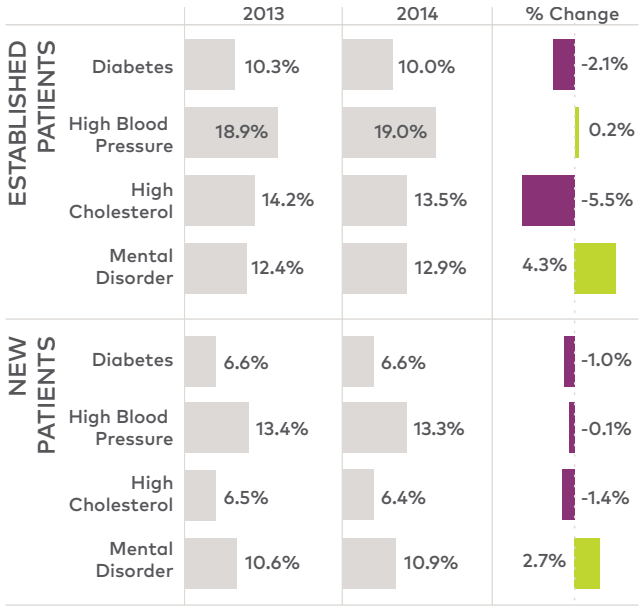
* ICD-9 Codes Diabetes: 250; High BP: 401-405; High Cholesterol: 272.0, 272.2, 272.4; Mental Disorders: 290-319
Sample: Over 14 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

Examining diagnoses separately for new and established patients further supports the conclusion that new patients were no sicker in 2014 than in 2013. Among the adults who were established patients in 2013 and 2014, the rates of diabetes and of high cholesterol fell, the rate of high blood pressure was virtually unchanged, and the rate of mental disorders rose (see Figure 6). Among these adults who were new patients, the rates followed a similar pattern, falling for diabetes and high cholesterol, steady for high blood pressure, and rising for mental disorders. The changes among the new patients, however, were smaller than those among established patients. Overall the data on visit intensity and chronic disease rates suggests that physician offices have not been overwhelmed by previously underserved patients with significant health needs.

The data shows a contrasting increase in patients with mental disorders, which include a wide range of diagnoses for mental illness and substance abuse disorders. New adult patients showed an increase of 2.7 percent in the diagnosis of mental disorders. But in the practices we are tracking, the prevalence of mental health diagnoses also increased for established patients. And the increase in the proportion of mental health visits was also evident in 2012-2013, before coverage expansion went into effect (Figure 5).

Figure 6. Chronic Disease Rates*

PCP Visits for Adults 18-64



* Percentage of encounters with diagnosis
Sample: Over 14 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

Increased Insurance Coverage

4. From the physician perspective, the proportion of patient visits by uninsured individuals has fallen much more in expansion states than in non-expansion states.

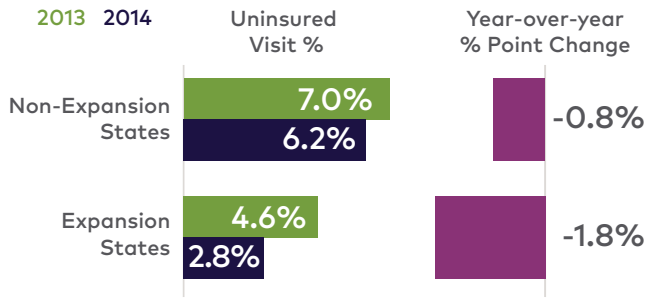
Although providers are not seeing many more new patients, their patients are less likely to be uninsured. The share of visits from uninsured patients fell in both Medicaid-expansion and non-expansion states, but much more steeply in the expansion states.

The states that have expanded Medicaid coverage include California, Illinois, Michigan, New York and a number of less populous states. The states that have not expanded Medicaid include Florida, North Carolina, Pennsylvania, Texas, Virginia and others. See the Appendix for a full list of the Medicaid-expansion and non-expansion states.

The proportion of visits from uninsured patients fell more sharply in the Medicaid-expansion states than in the non-expansion states. Figure 7 provides data for 2013 and 2014 on the proportions of visits to primary care providers (PCPs) that were made by uninsured patients in both the Medicaid-expansion states and the non-expansion states. For patients in the latter states, the proportion of uninsured visits fell from 7.0 percent in 2013 to 6.2 percent in 2014, a drop of 11 percent in relative terms. Among patients in the Medicaid-expansion states, the proportion of uninsured visits fell more sharply and from a lower

base, dropping from 4.6 percent to 2.8 percent, a relative decline of 39 percent. These different declines may be the result of broader Medicaid coverage and more positive publicity around new enrollment options in the expansion states.

Figure 7. Uninsured Visit %* for Adult (18-64) PCP Visits,
Medicaid Expansion States vs Non-Expansion States



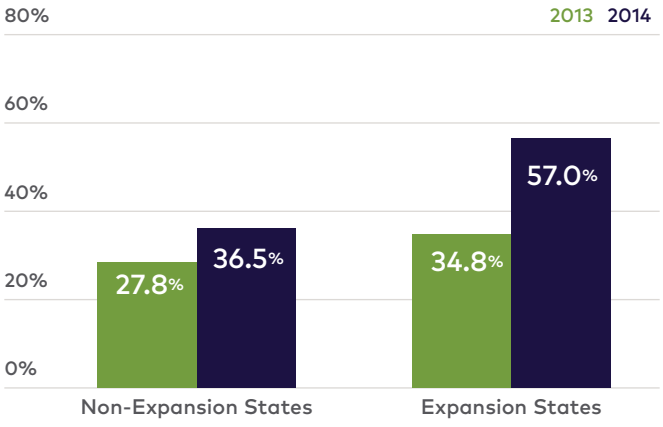
Sample: Over 25 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

5. The ACA has dramatically benefited uninsured individuals with stable provider relationships, particularly in expansion states.

This section looks at individuals who were uninsured for part of the 2012-2014 time periods and had physician visits in at least two of those three years. Although these individuals were uninsured, our data indicates that they had stable provider relationships. Looking at the proportions of patients in 2013 and 2014 who gained insurance after being uninsured the previous year, we find impressively high proportions of the uninsured gaining coverage. Figure 8 shows that in non-expansion states, 27.8 percent of patients who were uninsured in 2012 obtained insurance in 2013; with the ACA, this number increased to 36.5 percent between 2013 and 2014. In the expansion states, the proportion of these patients acquiring insurance increased from 34.8 percent between 2012 and 2013 to 57 percent between 2013 and 2014.

We caution readers on extrapolating from this data to the entire uninsured population. These findings were based on a sample of about 100,000 patients in fairly stable provider relationships. Their experience may therefore not be representative of the uninsured in the country as a whole.

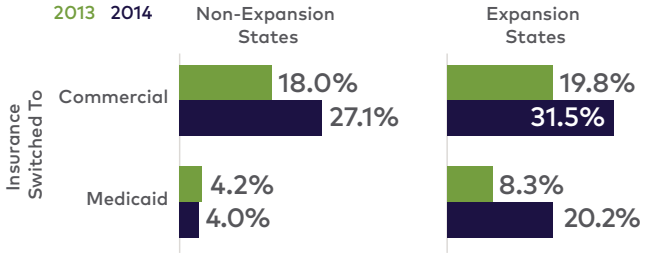
Figure 8. Proportion of Uninsured Patients* Gaining Coverage, by Type, in Subsequent Year



*18-64 Years Old
Sample: Approximately 100K Patients per year, practices active on the athenahealth network before 2011
Source: athenaResearch

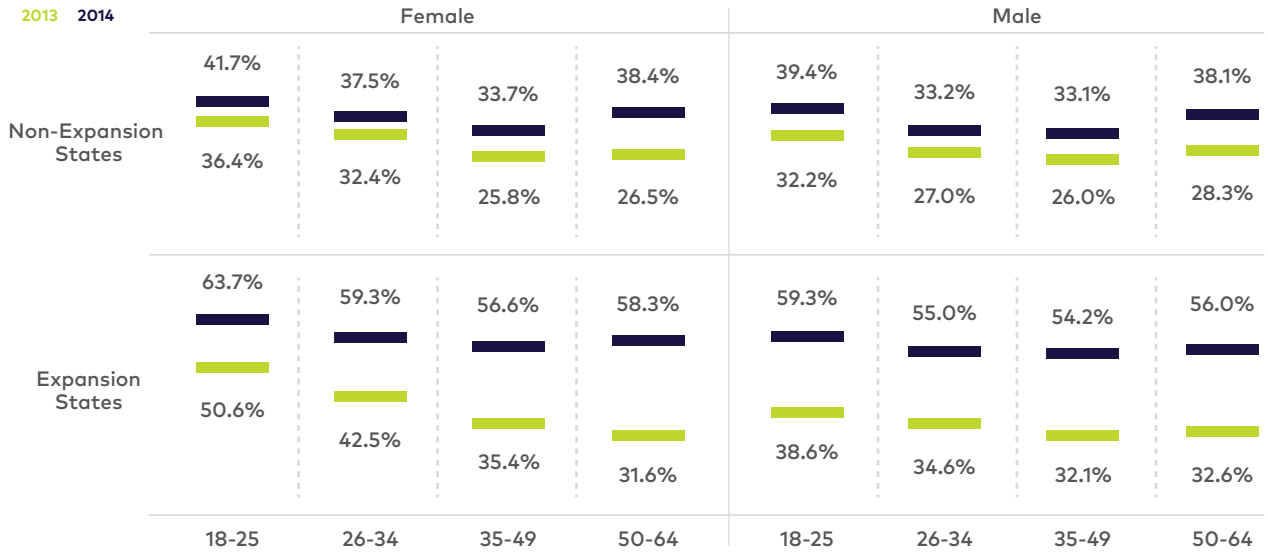
Most of the patients who gained insurance did so by gaining commercial or Medicaid coverage. Figure 9 shows that in the non-expansion states a large share of those who had been uninsured one year gained coverage through commercial insurance (in 2014, 27.1 percent) and very few through Medicaid (in 2014, 4.0 percent). By contrast, in the expansion states, larger shares of those who had been uninsured in one year gained insurance the next year via Medicaid: in 2014, 20.2 percent of those who had been uninsured in 2013 gained coverage through Medicaid.

Figure 9. Proportion of Medicaid and Commercially Insured Patients, Adults* Previously Uninsured



* 18-64 Years Old
Sample: Approximately 100K patients per year, practices active on the athenahealth network before 2011
Source: athenaResearch

Figure 10. Proportion of Adult* PCP Patients Uninsured in the Prior Year Who Gained Insurance in 2013 and 2014, By Gender and Age Groups



* 18-64 Years Old
Sample: Approximately 100K patients per year, practices active on the athenahealth network before 2011
Source: athenaResearch

6. Prior to coverage expansion, fewer uninsured adults in older age brackets obtained insurance; the ACA has all but eliminated these age disparities.

The varied effects on coverage expansion for different demographic groups merit special attention. Figure 10 shows the proportion of patients gaining insurance in 2013 and 2014 for four major age groups among men and women in the expansion states and non-expansion states. Again, the data describes patients that were uninsured for part of the period 2012-2014 and who visited providers in two of those three years.

For all four major demographic groups (men and women in the expansion states and non-expansion states) the proportion of patients gaining insurance is higher in every age group from 2013 to 2014. For example, 50.6 percent of women aged 18-25 in expansion states who did not have insurance in 2012 gained insurance in 2013, compared with 63.7 percent in 2014. The proportion gaining insurance rose for all 16 demographic groups shown in Figure 10. Men in the expansion states also showed substantially larger gains in 2014. For example the proportion of men aged 50-64 gaining insurance increased from 32.6 percent in 2013 to 56.0 percent in 2014.

The data also indicates an important shift between 2013 and 2014 in the pattern of gaining insurance across age groups. The four major demographic groups in 2013 show lower rates of gaining insurance among the older age groups. The declining rates of gaining insurance at older ages was especially pronounced among women. For example, in 2013 36.4 percent of the women aged 18-25 in the non-expansion states gained insurance after being uninsured in 2012, while only 26.5 percent of the women aged 50-64 did so.

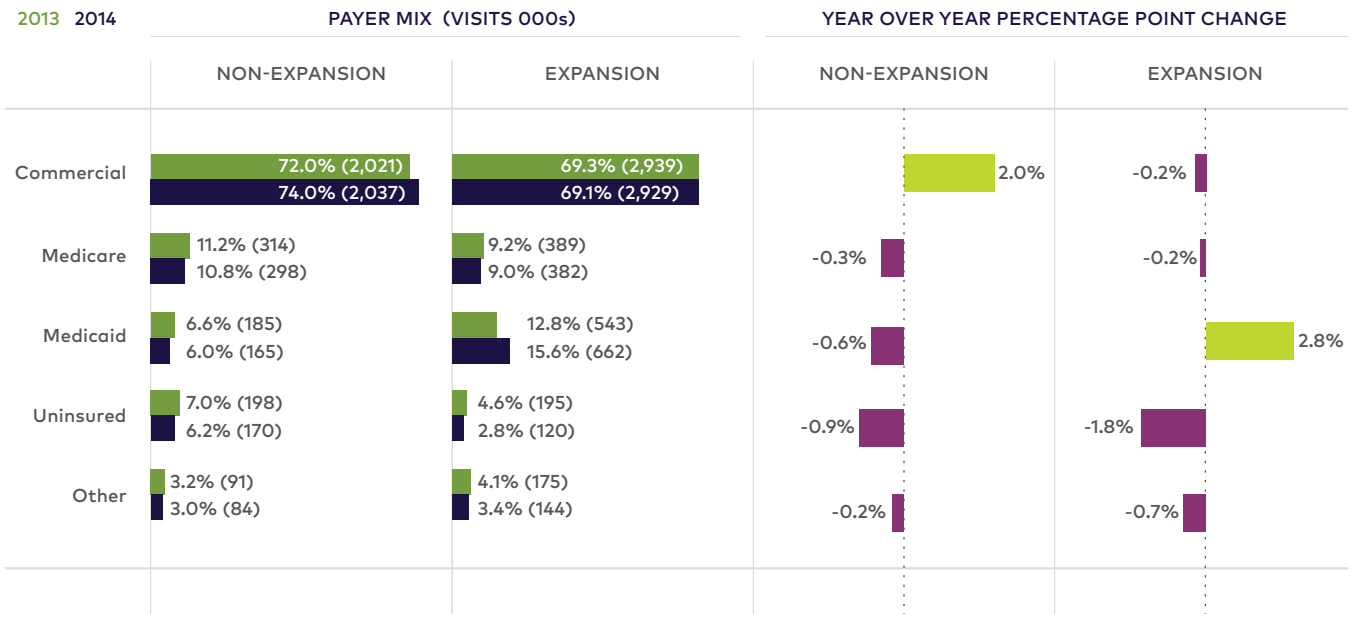
Looking at the same data for 2014 shows a much different pattern. The rates at which people gained insurance no longer seem to vary consistently by age: the rates are nearly flat across the age groups for women in the expansion states and fall only moderately for women in the non-expansion states. Among men, the rates across the age groups in 2014 appear to rise moderately. It appears that the ACA is changing the lower rates of insurance coverage acquisition among older adults.

Changing Payer Mix

7. Coverage expansion has changed the payer mix in physician practices, boosting the proportion of Medicaid patients in the Medicaid-expansion states and increasing the share of commercially-insured patients in the non-expansion states.

In addition to the reductions in visits by uninsured patients, providers are also seeing significant shifts in the proportion of commercial and Medicaid patients that they see. Figure 11 summarizes payer mix

Figure 11. Payer Mix for Adult (18-64) PCP Visits
Medicaid Expansion States vs Non-Expansion States



Sample: Over 14 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

changes from 2013 to 2014 for PCPs providing over 14 million office visits. The changes in the expansion states differ markedly from those in the non-expansion states. Notably, PCPs in the expansion states are seeing a higher proportion of visits by Medicaid patients, reflecting the expanded number of Medicaid beneficiaries. PCPs in the non-expansion states show a higher proportion of visits from patients with commercial insurance and lower proportions of patients with other insurance or no insurance.

The number of Medicaid-covered visits in our sample in the expansion states increased from 12.8 percent of visits to PCPs to 15.6 percent (from 543,000 to 662,000 visits). In the non-expansion states, the major change was an increase in the proportion of commercially insured patient visits, which increased from 72 percent to 74 percent. The providers in these non-expansion states are likely seeing more patients newly insured through the health care marketplaces.

8. Although Medicaid enrollment increased in non-expansion states, Medicaid patient volumes in these states are actually declining.

Providers in non-expansion states are seeing proportionally fewer Medicaid patients. The proportion of provider visits made by Medicaid patients in the non-expansion states actually declined from 6.6 percent to 6.0 percent between 2013 and 2014 (see Figure 11). This decline is noteworthy, since the number of Medicaid patients increased even in the non-expansion states by an estimated 1.5 million in 2014, as many people realized they were eligible for Medicaid during a period of intensive media attention on health insurance.[9] We speculate that providers in non-expansion states may have prioritized seeing new patients with commercial coverage obtained through the exchanges over patients who gained coverage through Medicaid.

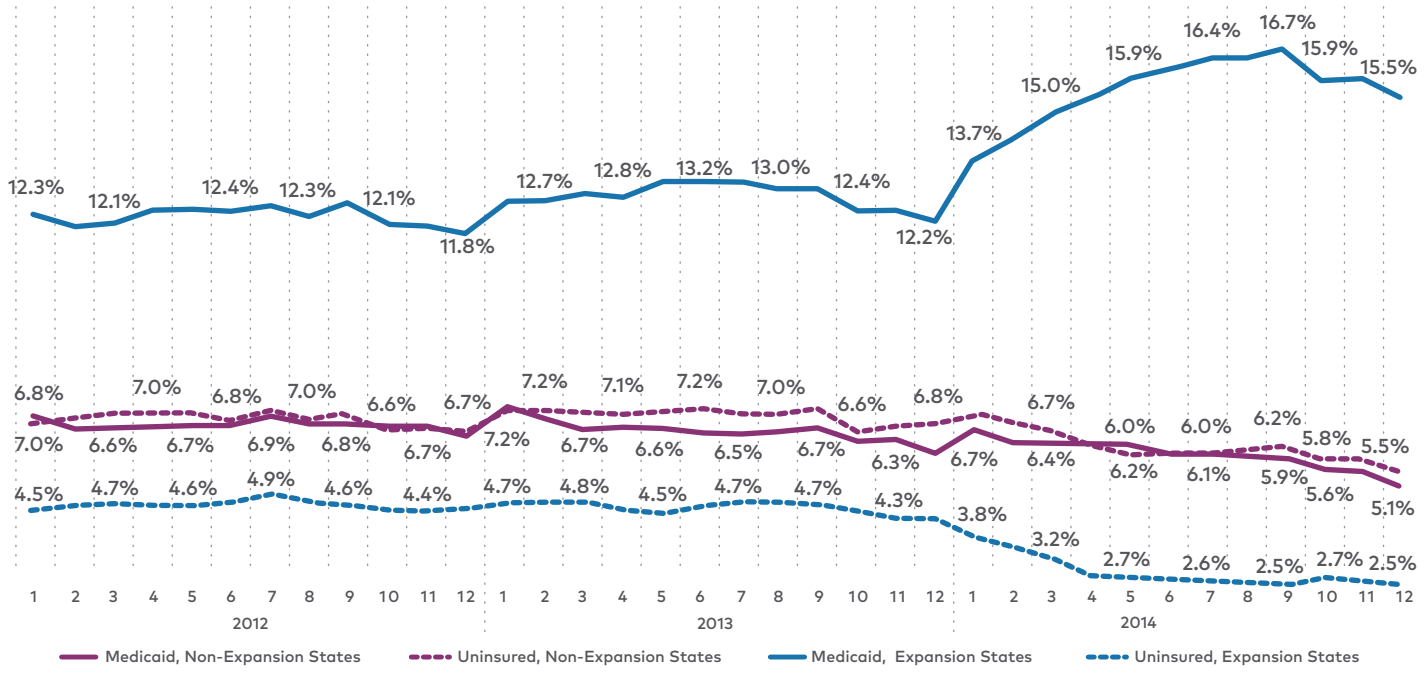
9. The increase in Medicaid utilization in expansion states occurred very quickly, with a substantial uptick occurring within three months of ACA implementation.

The timing of payer-mix changes, shown in Figure 12, provides useful information about the speed at which the ACA brought changes to physician offices. In Medicaid-expansion states, Medicaid case mix increased remarkably quickly. Medicaid visits rose from 12.2 percent percent of all primary care visits in December 2013 to 15 percent in March 2014. Medicaid mix peaked at 16.7 percent of all visits in September before declining to 15.5 percent in December. (Although the decline in 2014 was somewhat more pronounced, Medicaid has declined as a proportion of all visits in the fourth quarter in each of the last three years in both expansion and non-expansion states.)

[9] Kaiser Family Foundation, Total Monthly Medicaid and CHIP Enrollment, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/#, accessed 9 February 2015.

Figure 12. Proportion of Adult (18-64) PCP Visits From Medicaid and Uninsured Patients

Medicaid Expansion States vs Non-Expansion States



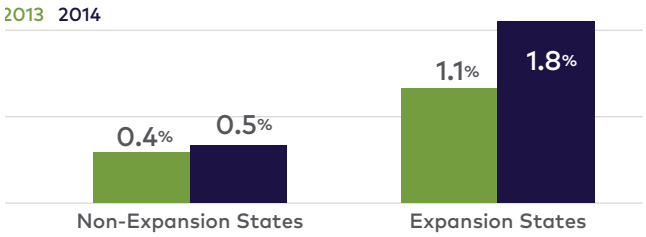
Sample: Over 21 million visits to practices active on the athenahealth network before 2011
Source: athenaResearch

10. A small but increasing number of patients switched from commercial insurance coverage to Medicaid.

As Medicaid eligibility criteria are loosened in expansion states, Medicaid may be an increasingly attractive option for low-income workers. An employed individual who qualifies for Medicaid may find it more attractive than commercial insurance, which typically involves employee premium contribution, and significant copays and deductibles. Medicaid programs do not require premium contributions, and out-of-pocket obligations are very small or completely eliminated.

Figure 13 shows Medicaid is indeed attracting a small but significantly increased share of commercially insured patients. In the non-expansion states, only 0.4 percent shifted to Medicaid in 2013 and 0.5 percent in 2014. In contrast, a larger and faster-growing share of patients shifted from commercial to Medicaid coverage in expansion states. In these states, 1.1 percent of commercially insured individuals switched to Medicaid in 2013 and 1.8 percent in 2014.

Figure 13. Medicaid Patients as a Proportion of Commercially Insured in Prior Year



*18-64 Years Old
Sample: Approximately 1.5M patients of practices active on the athenahealth network before 2011
Source: athenaResearch

Ongoing ACA implementation will surely bring more changes to American health care in 2015. ACAView will continue to track changes in the number and health status of patients in 2015. We will also continue tracking the number of uninsured patients and the shares of patients with different payers.

Our plans for 2015, however, are not yet set in stone, and we welcome your input. What aspects of change should ACAView focus on? We invite readers to share their thoughts on how ACAView can be most useful.

Please email your thoughts on our current work and suggestions for future efforts to Josh Gray at **jogray@athenahealth.com**.

Appendix

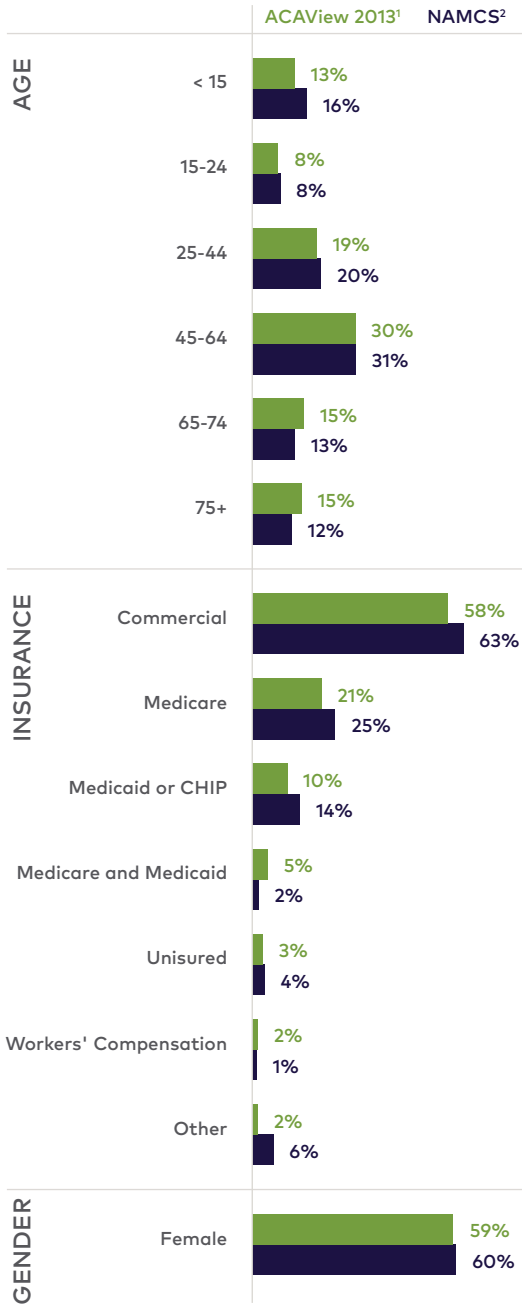
Medicaid Expansion Status, 2014

Expansion	Non-Expansion
Arizona	Alabama
Arkansas	Alaska
California	Florida
Colorado	Georgia
Connecticut	Idaho
Delaware	Indiana
District of Columbia	Kansas
Hawaii	Louisiana
Illinois	Maine
Iowa	Mississippi
Kentucky	Missouri
Maryland	Montana
Massachusetts	Nebraska
Michigan	New Hampshire
Minnesota	North Carolina
Nevada	Oklahoma
New Jersey	Pennsylvania
New Mexico	South Carolina
New York	South Dakota
North Dakota	Tennessee
Ohio	Texas
Oregon	Utah
Rhode Island	Virginia
Vermont	Wisconsin
Washington	Wyoming
West Virginia	

Athenahealth ACAView Practice Cohort vs. NAMCS

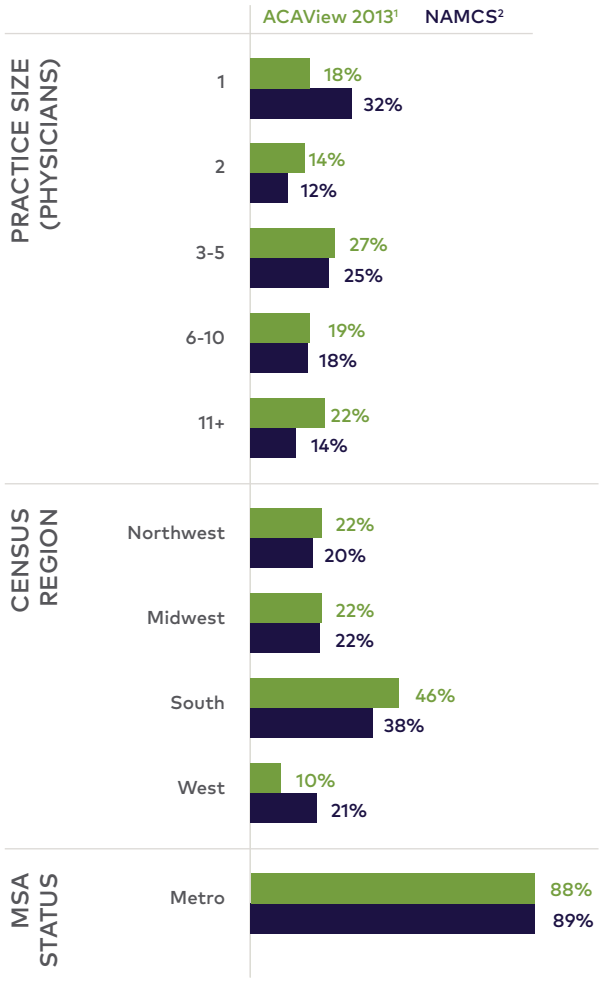
The following practice visit characteristics compare ACAView's sample with data from the National Ambulatory Medical Care Survey (NAMCS). NAMCS is administered by the Centers for Disease Control and Prevention and provides an authoritative statistical profile of ambulatory medical care in the United States. ACAView's sample is based on 30 million ambulatory visits to practices who have been on athenahealth's network since January 1, 2011. Given the similarity in distribution of patient demographics and ACAView's robust representation across provider demographic segments, we believe our data provides a reliable reflection of community ambulatory practice patterns in the United States.

Office Visit Characteristics: Patient Demographics Athenahealth ACAView Practices vs. NAMCS



1: 30 million visits to practices active on the athenahealth network before 2011
2. http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf
Source: athenaResearch

Office Visit Characteristics: Provider Demographics Athenahealth ACAView Practices vs. NAMCS



1: 30 million visits to practices active on the athenahealth network before 2011
2. http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf
Source: athenaResearch

Acknowledgments

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ACAView

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CALIFORNIA

HEALTH CARE ALMANAC

California HealthCare Foundation

Survey Says: Californians' Perspectives on Health Care

MARCH 2015

Introduction

While there is good news in terms of coverage, too many Californians struggle to find access to health care. This is particularly true of those with the greatest need: One in two adults who report they are in fair or poor health delayed care in the past 12 months due to cost.

Survey Says: Californians' Perspectives on Health Care describes findings from a 2014 poll of California adults, which asked about health insurance coverage, access to care, cost and affordability, use of health information technology, and data on care quality.

KEY FINDINGS INCLUDE:

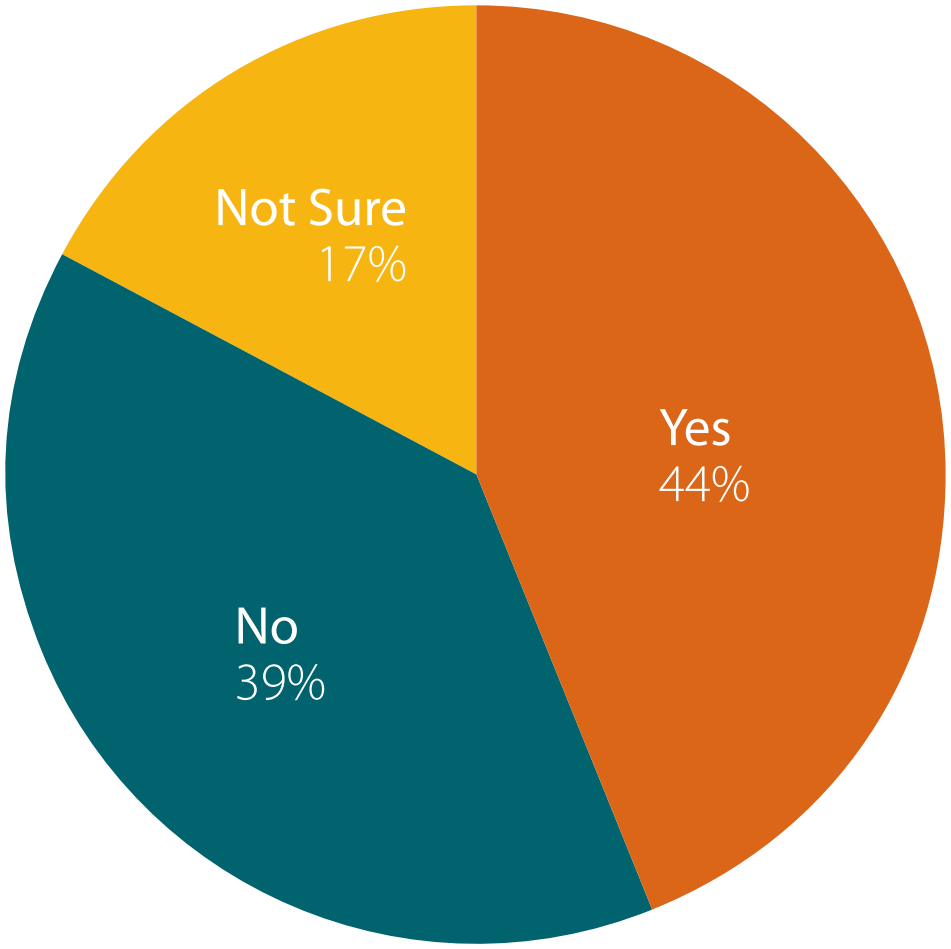
- More than half of adults with the greatest need — those reporting fair or poor health — delayed care in the past 12 months due to cost.
- Finding health care providers who accept Medi-Cal was challenging. One in five enrollees (21%) reported difficulty finding a primary care physician who accepted Medi-Cal.
- Among adults who needed to see a specialist, those in fair or poor health were more likely to have difficulty getting an appointment than those in excellent or very good health (43% vs. 17%).
- In 2014, 40% of adults delayed care in the previous 12 months due to costs.

CONTENTS

Health Insurance Deductibles
California, 2014

Does your health insurance plan have a deductible?

Base: Insured adults (n=1,317)



Note: A deductible is the amount the insured pays for health care services before the health insurance begins to pay.

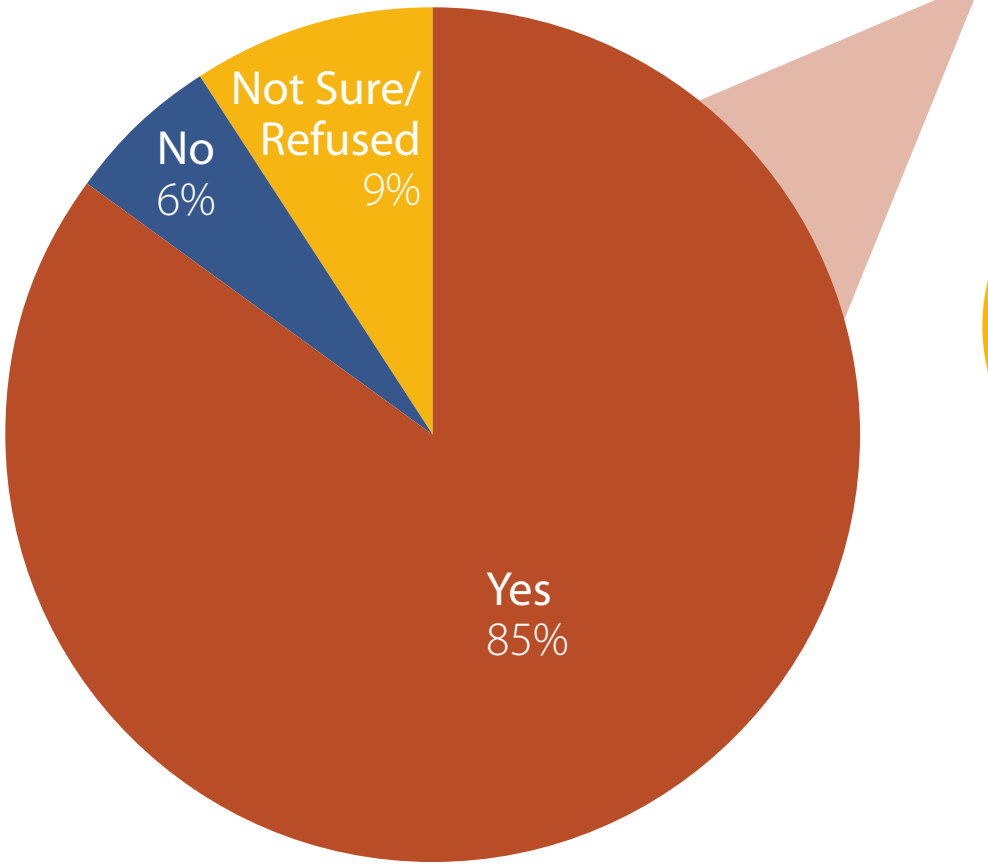
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Forty-four percent of insured Californians said their plan had a deductible. About one in six did not know if they had a deductible.

Plan Coverage of Prescription Medication and Copayments
California, 2014

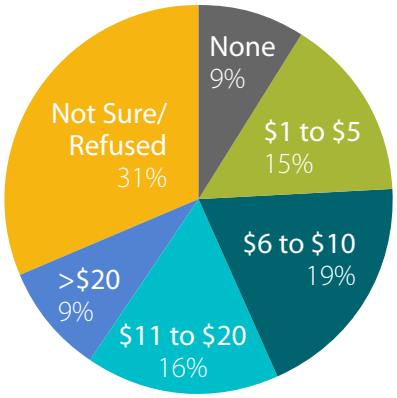
Does your health insurance plan cover prescription medications?

Base: Insured adults (n=1,317)



What is your typical copayment for a prescription?

Base: Insured adults with Rx coverage (n=1,135)



Note: Segments may not add to 100% due to rounding.

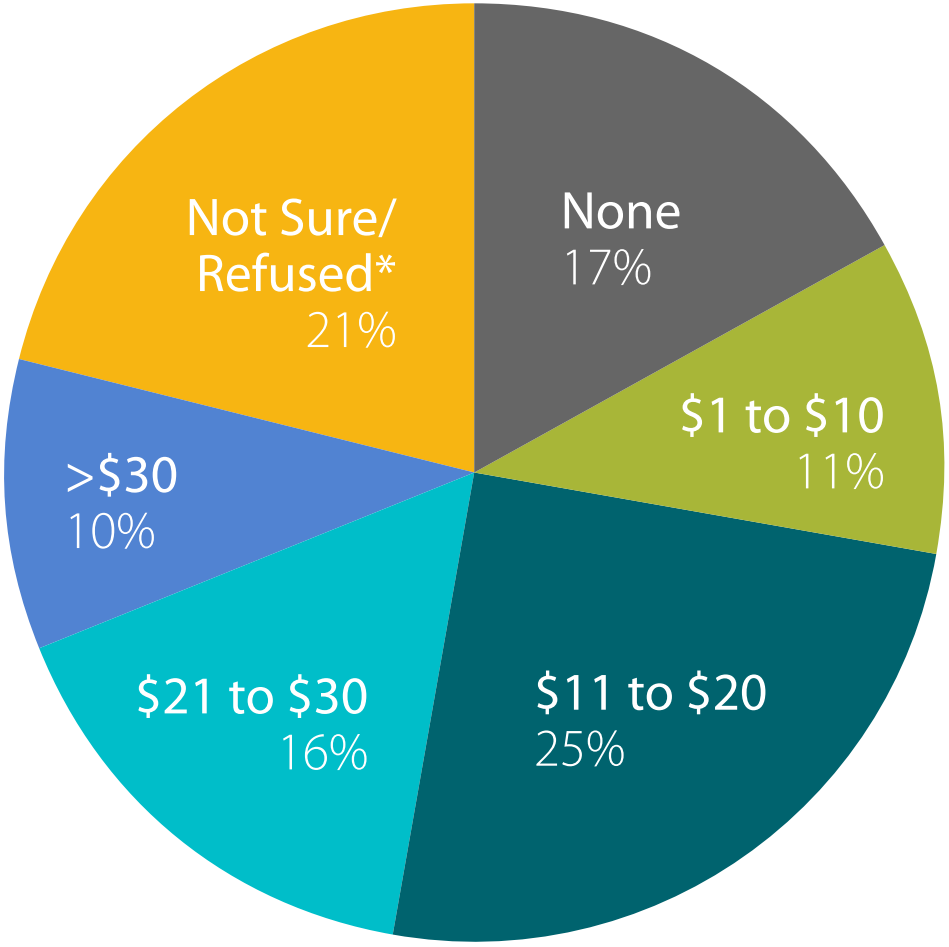
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Most insured adults (85%) said their plan covered prescription medications. Nearly one-third (31%) of those with this coverage did not know their copayment amount.

Doctor Visit Copayments
California, 2014

What is your typical copayment for a regular doctor visit?

Base: Insured adults with doctor visit copay (n=1,317)



*Includes 20% of respondents reporting "not sure" and 1% who refused to answer.

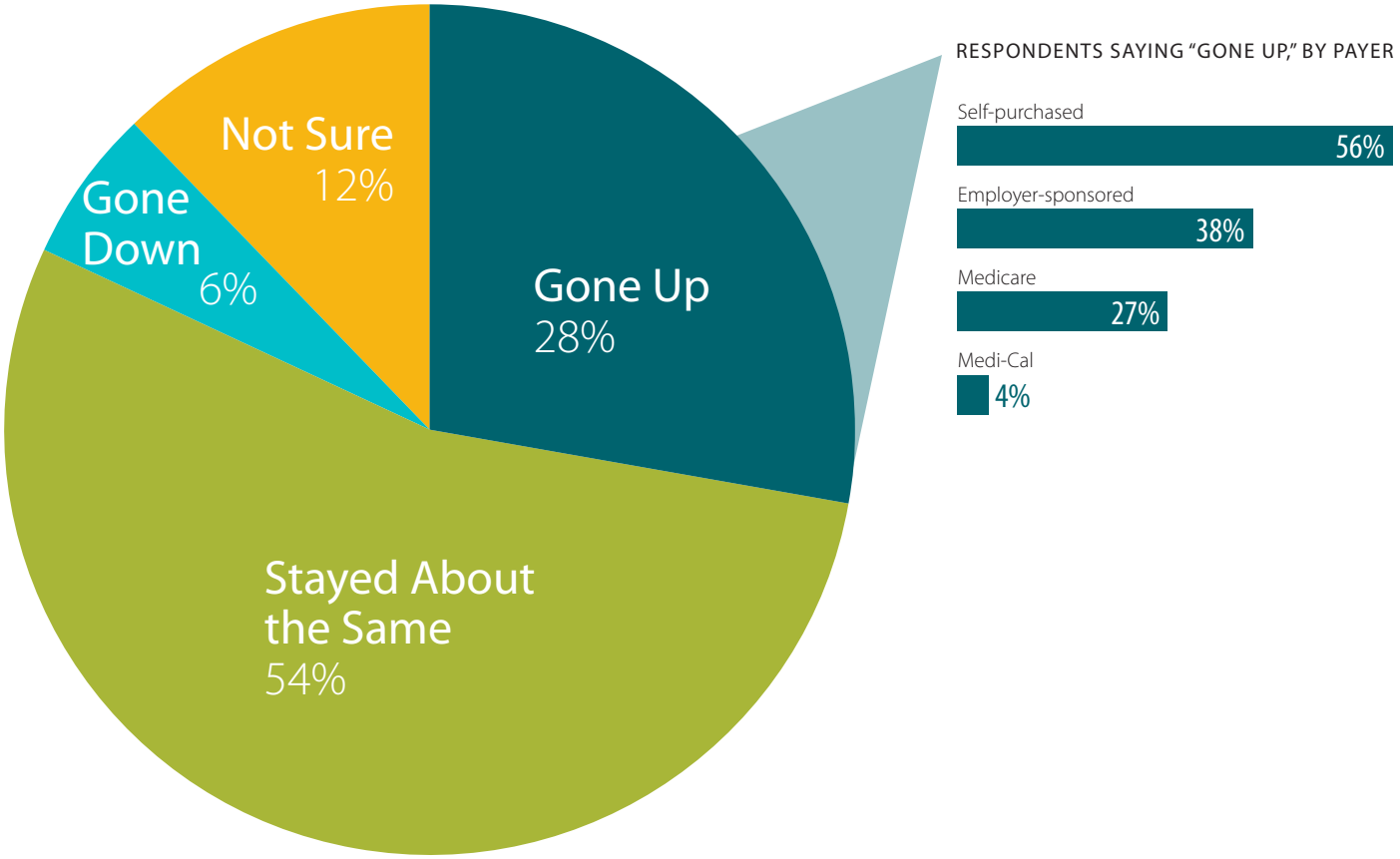
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

One in four insured adults said their copayment was more than $20 for doctor visits. One in five was unsure of their copayment.

Health Insurance Costs, Overall and by Payer
California, 2014

In the past 12 months, have your health insurance costs such as premiums, copayments, or deductibles…

Base: Insured adults (n=1,317)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

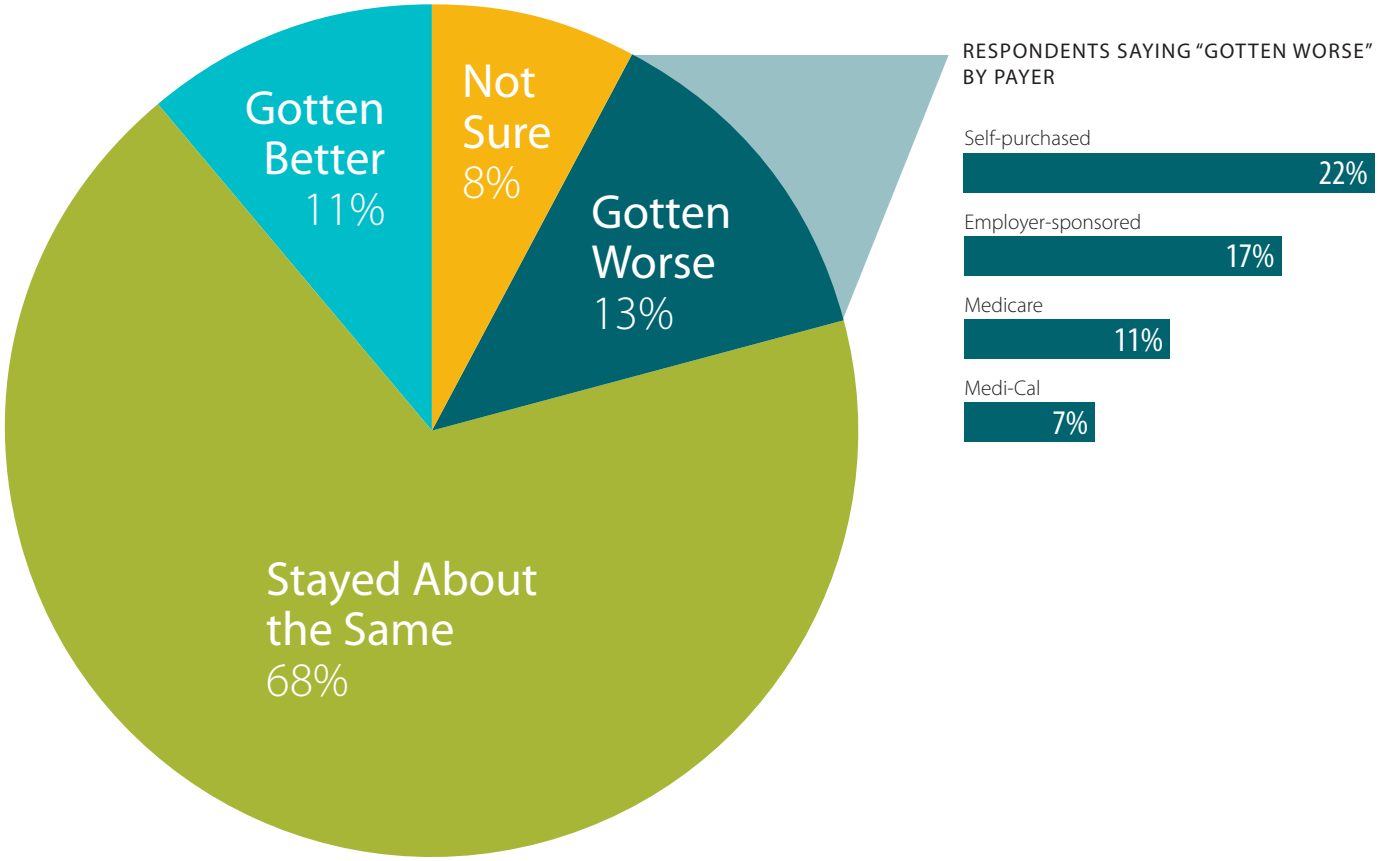
More than one-quarter (28%) of insured adults in California said their insurance costs had gone up in the past year.

Californians who purchased private coverage on their own were more likely than those with employer-sponsored or public insurance to report these increases.

Quality of Plan Benefits Over Past Year, Overall and by Payer
California, 2014

In the past 12 months, have your health insurance benefits…

Base: Insured adults (n=1,317)



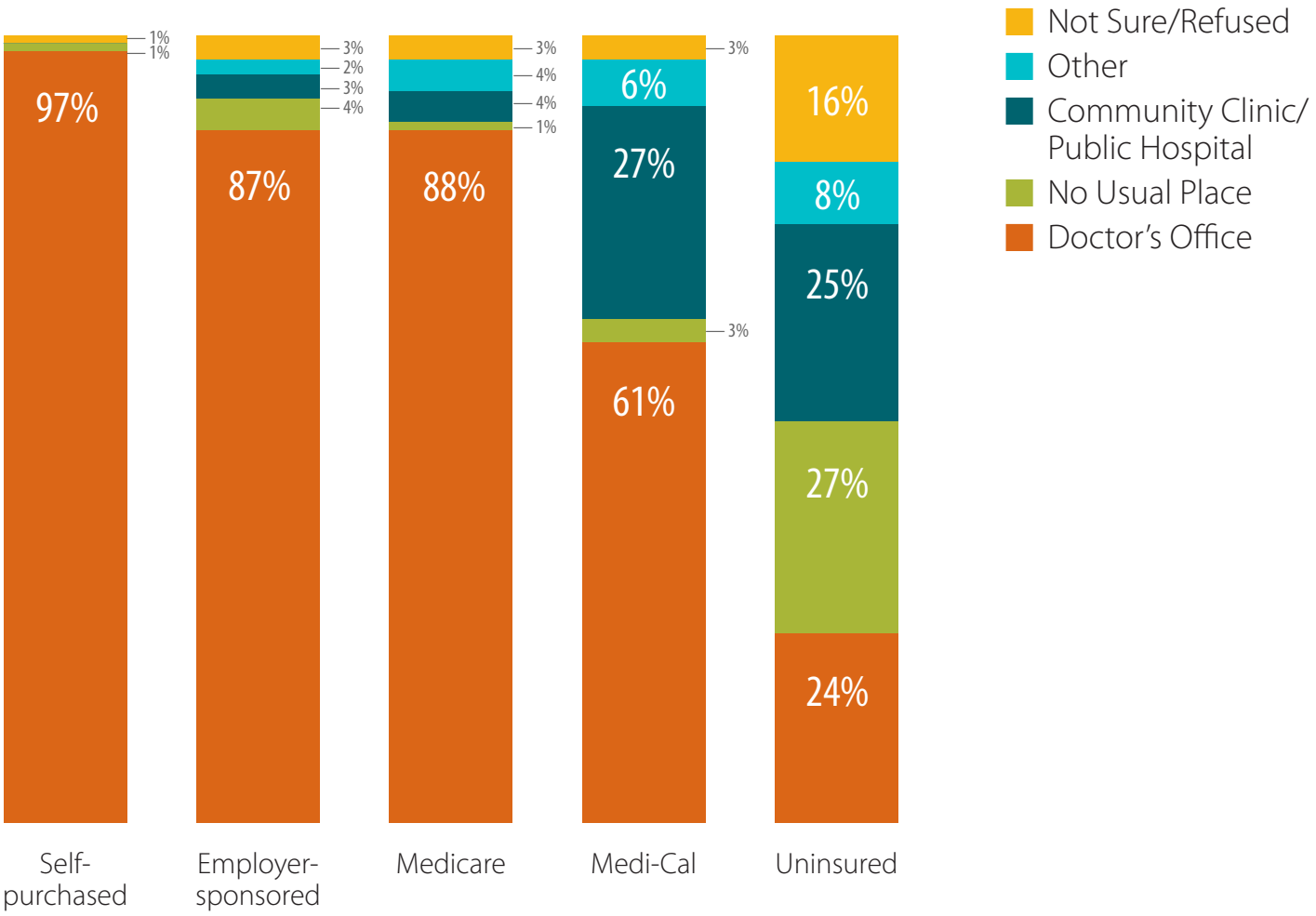
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Most insured Californians (68%) reported that their plan benefits stayed about the same over the past year. Thirteen percent said their benefits worsened. More people with self-purchased plans reported worsening benefits than did those with employer-based or public insurance.

Source of Routine Medical Care, by Coverage Type
California, 2014

Where do you usually go when you need routine medical care, like a physical or a check-up?

Base: All adults (n=1,548)



Notes: Other includes emergency room, walk-in clinic, and somewhere else. Segments may not add to 100% due to rounding.

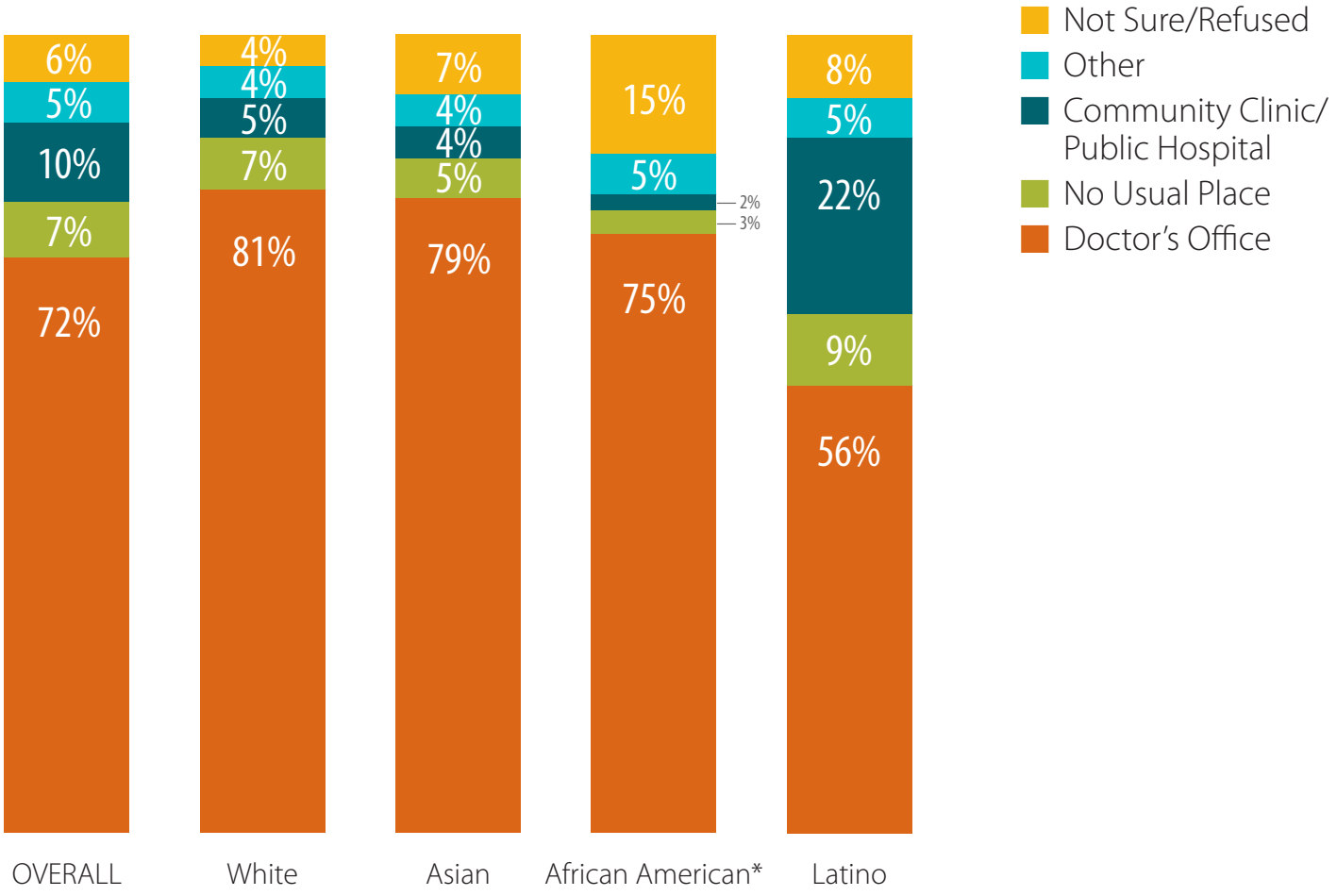
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

More than one-quarter of uninsured adults (27%) said they did not have a usual place to go for routine care. A similar proportion (25%) said that they got routine care at a community clinic or public hospital. Medi-Cal recipients and the uninsured were least likely to get care in a doctor's office.

Source of Routine Medical Care, by Race/Ethnicity
California, 2014

Where do you usually go when you need routine medical care, like a physical or a check-up?

Base: All adults (n=1,548)



*The sample size among African Americans was small (n=99).

Note: Segments may not add to 100% due to rounding.

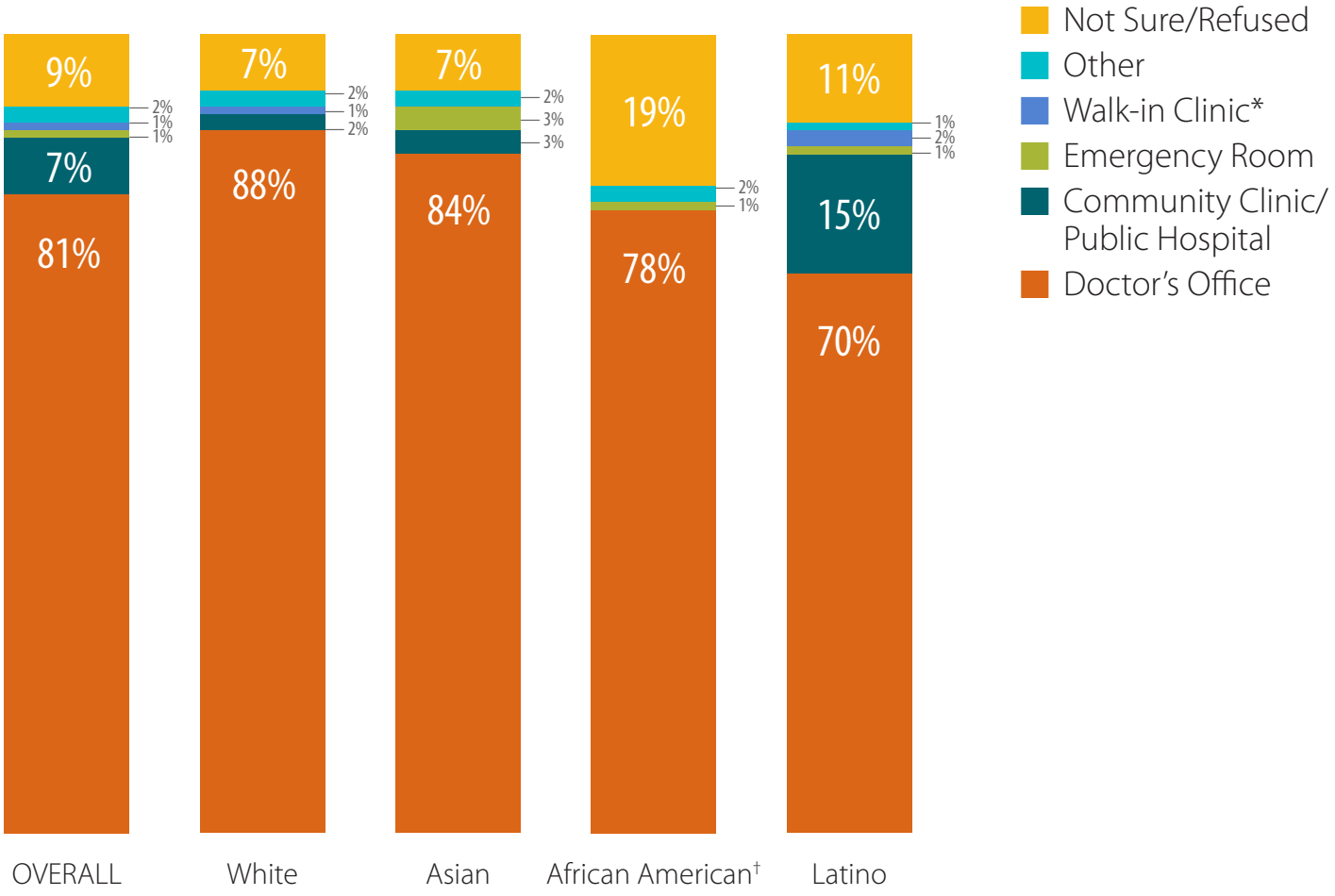
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Latinos were much more likely than other ethnic groups to receive routine care at a community clinic and least likely to receive care at a doctor's office.

Desired Source of Routine Medical Care, by Race/Ethnicity
California, 2014

If you could go anywhere for routine medical care, where would you want to go?

Base: All adults (n=1,548)



*Clinic at a store like Walmart or Rite Aid. See chart on page 11 for further breakdown of this care source.
†The sample size among African Americans was small (n=99).
Note: Segments may not add to 100% due to rounding.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

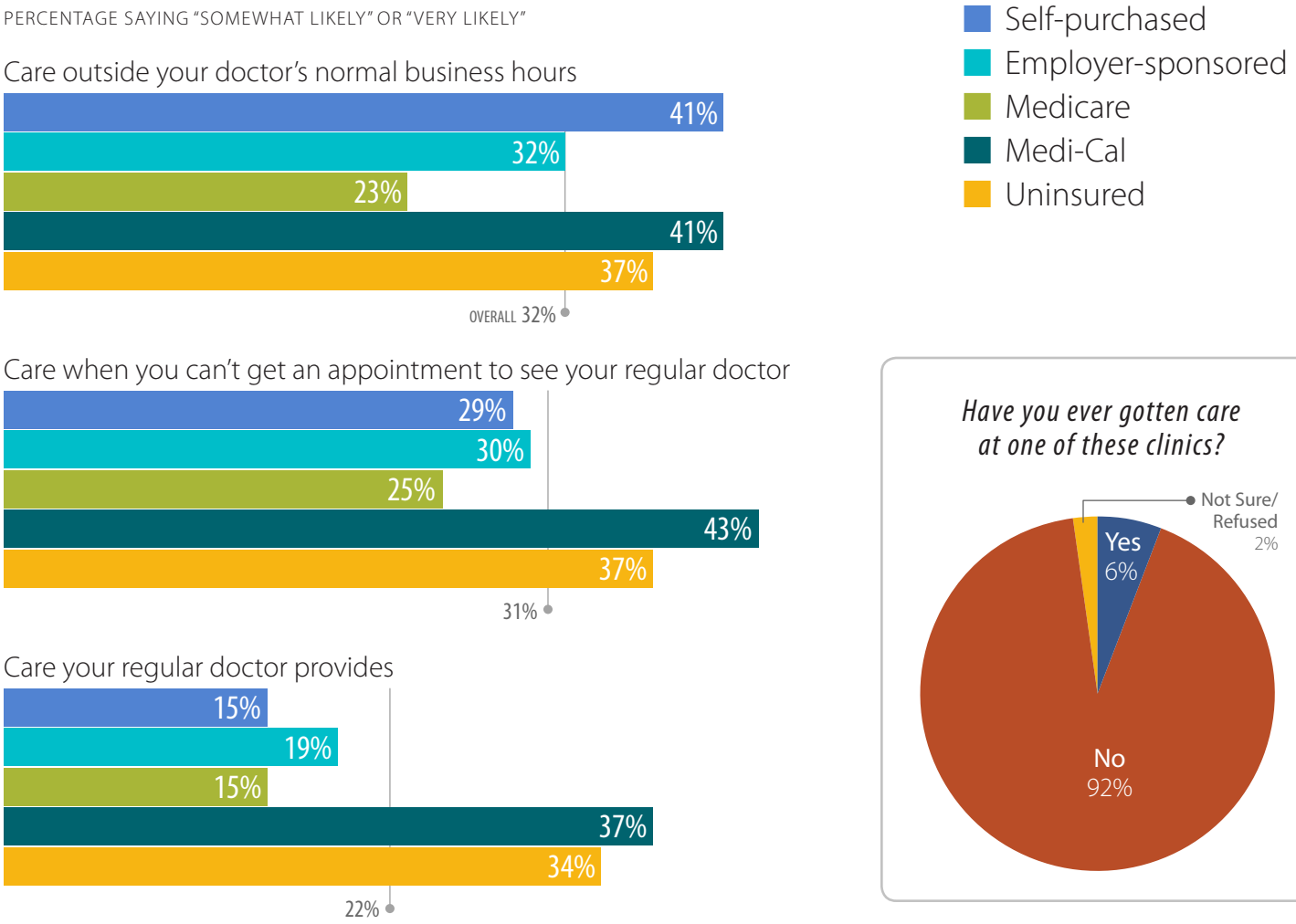
Most Californians reported a preference to get routine care at a doctor's office (81%). Latinos were more likely than other ethnic groups to prefer care from a community clinic or hospital (15%).

Retail Clinics, Likelihood of Use, by Service Type, and Actual Use
California, 2014

Some stores like Walmart and Rite Aid now have walk-in clinics you can go to without an appointment. In the future, how likely would you be to use a clinic in a store for…

Base: All adults (n=1,548)

PERCENTAGE SAYING "SOMEWHAT LIKELY" OR "VERY LIKELY"



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Adults with Medicare were the least likely to say they would use retail clinics for care in the future.

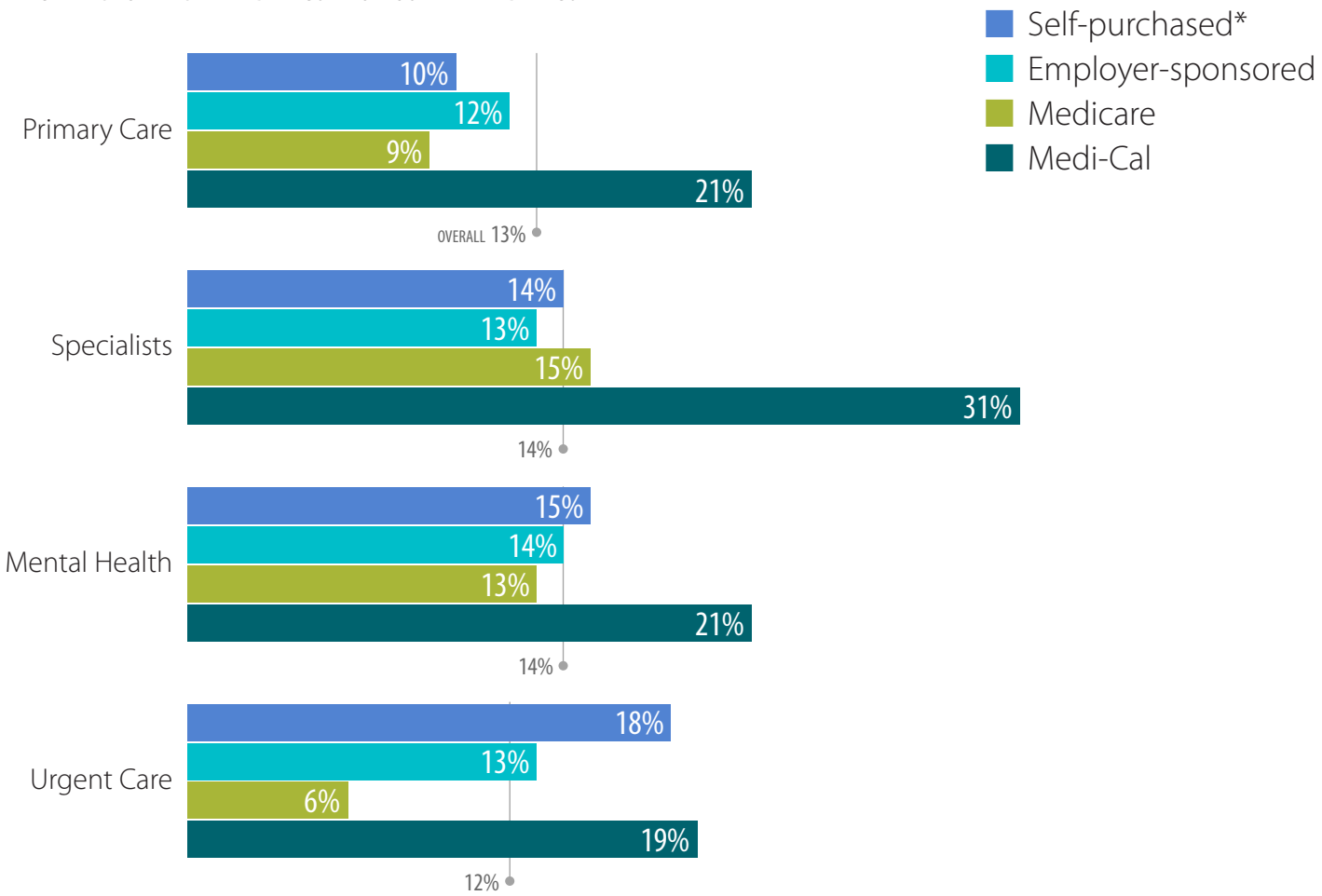
The vast majority of Californians (92%) reported they had never received care at a retail clinic.

Difficulty Accessing Health Care, by Coverage Type
California, 2014

How easy or difficult is it to find primary care or regular doctors nearby who accept your insurance?

Base: Insured adults (n=1,317)

PERCENTAGE SAYING "VERY DIFFICULT" OR "SOMEWHAT DIFFICULT"



*Small base for self-purchased (n=79).

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Adults with Medi-Cal were more likely to report difficulty in finding providers that accepted their insurance than were adults with other types of insurance.

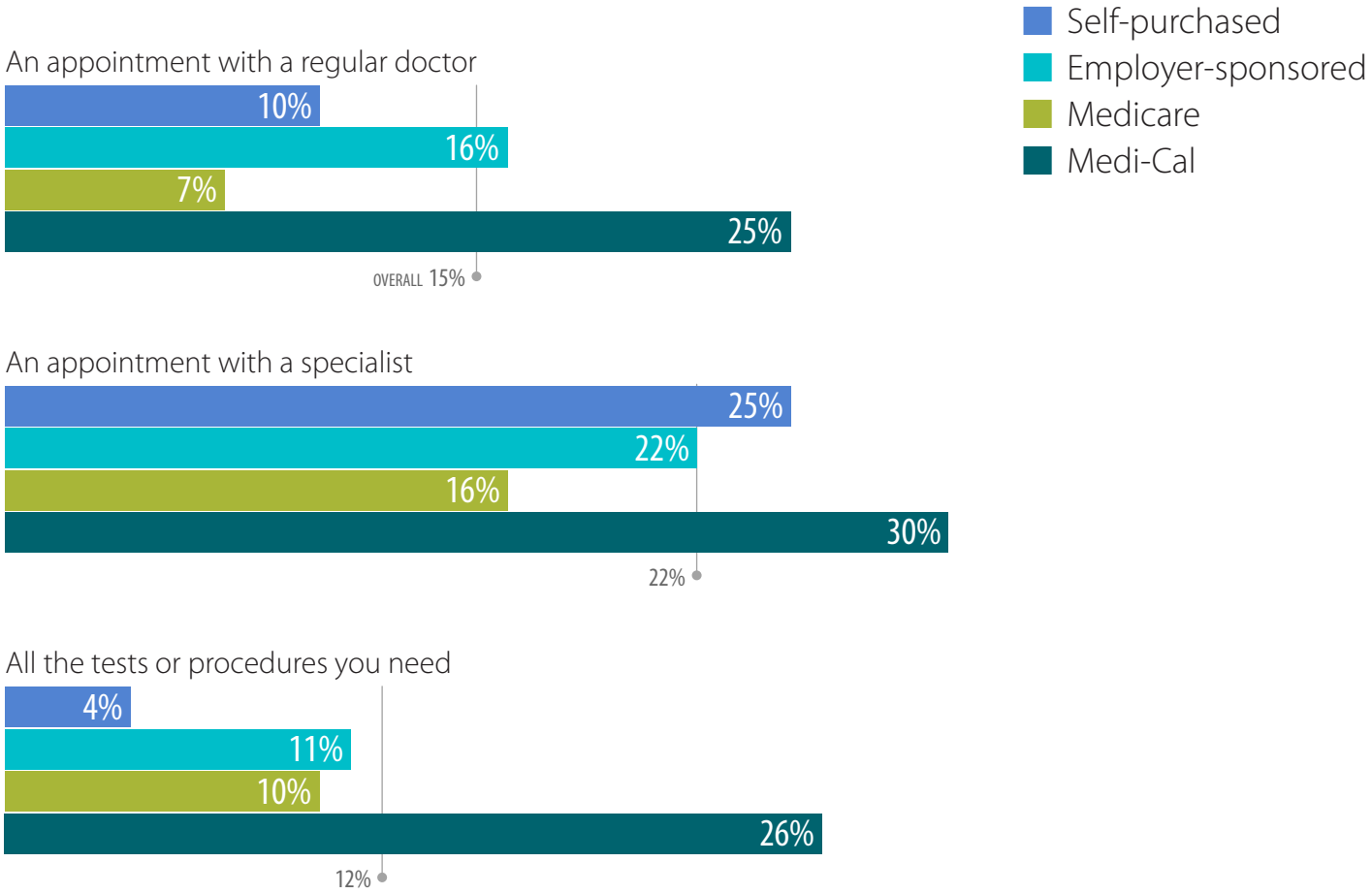
Difficulty Getting Health Care, by Coverage Type
California, 2014

Medi-Cal enrollees were more likely to report difficulty getting health care than those with other types of coverage.

In the past 12 months, have you had difficulty getting…

Base: Insured adults who have needed to see a doctor (n=1,099), a specialist (n=809), get tests and procedures (n=1,028)

PERCENTAGE SAYING "YES"

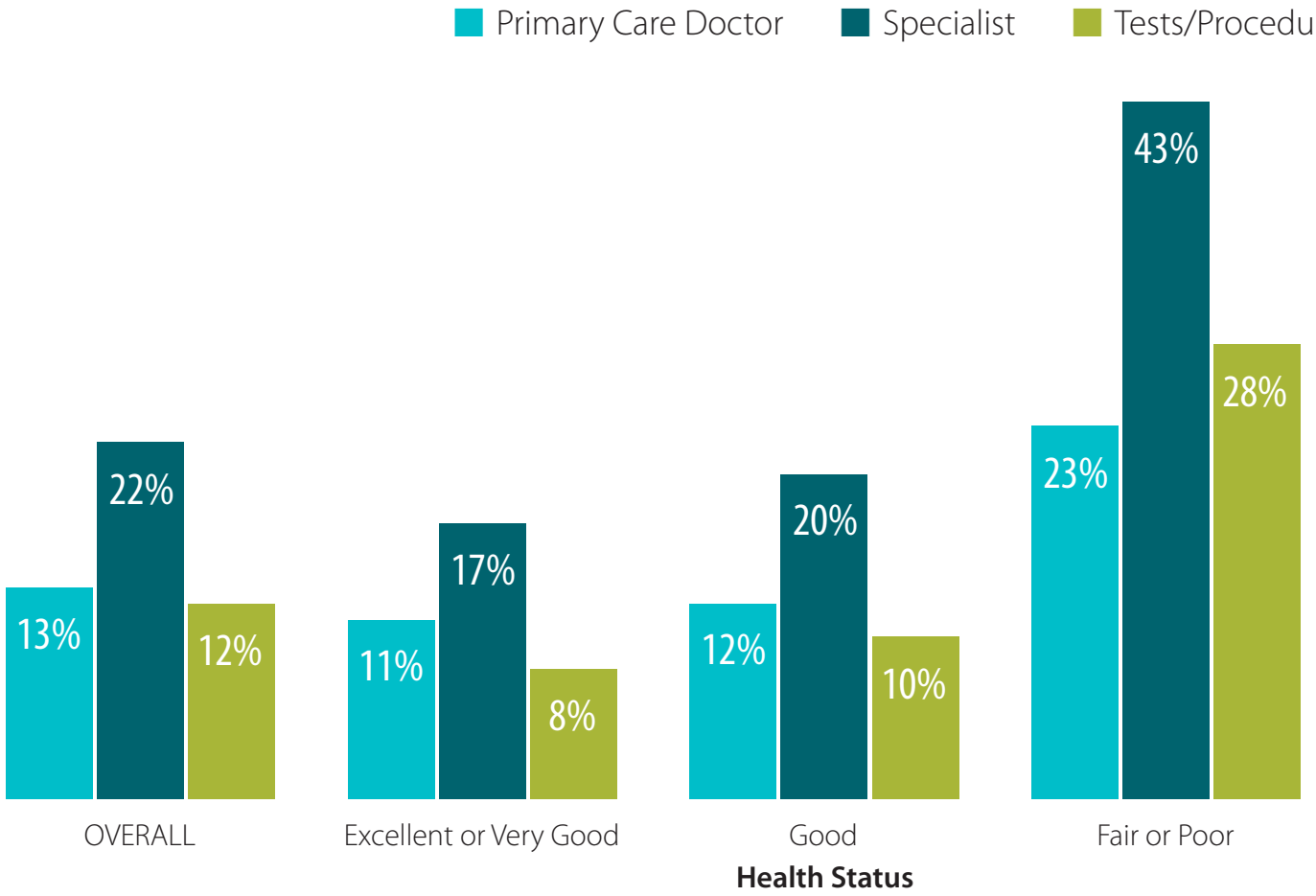


Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Difficulty Getting Health Care, by Self-Perceived Health Status
California, 2014

In the past 12 months, have you had difficulty getting an appointment with a doctor or specialist or getting all the tests or procedures you need?

Base: Insured adults who have needed a doctor (n=1,099), specialist (n=809), tests/procedures (n=1,028)



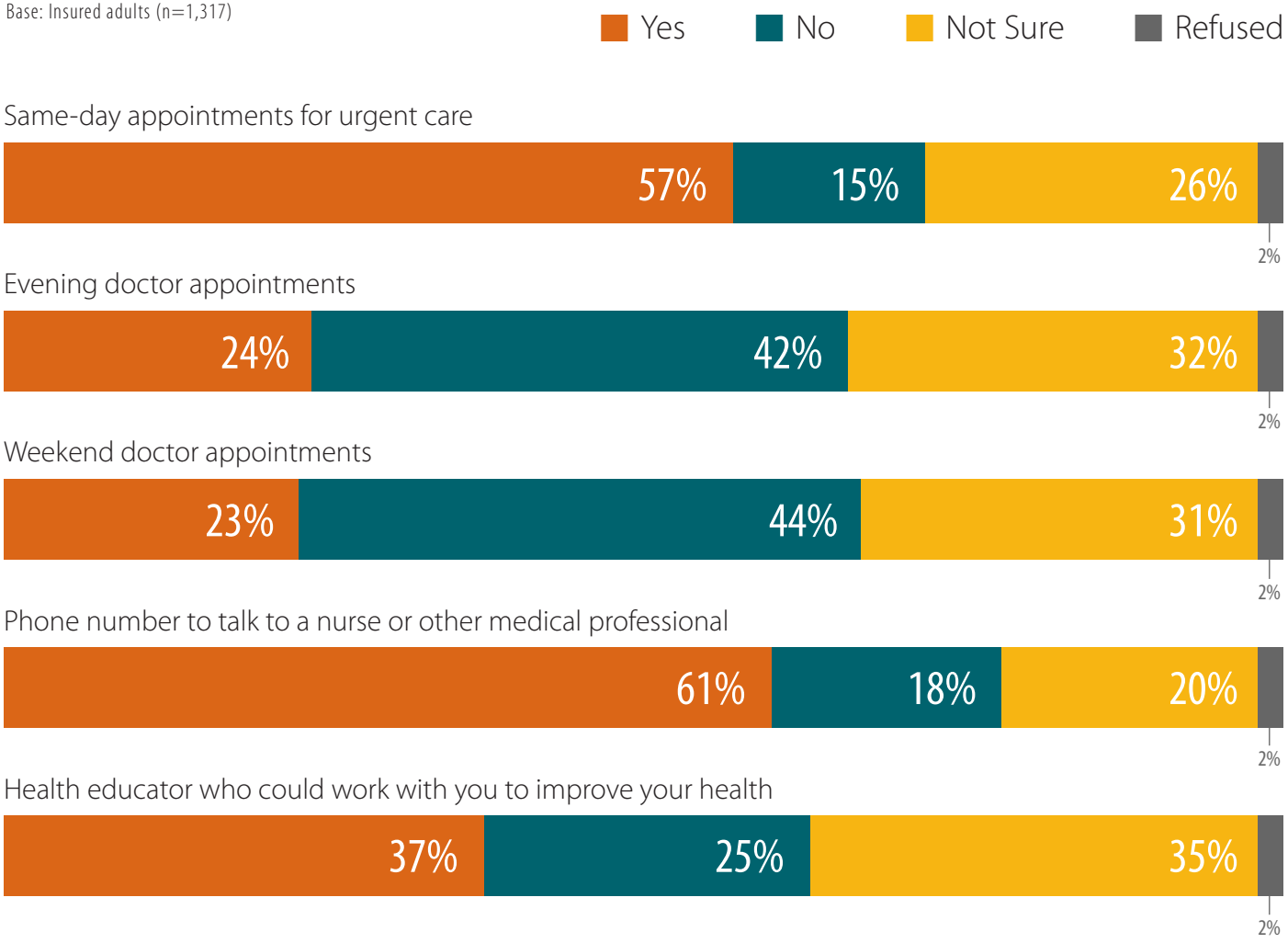
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Compared with those in good or excellent health, adults in fair or poor health were more likely to report having a difficult time getting an appointment with a primary care doctor or specialist when needed. The same was true among those who needed a test or procedure.

Access to Evening and Weekend Appointments
California, 2014

Do you currently have access to…

Base: Insured adults (n=1,317)



Note: Segments may not add to 100% due to rounding.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

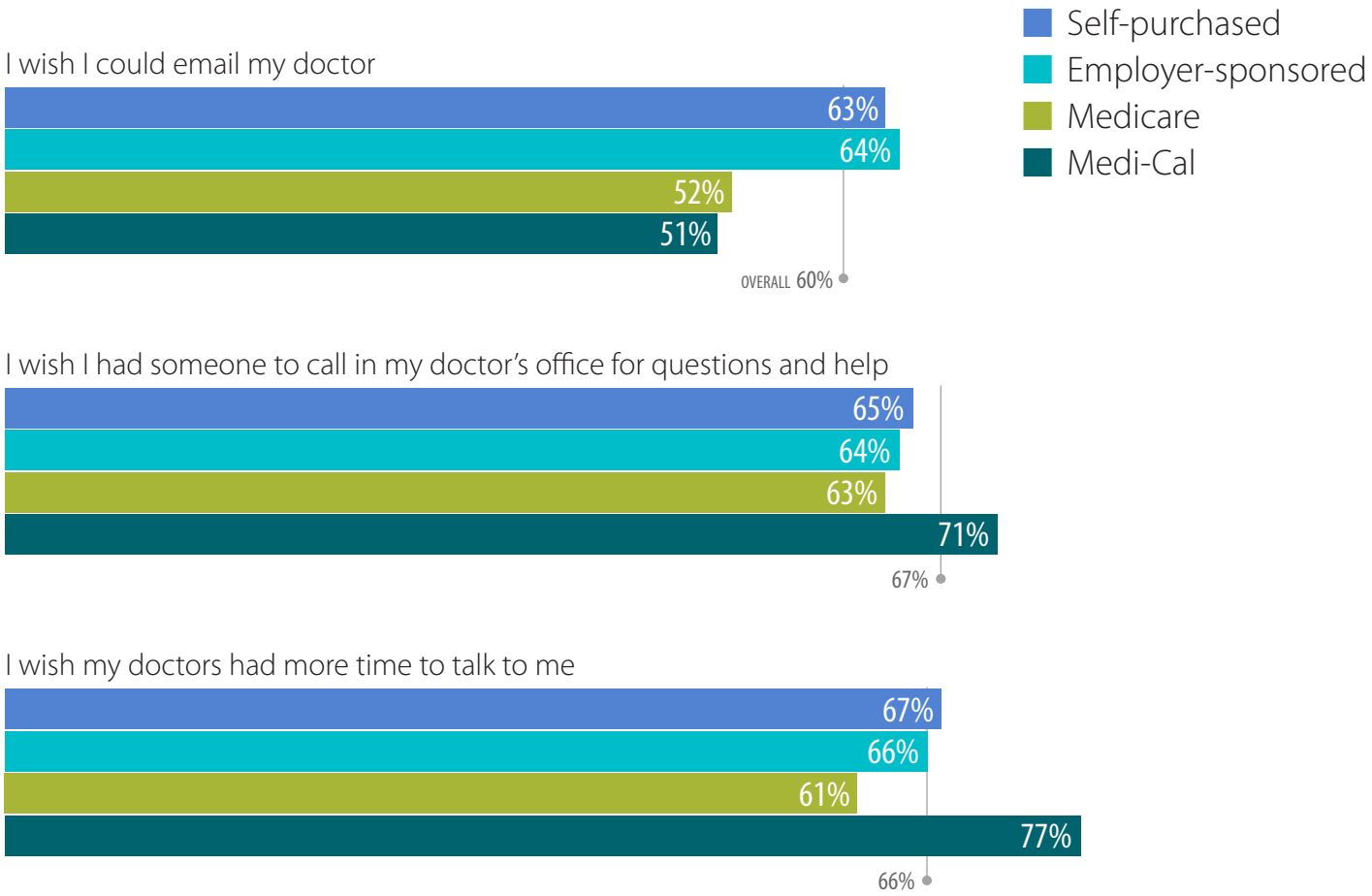
About 4 in 10 insured adults surveyed reported that they did not have access to appointments during evenings (42%) or weekends (44%). A larger proportion — about 6 in 10 — had access to same-day appointments for urgent care (57%) and a phone number to talk to a medical professional (61%).

Attitudes Toward Access-Related Issues, by Coverage Type
California, 2014

Do you agree or disagree with the following statements?

Base: All adults (n=1,548)

PERCENTAGE SAYING THEY "STRONGLY AGREED" OR "SOMEWHAT AGREED"



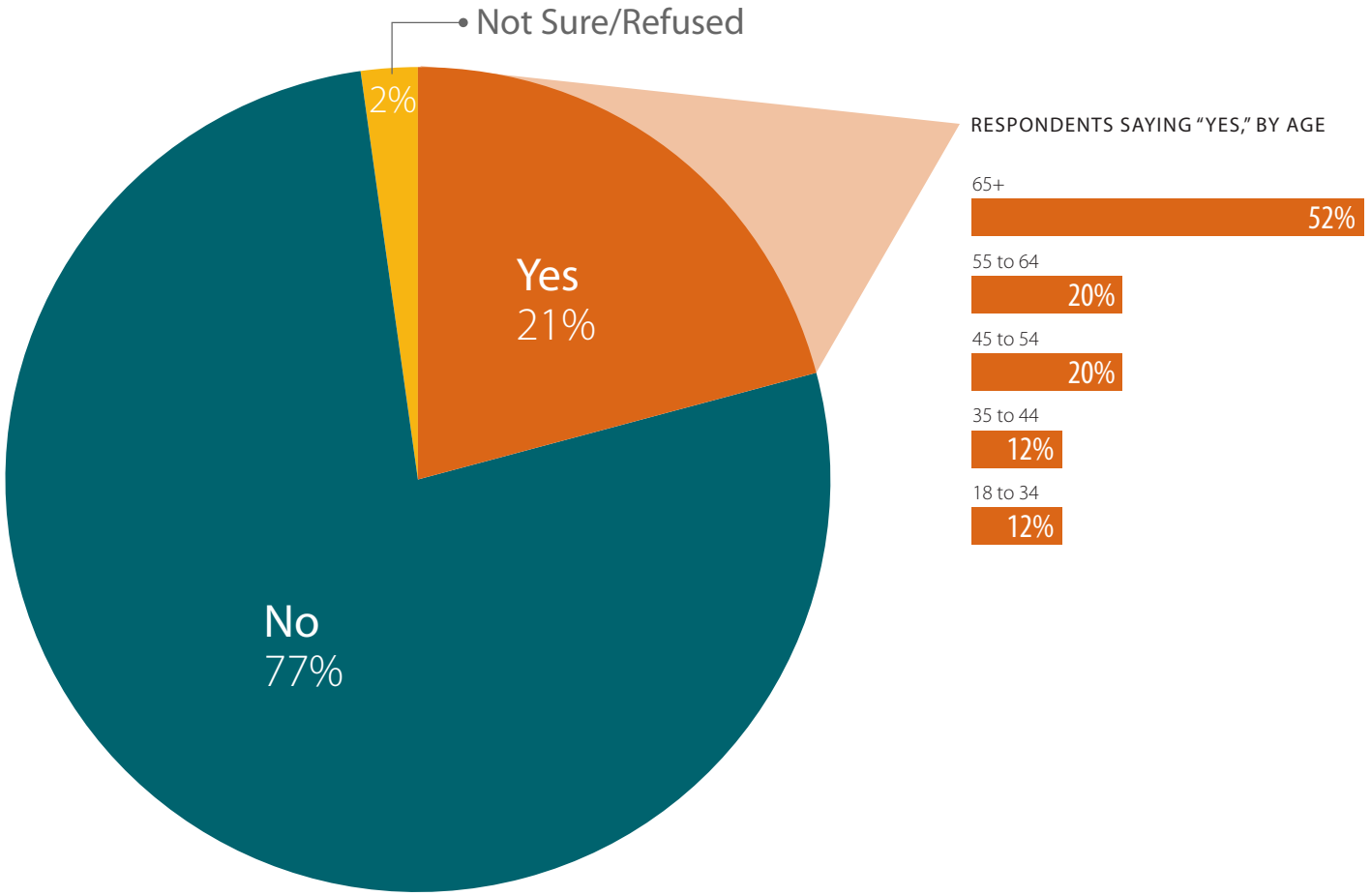
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Adults with Medi-Cal coverage were more likely than those with other forms of insurance to desire more time to talk with their doctors or other health care professionals who could answer questions and provide help.

Discussed Care Preferences with Doctor, Overall and by Age
California, 2014

Has your doctor ever talked with you about what you would want in case you were unable to make health care decisions for yourself? This could be things like whether you would want life support, who you would want to make decisions for you, or other wishes.

Base: All adults (n=1,548)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

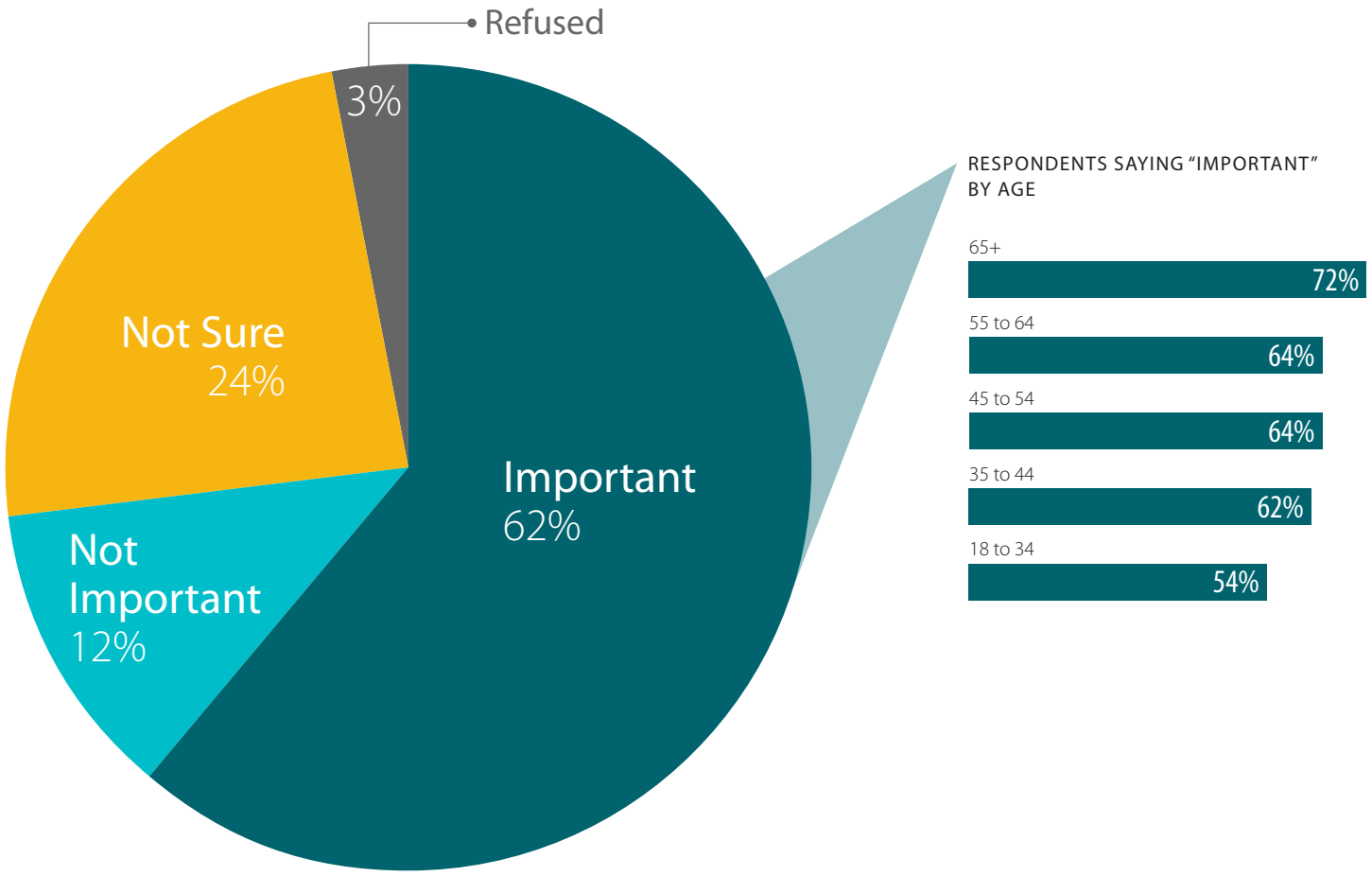
Many adults — including about half of those 65 and older — had not discussed health care wishes with their doctor.

Attitudes on Care Preference Conversations with Doctors

Overall and by Age, California, 2014

Do you think discussing health care preferences with your doctor is…

Base: All adults (n=1,548)



Note: Segments do not add to 100% due to rounding.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

The majority of adults overall (62%) said they thought it was important to have discussions about health care preferences with their doctors.

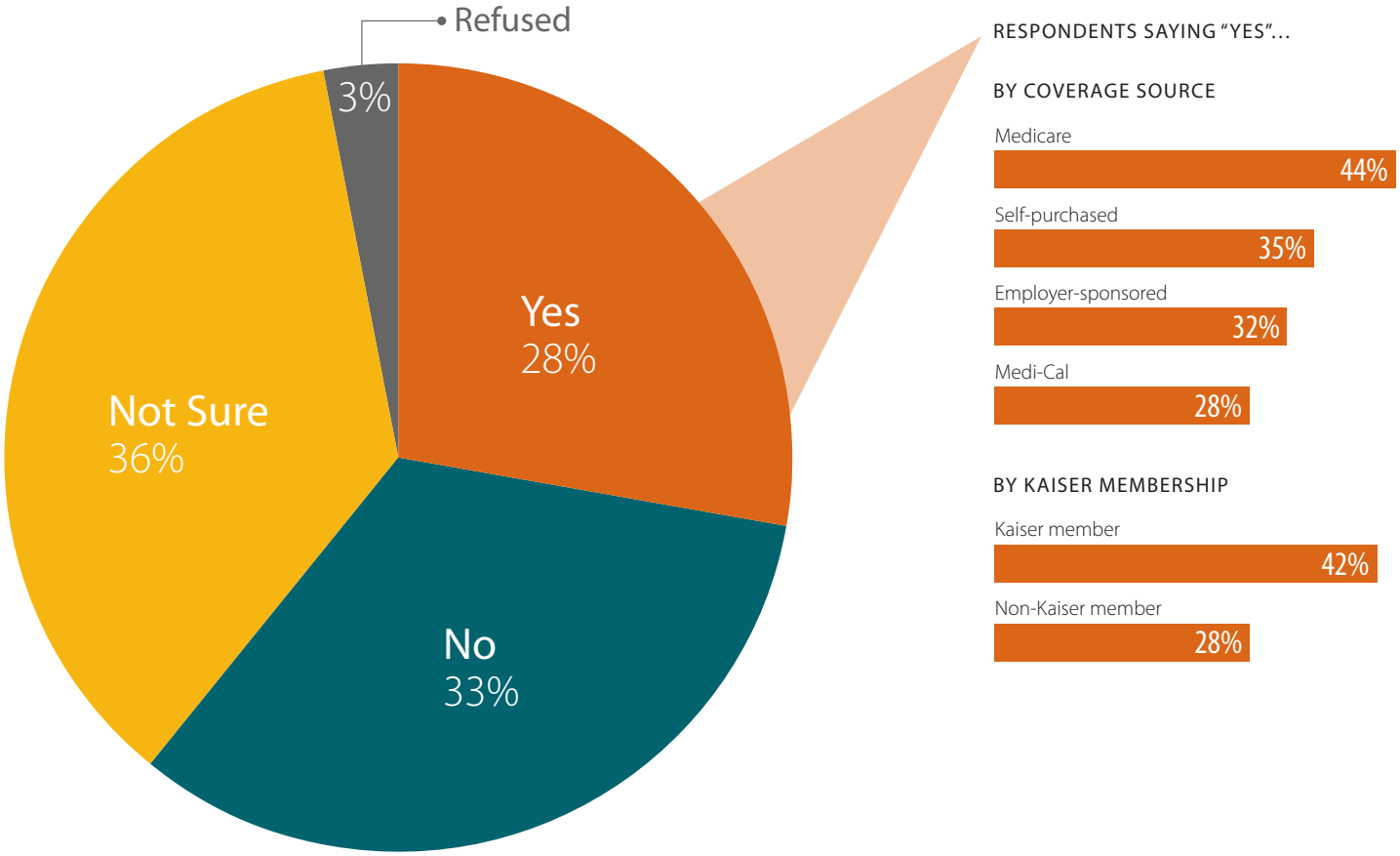
Experience with Team-Based Care

Overall and by Coverage Type and Kaiser Membership, California, 2014

EXCERPT FROM SURVEY QUESTION: ***Some doctors and health care systems are changing to a new model of providing health care that is more centered on the patient. In this type of care, your primary care provider takes the lead in all of your health care. His or her team would work with you to get all the care you need, schedule appointments, and communicate with all of your providers. This is often called "team care."***

Does this sound like the type of health care you get now?

Base: Insured adults (n=1,317)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

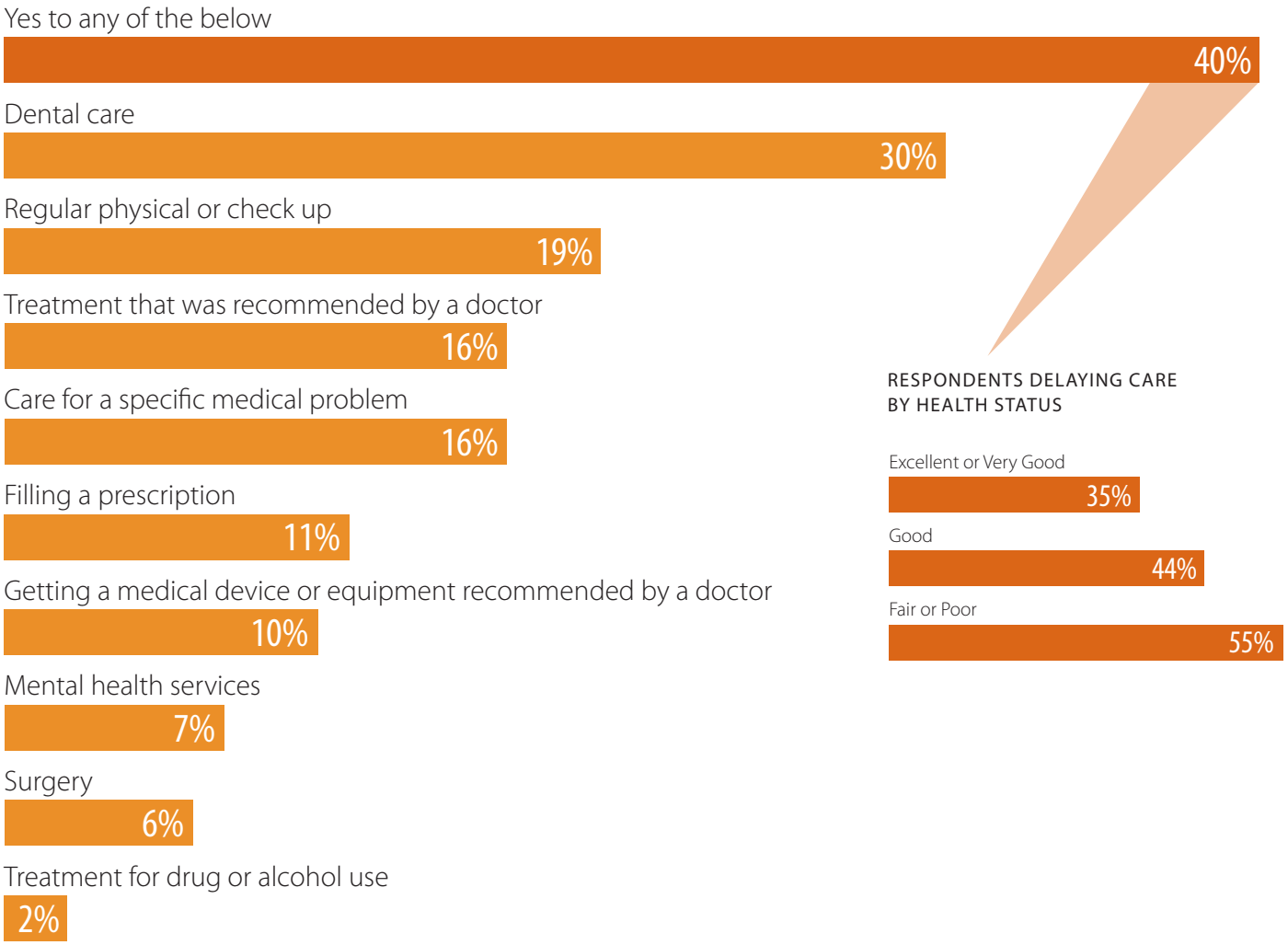
While the ACA encourages providers to adopt a team-based model of care, only 28% of adults said they were receiving "team care."

Adults with Medicare (44%) were more likely than those with other insurance to report that they received team-based care. Kaiser members were more likely to experience team-based care than non-Kaiser members.

Delayed Care Due to Costs, Overall and by Health Status
California, 2014

Have you delayed any of the following in the last 12 months because of the costs involved?

Base: All adults (n=1,548)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

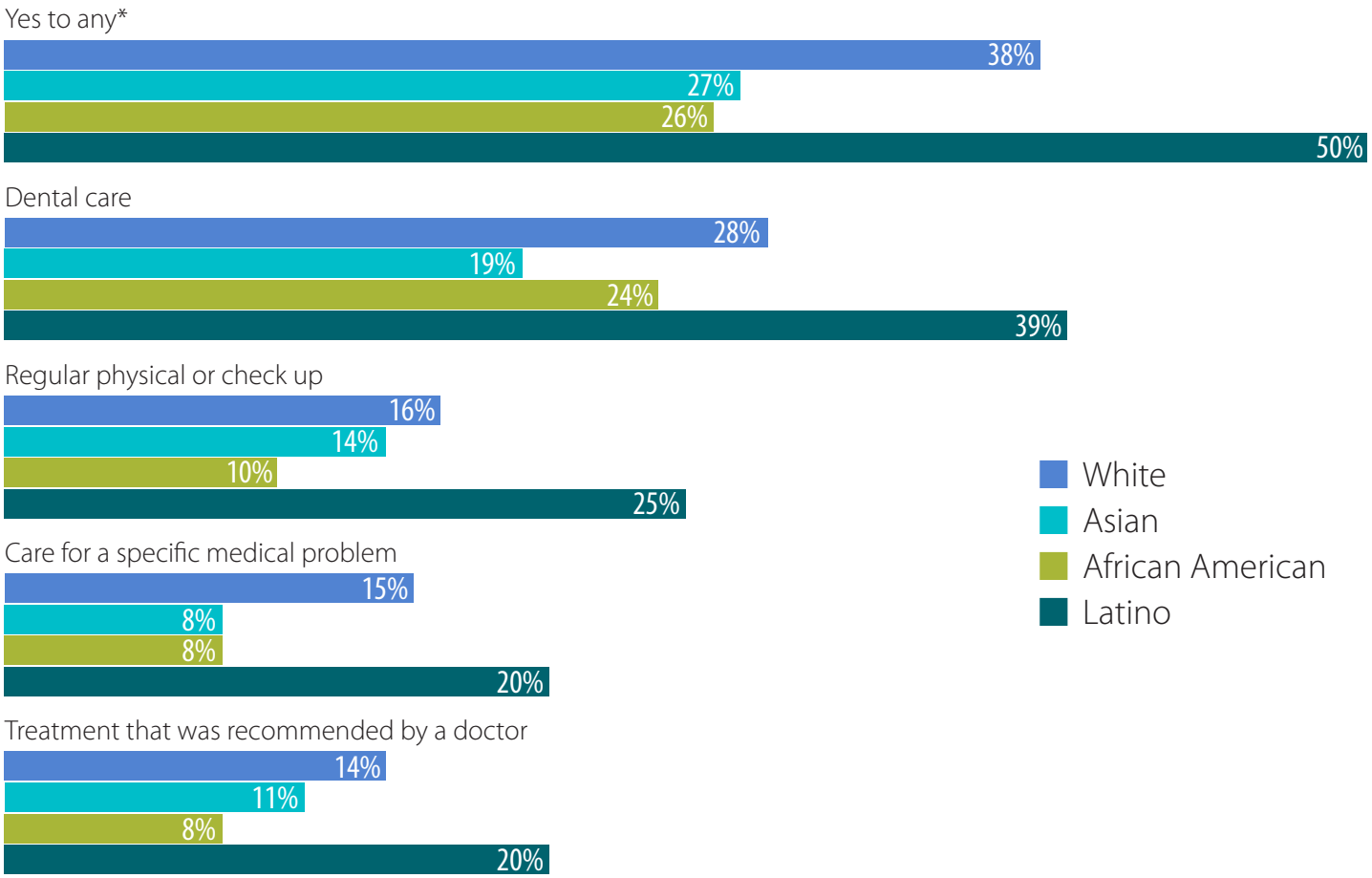
Four in 10 adults reported delaying care in the past year due to costs. Dental services were the most commonly cited health service to be delayed. Those in fair or poor health were more likely than healthier adults to have put off care.

Delayed Care Due to Costs, by Race/Ethnicity
California, 2014

Have you delayed any of the following in the last 12 months because of the costs involved?

Base: All adults (n=1,548)

PERCENTAGE SAYING THEY DELAYED CARE



*Includes filling a prescription; getting a medical device or equipment; and getting mental health services, surgery, and treatment for drug or alcohol use.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

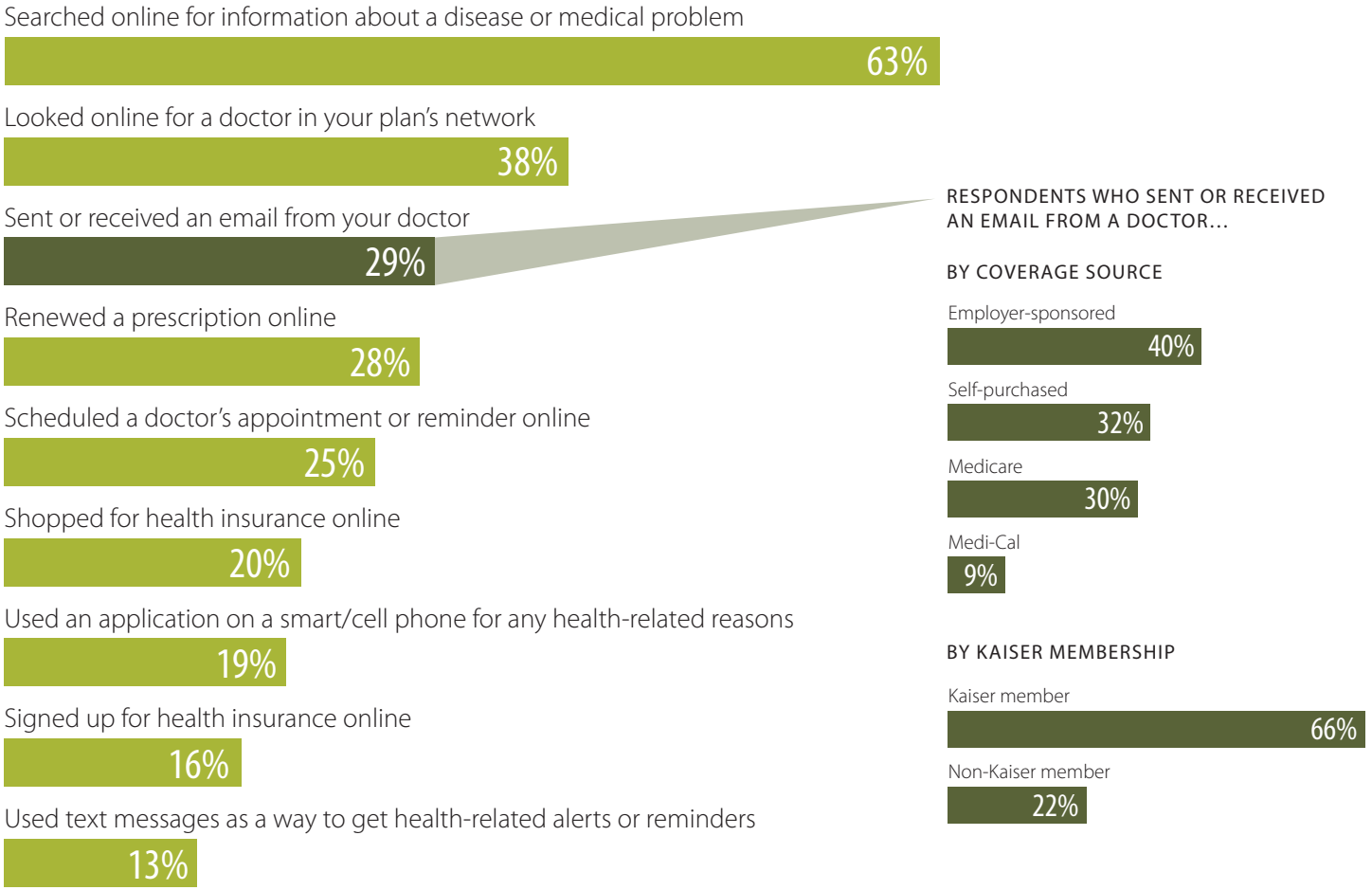
Latinos were more likely than any other ethnic group to delay care because of costs. This was especially true with dental care: 39% of Latinos reported putting off dental care due to costs.

Use of Health Information Technology, Overall and by Insurance
California, 2014

Have you ever done any of these things online?

Base: All adults (n=1,548)

PERCENTAGE SAYING "YES"



RESPONDENTS WHO SENT OR RECEIVED AN EMAIL FROM A DOCTOR...

BY COVERAGE SOURCE

BY KAISER MEMBERSHIP

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

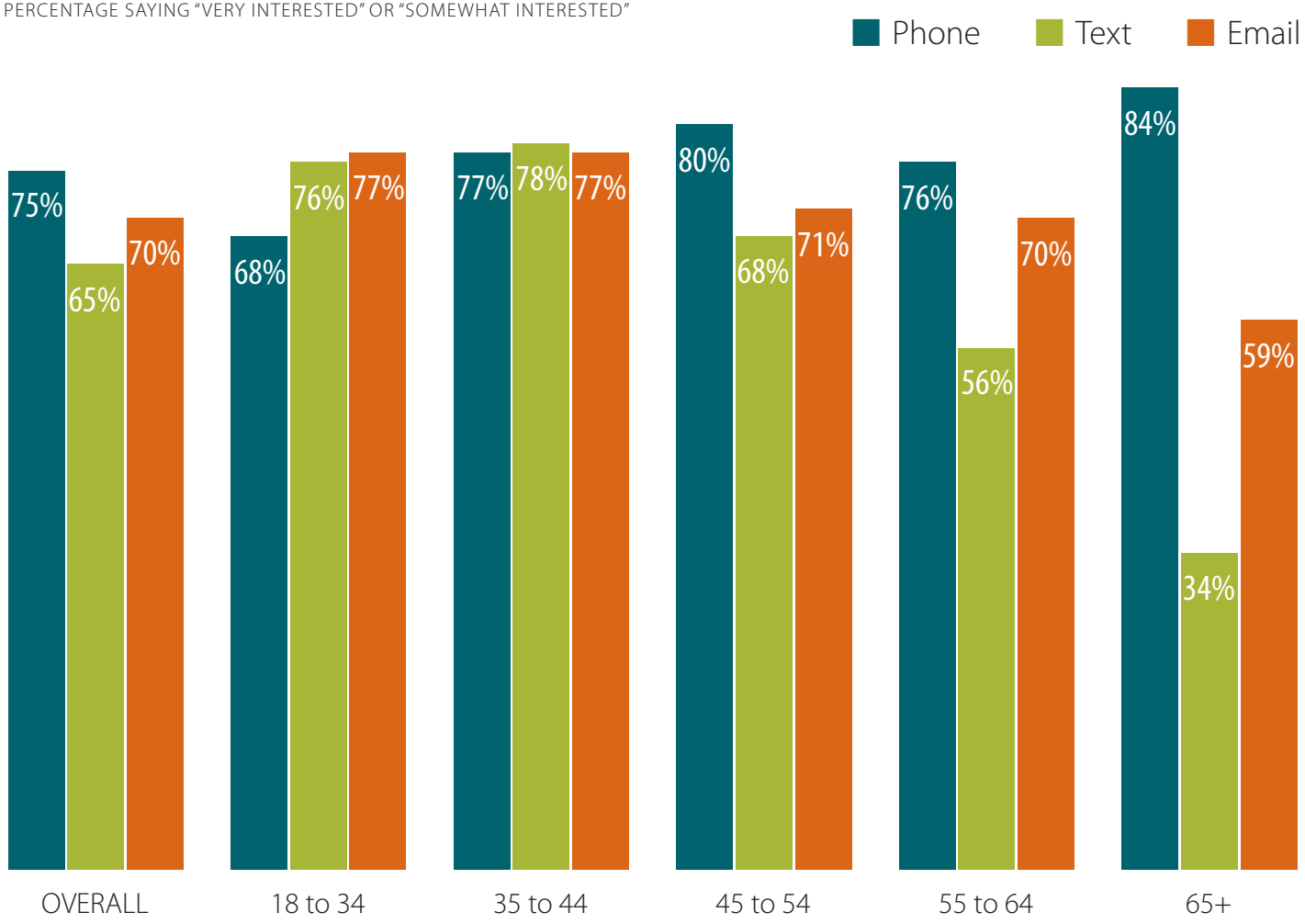
Almost two-thirds of adults (63%) reported looking online for information about a disease or medical problem. Kaiser members were three times more likely than others to report communicating with their providers via email.

Interest in Doctor Updates via Phone, Text, or Email, by Age
California, 2014

How interested would you be in getting updates or reminders from your doctor by phone, text, or email?

Base: All adults (n=1,548)

PERCENTAGE SAYING "VERY INTERESTED" OR "SOMEWHAT INTERESTED"



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

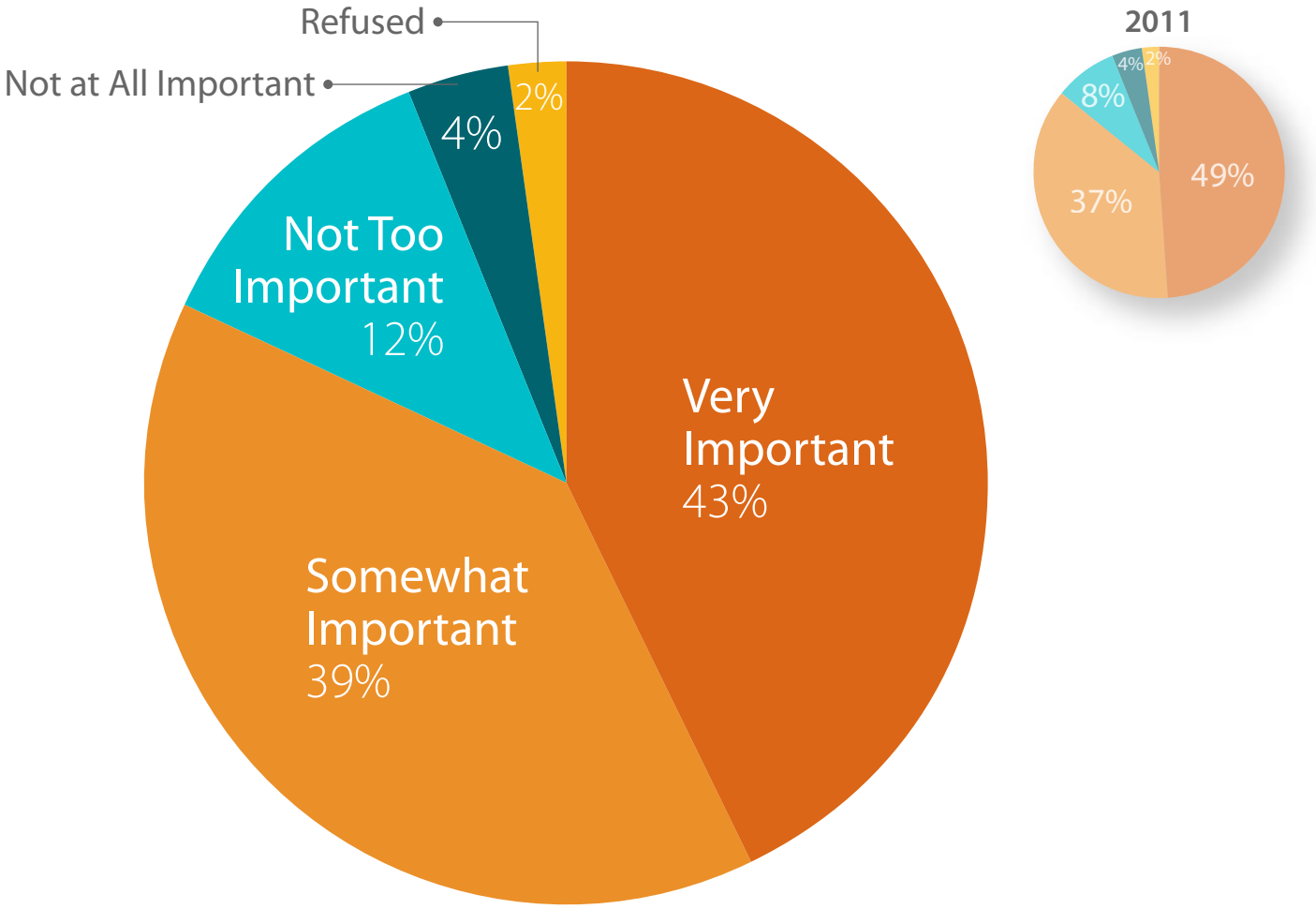
Older adults (those 65 and over) were less interested in receiving reminders from their doctor by text or email than those in other age groups.

Attitudes Toward Providers' Use of Electronic Medical Records

California, 2011 vs. 2014

How important do you think it is for doctors and hospitals to use electronic medical records instead of paper records?

Base: All adults, 2011 (n=1,528), 2014 (n=1,548)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Consumer Perspectives

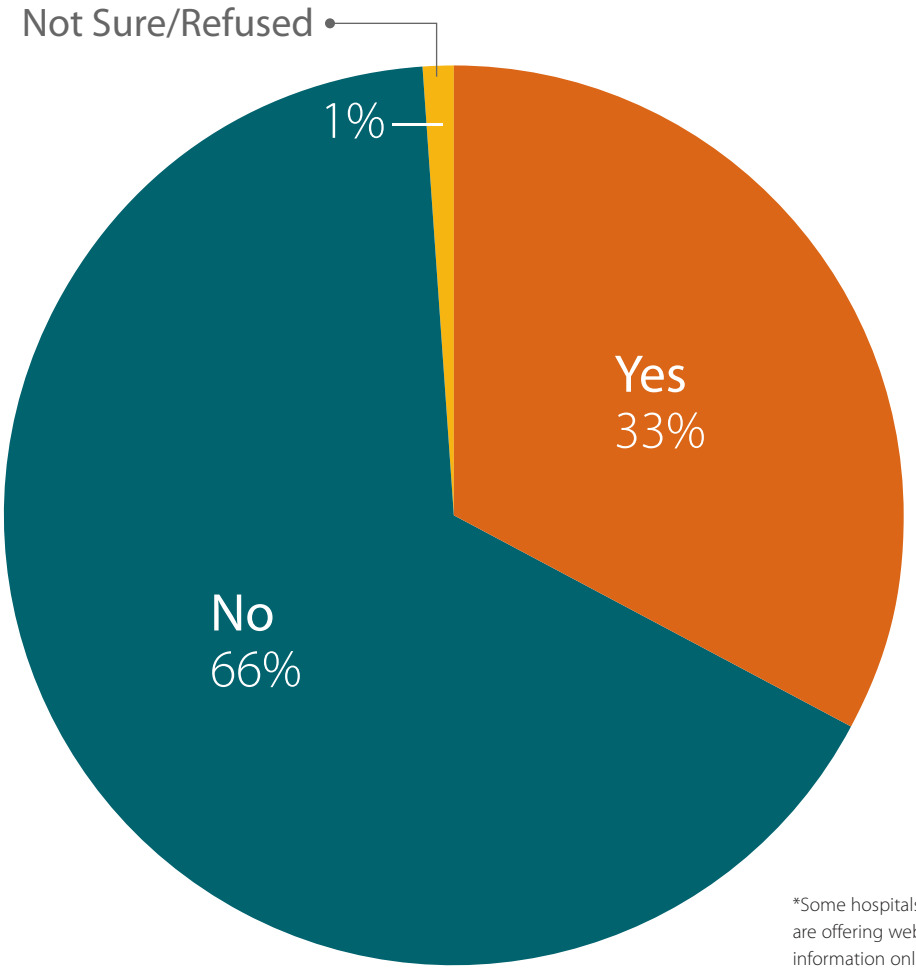
Health IT

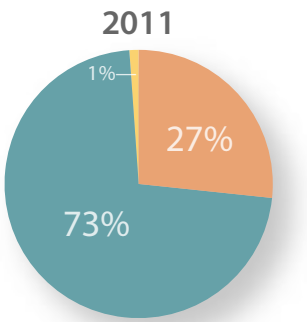
A large majority of Californians (82%) said it was important for doctors and hospitals to use electronic versus paper medical records.

Use of Online Personal Health Record
California, 2011 vs. 2014

Have you ever used a website where you can get, keep, or update your health information?*

Base: All adults, 2011 (n=1,528), 2014 (n=1,548)





Note: Segments may not add to 100% due to rounding.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

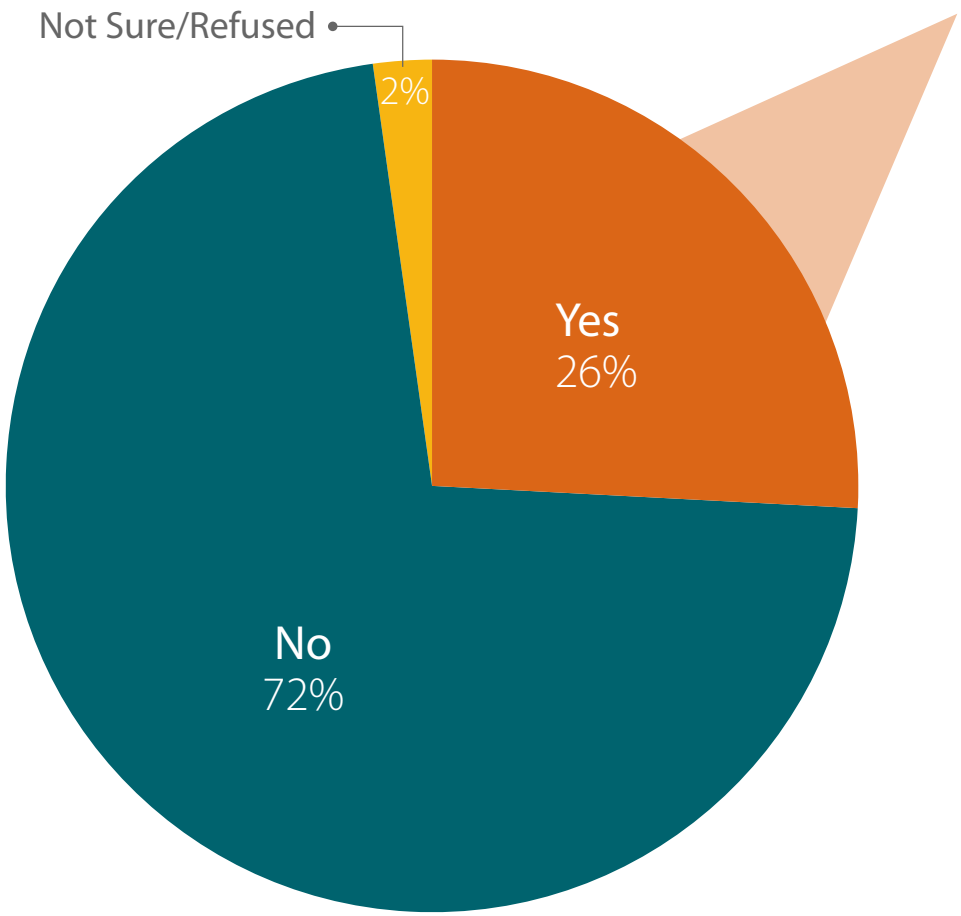
*Some hospitals, doctor's offices, health plans, and different companies are offering websites where you can get, keep, and update your health information online. This information could be lab test results, medicines, doctors' visits, or other information. You get a user name and password so that only you can see your information on this website.

One in three adults (33%) reported using an online personal health record, up slightly from 27% in 2011.

Searched for Cost Information Prior to Getting Care
California, 2014

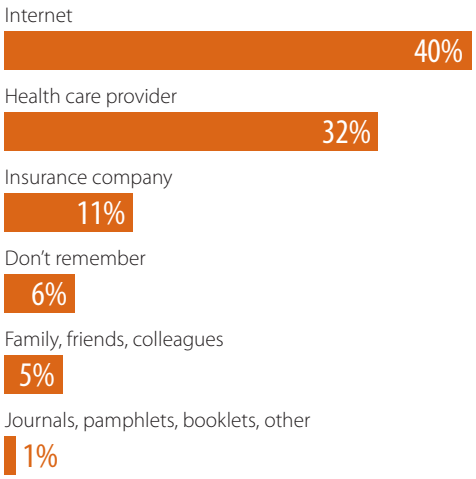
Have you ever looked for information about the cost of a test, treatment, or other type of health care you needed, before you actually got the care?

Base: All adults (n=1,548)



Who did you ask or where did you look for information about costs?

Base: Adults who looked for cost information prior to care (n=340)



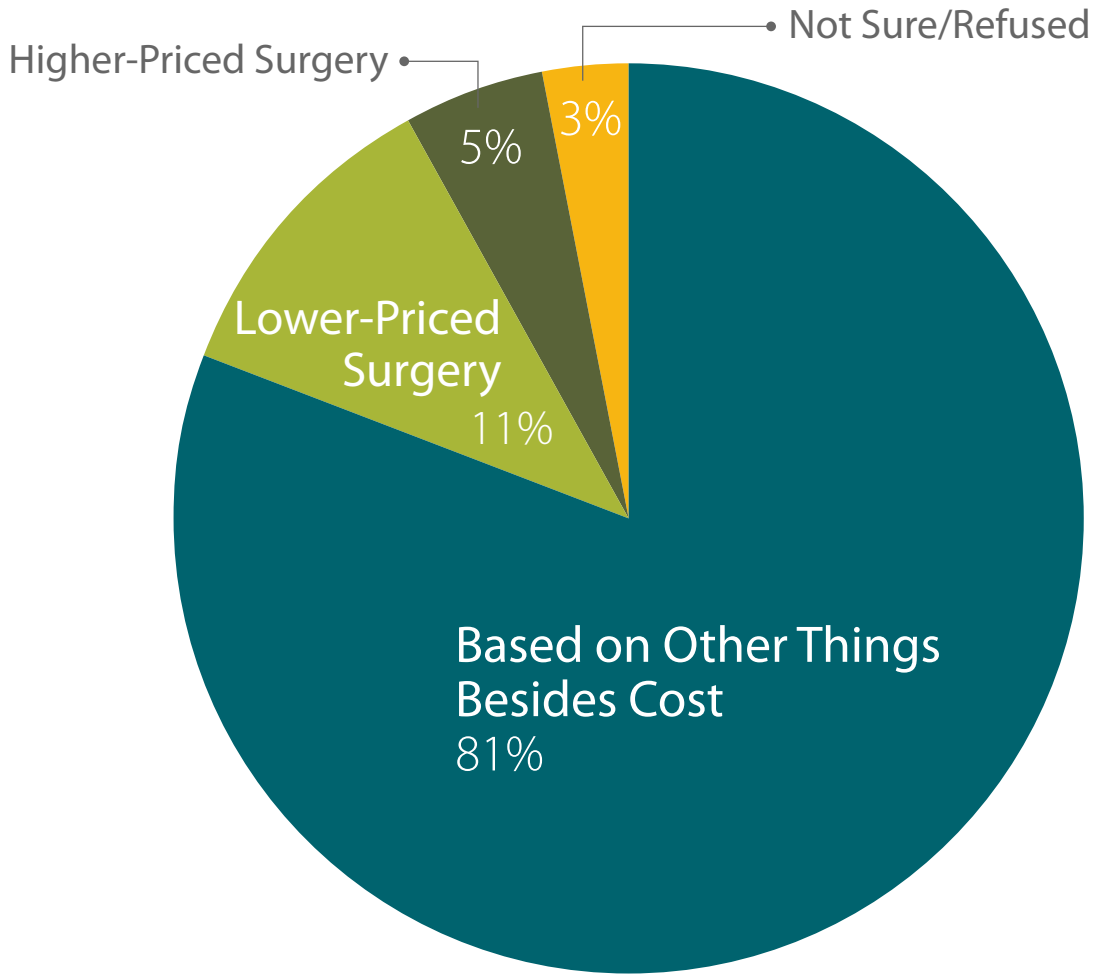
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

One in four Californians surveyed reported having searched for information about costs before receiving care. The Internet was the most commonly reported source of cost information.

Price Perceptions
California, 2014

Let's say two hospitals charge different prices for a surgery you need. If your insurance covered surgeries at both hospitals and your out-of-pocket costs were the same, would you choose…

Base: All adults (n=1,548)

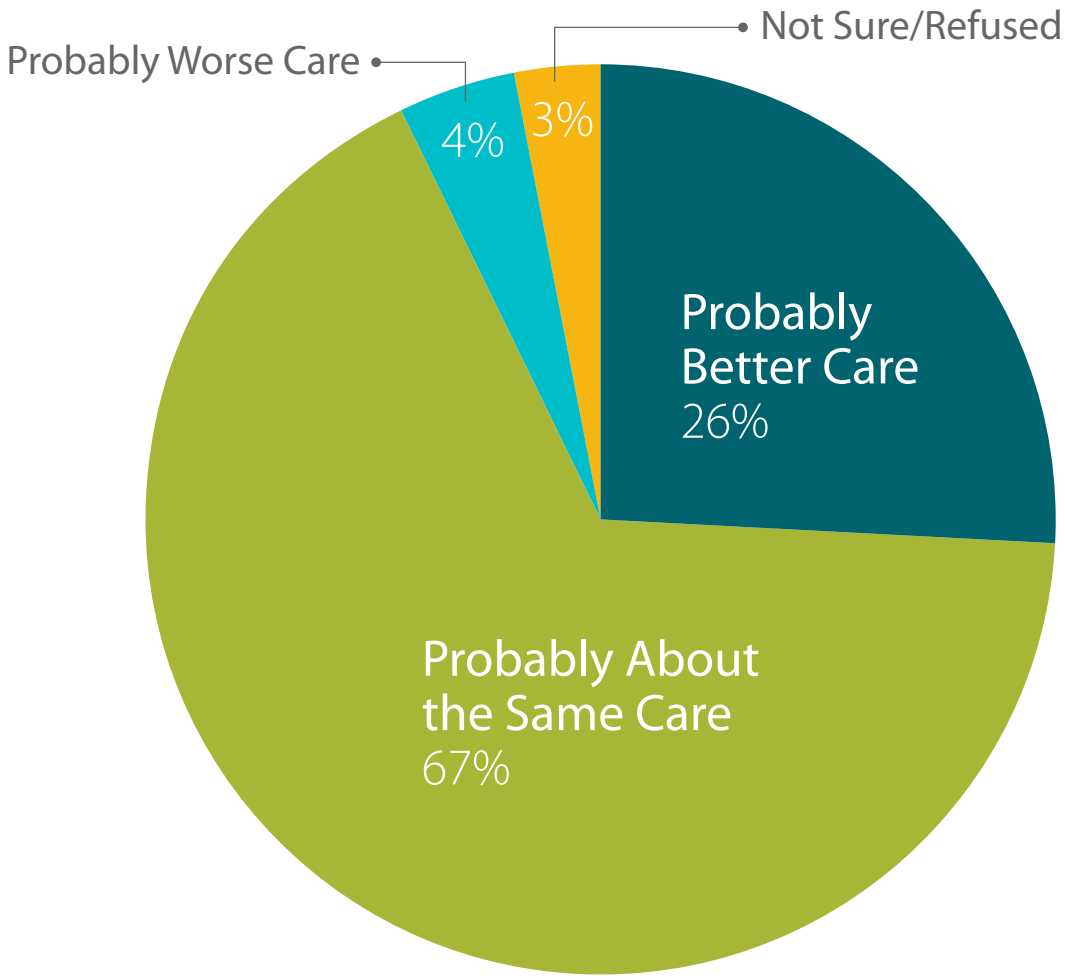


Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Eight in 10 Californians (81%) said they would choose a hospital for surgery based on factors other than cost.

Perceptions of a Higher-Priced Surgery
California, 2014

Let's say two hospitals charge different prices for a surgery you need. Would you think the higher-priced surgery is…
Base: All adults (n=1,548)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

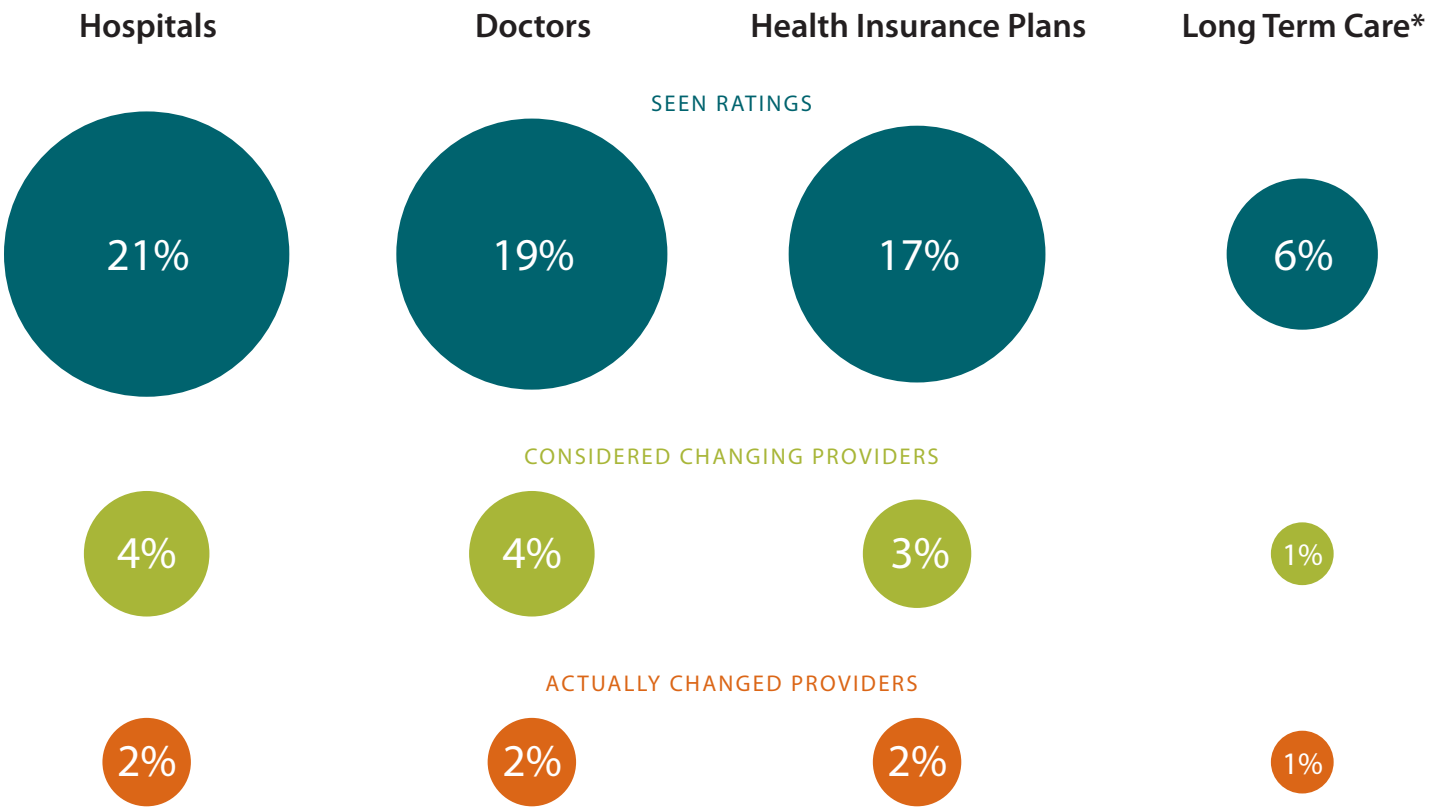
A majority of Californians surveyed did not think a higher-priced surgery would be of better quality than a lower-priced surgery.

Awareness and Use of Ratings
California, 2014

In the past 12 months, have you seen any ratings for doctors, health insurance plans, hospitals, or long term care facilities? Did you consider changing or change providers as a result?

Base: All adults (n=1,548)

PERCENTAGE SAYING "YES"



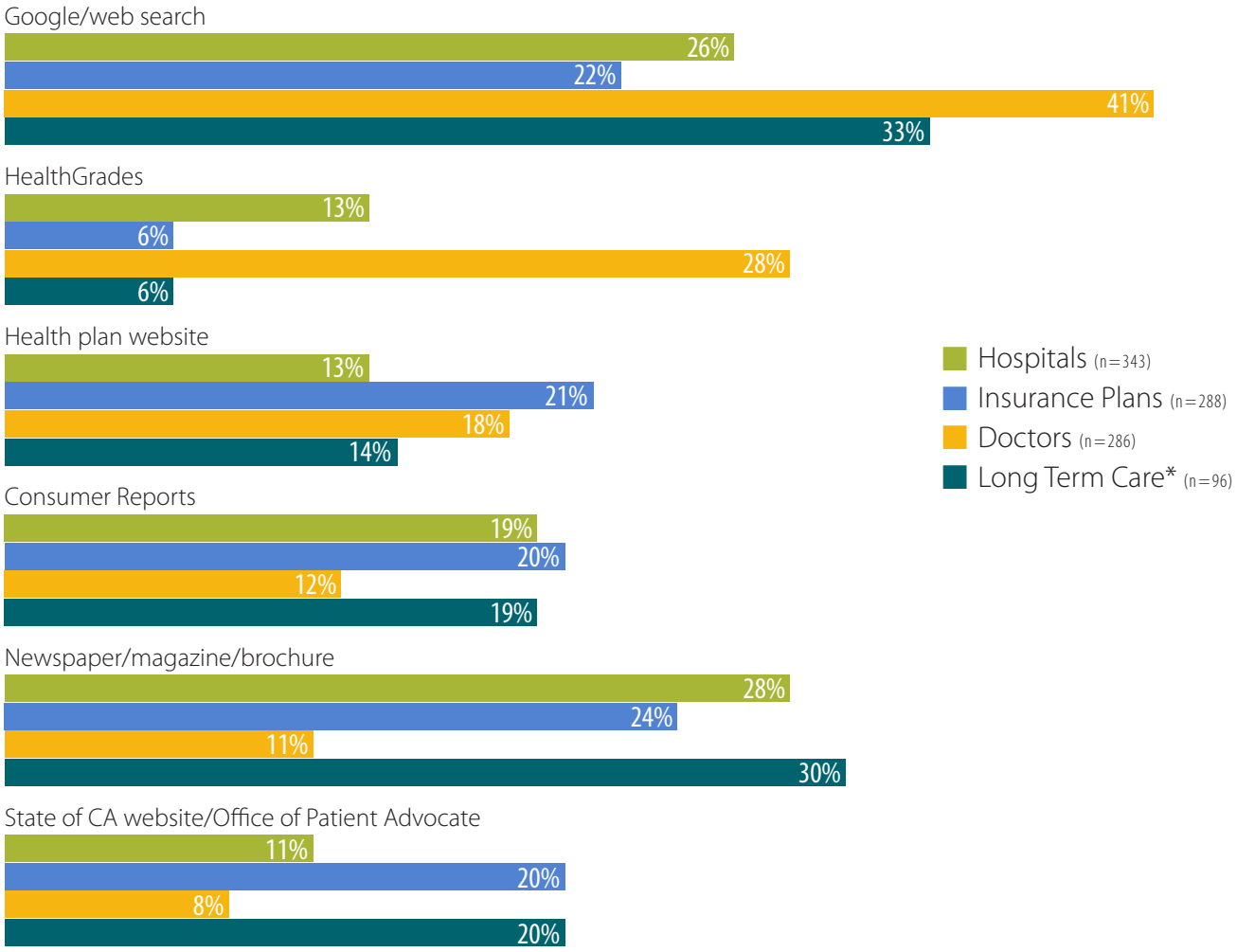
*Facilities, such as nursing homes or assisted living.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

One in five Californians reported looking at quality ratings for hospitals (21%) and doctors (19%) in the past 12 months.

Selected Sources of Quality Ratings
California, 2014

Where did you see the ratings for hospitals, health insurance plans, doctors, or long term care facilities?



*Facilities, such as nursing homes or assisted living.

Notes: Margin of error is greater when analyzing smaller sample sizes. Other rating sources include: doctor's office/website, Medicare website, CalQualityCare, Leapfrog, TV.

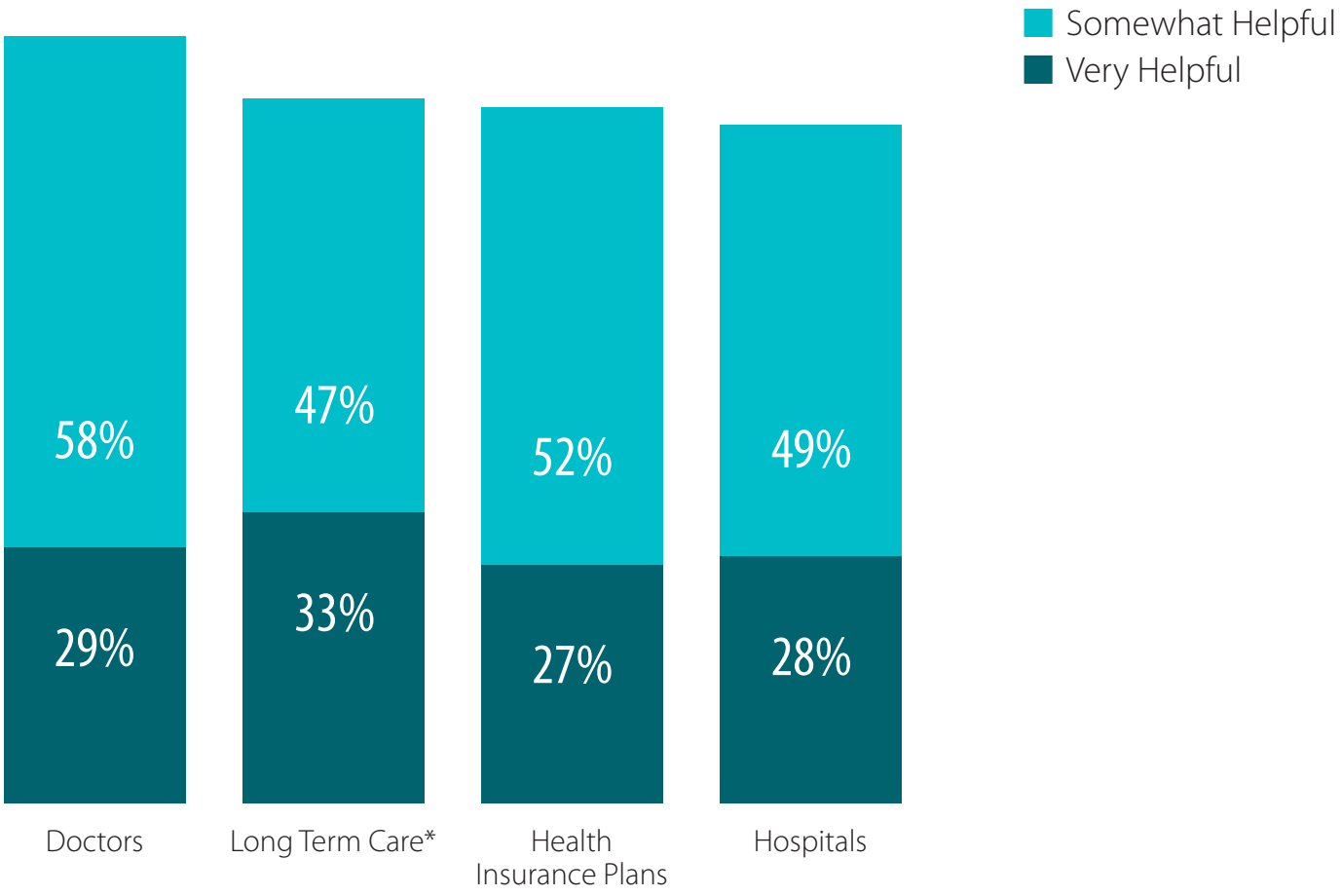
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Californians reported seeing ratings for health care services in a variety of media. Google/web searches were frequently mentioned as a main source of this information.

Helpfulness of Quality Ratings
California, 2014

How helpful were the ratings to you?

Base: Adults who reported seeing ratings for… doctors (n=286), long term care facilities (n=96), health insurance plans (n=288), hospitals (n=343)



*Facilities, such as nursing homes or assisted living.

Note: Margin of error is greater when analyzing smaller sample sizes.

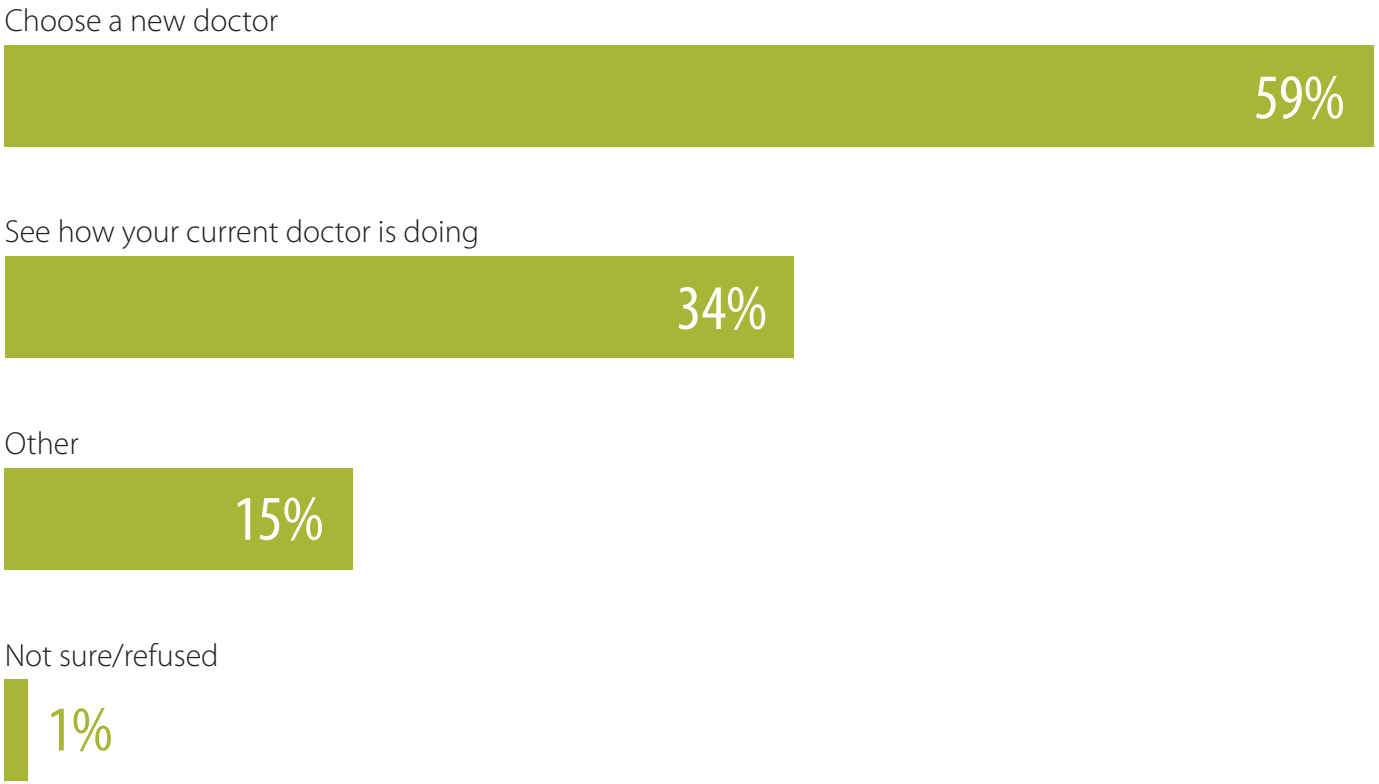
Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Of those adults who reported seeing quality ratings, a majority found the information helpful.

Reasons for Looking at Doctors' Ratings
California, 2014

Why did you look at ratings for doctors?

Base: Adults who viewed ratings for doctors (n=286)



The majority of those who looked at physician ratings (59%) did so to choose a new doctor.

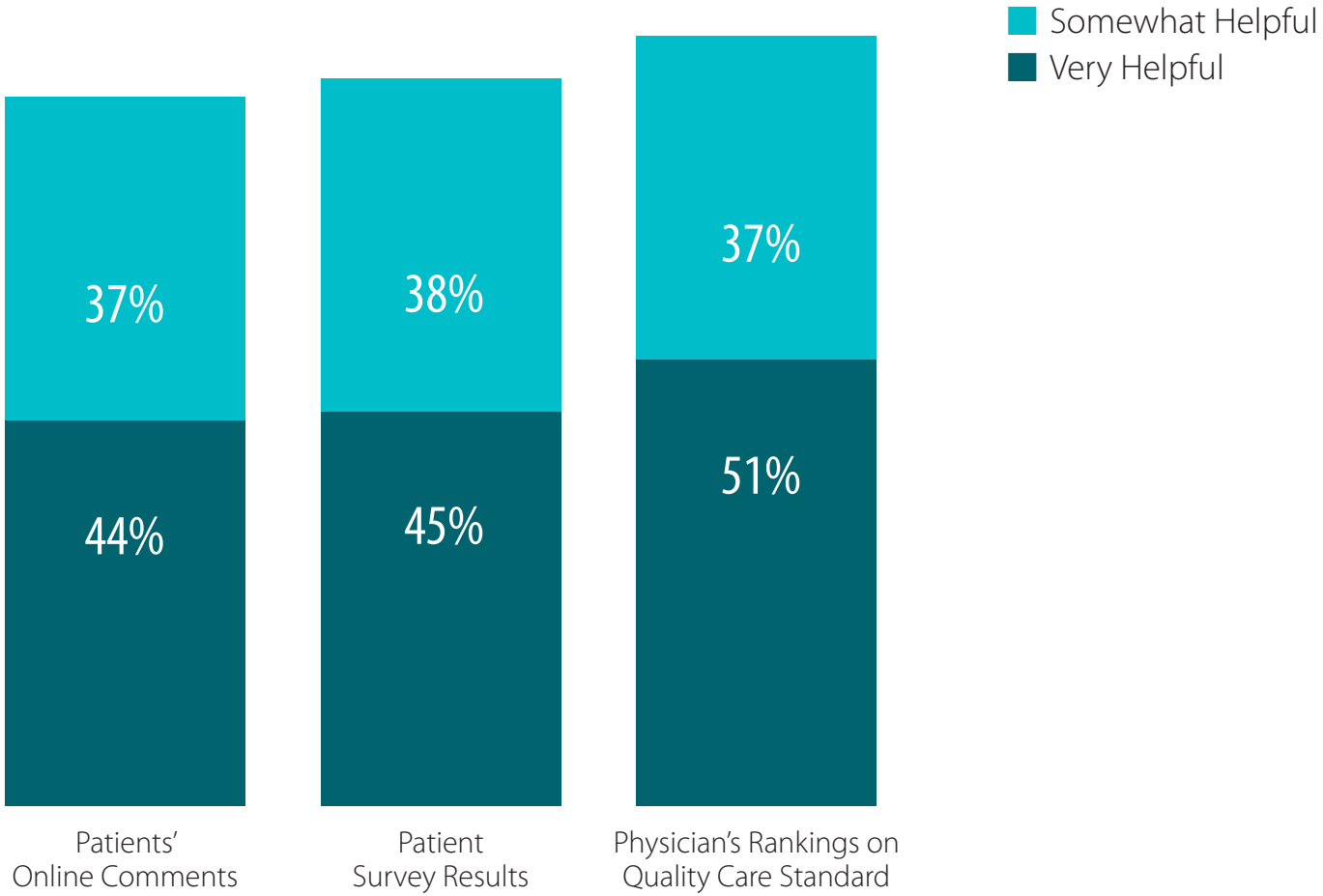
Note: Margin of error is greater when analyzing smaller sample sizes.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Helpfulness of Resources in Choosing a New Doctor
California, 2014

When you are searching for a new doctor, how helpful would it be to see…

Base: All adults (n=1,548)

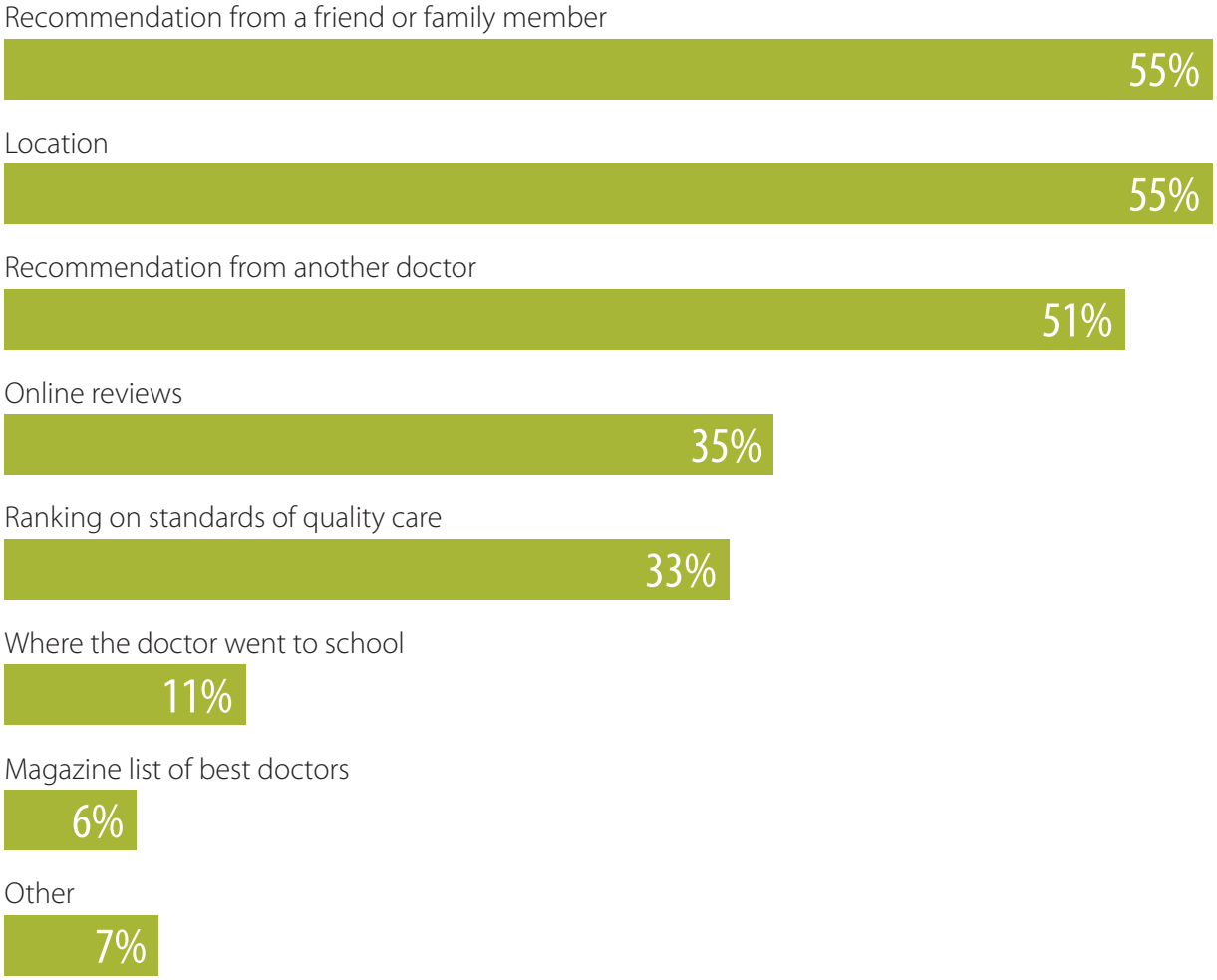


Source: California General Public Survey, conducted by PerryUndem Research and Communication.

When choosing a new doctor, almost 9 in 10 Californians surveyed (88%) said it would be helpful to see a physician's ranking on standards of quality care.

Influences on Choosing a New Doctor
California, 2014

Let's say you had to choose a new doctor. How would you choose a doctor?
Base: All adults (n=1,548)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

Of the many factors that could be used to choose a new doctor, Californians were more likely to say they would use location and personal recommendations than reviews, rankings, and where the doctor went to school.

Methodology

The survey was conducted from July 18 through August 4, 2014, among a representative sample of 1,548 adults 18 and older in California, using Knowledge Networks. The margin of sampling error for the total results is ±3.0 percentage points.

Survey Respondent Demographics

GENDER

Female	52%
Male	48%

AGE GROUP

18 to 34	30%
35 to 44	20%
45 to 54	18%
55 to 64	16%
65+	15%

RACE/ETHNICITY

White	44%
Latino	34%
Asian	13%
African American	6%
Other	3%

EDUCATION

High school/less	39%
Some college	30%
College graduate	19%
Graduate school	12%

FEDERAL POVERTY LEVEL (FPL)

<138% FPL	24%
138% to 399% FPL	43%
400%+ FPL	32%

INCOME

<$25K	18%
$25K to $49K	20%
$50K to $74K	17%
$75K+	45%

HEALTH STATUS

Excellent	14%
Very good	36%
Good	34%
Fair	11%
Poor	3%

SOURCE OF COVERAGE

Employer-sponsored	30%
Medicare	15%
Medi-Cal	11%
Self-purchased	5%
Other*	24%
Uninsured	15%

*Includes: Covered under spouse/partner's plan, covered under parent's plan, Tri-Care/VA/Military, and people who said "I have something else".

Note: Categories may not add to 100% due to rounding.

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

AUTHOR

PerryUndem Research/Communication is a non-partisan public opinion research firm with expertise nationally and in California on consumer attitudes toward health care.

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ASPE
ISSUE BRIEF

HEALTH INSURANCE MARKETPLACES 2015 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT[1]

For the period: November 15, 2014 – February 15, 2015
(Including Additional Special Enrollment Period Activity Reported through 2-22-15)[2]

March 10, 2015

The Health Insurance Marketplaces ("the Marketplaces") play a critical role in achieving one of the Affordable Care Act's core goals: reducing the number of uninsured Americans by providing affordable, high-quality health insurance. This report provides summary data for enrollment-related activity in the individual market Marketplaces during the 2015 Open Enrollment period for all 50 states and the District of Columbia (11-15-14 to 2-15-15), including data relating to individuals who qualified for an "in-line" or other Special Enrollment Period (SEP). (Unless otherwise noted, the data in this report include SEP activity through 2-22-15).[3] It is important to note that this report does not include data on effectuated enrollment (that the number of people who have paid monthly premiums to the insurer). Additionally, this report does not include data relating to any individuals who qualified for an SEP after 2-22-15, including any upcoming SEP for individuals who were unaware of, or did not understand the implications of the fee for not enrolling in health insurance coverage.[4] [5]

[1] As additional data are available from special enrollment periods extending into April, this data will be provided.
[2] Most of the data in this report are for the 11-15-14 to 2-15-15 reporting period (including additional special enrollment period (SEP) activity reported through Sunday, February 22nd), with the following exceptions: the data for the State-Based Marketplaces (SBMs) that are using their own Marketplace platforms include additional SEP activity through 2-21-15 (with the exception of California, which is reporting data including additional SEP activity through 2-22-15).
[3] The SEP for individuals who were "in-line" on 2-15-15 ended on 2-22-15 for the states that are using the HealthCare.gov platform. Most of the SBMs that are using their own Marketplace platforms allowed individuals who started the process before 2-15-15, but could not finish, to complete the application and select a plan by varying dates, mostly within February, with the exception of Colorado, which allowed applicants through March 2 to complete their applications, and Washington, which allowed applicants to enroll through April 17. Vermont has indicated that the state will assist consumers with enrollment if they report a problem trying to enroll, but did not provide for a formal extension period.
[4] CMS recently announced a special enrollment period (SEP) for tax season. For individuals and families in the HealthCare.gov states who did not have health coverage in 2014 and are subject to the fee or "shared responsibility payment" when they file their 2014 taxes. For those who were unaware or did not understand the implications of the fee for not enrolling in coverage, CMS will provide consumers with an opportunity to purchase health insurance coverage from March 15 to April 30, 2015. (For additional information, see http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-02-20.html).
[5] Most of the SBMs that are using their own Marketplace platforms also announced an SEP for individuals and families that were unaware or did not understand the implications of the fee for not enrolling in coverage, but the timeframes for the SEP varied among the states. s -

Section I of the report focuses on the 37 states that are using the HealthCare.gov platform for the 2015 Open Enrollment period (also known as "HealthCare.gov states") and covers the period 11-15-2014 to 2-15-2015, including activity that was reported through 2-22-15 associated with enrollment through a Special Enrollment Period (SEP). The data on SEP activity include information for those who qualified for an SEP because they were "in line" on 2-15-15, as well as those who qualified for an SEP for other reasons with coverage that was effective on March 1, 2015.[6]

The 37 HealthCare.gov states include 35 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.[7] These 37 states account for 76 percent (8.8 million) of the total plan selections through the Marketplaces in this report.

The data available for these states include plan selections through the Marketplaces for new consumers and those that are reenrolling in coverage. The reenrollee data include separate breakouts for consumers who actively reenrolled in coverage through the Marketplaces (i.e., people who returned to the Marketplaces to select a new plan or actively renew their existing plan),[8] and consumers who were automatically reenrolled into coverage. The report also includes the number of reenrollees who switched plans, as well as updated data on several metrics related to the impact of the advance premium tax credit on net premium costs.[9]

The data included in this report cover the same reporting period as the Week 14 Weekly Enrollment Snapshot for the 37 HealthCare.gov states, and the metrics that are reported in both places are generally consistent (see Appendix Table D1 for additional information on how the data in this report compare with the data in the Week 14 Weekly Enrollment Snapshot).[10] This report also includes data relating to completed applications, eligibility determinations, website visitors, and call center activity for the HealthCare.gov states; data on the overall distribution of plan selections through the Marketplaces in these states by gender, age, metal level, financial assistance status (i.e., whether the consumer has been determined eligible for advance premium tax credits and/or cost-sharing reductions), race/ethnicity, rural status, household income.

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[6] This includes persons who had a qualifying life event that qualifies them for an SEP (such as a change in marital status, a change in dependents, or losing minimum essential health coverage), or a complex situation related to applying for coverage in the Marketplace. Additional information on Marketplace SEPs can be found at https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/#part=2.

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

[8] Active reenrollees includes individuals who actively selected a 2015 plan through the Marketplaces prior to the 12-15-14 deadline for coverage beginning on January 1st, as well as those who returned to the Marketplaces and selected a plan after having initially been automatically reenrolled.

[9] For additional information about these premium-related metrics, please see "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits through January 30 in 37 States Using the HealthCare.gov Platform," ASPE Research Brief, U.S. Department of Health and Human Services, February 9, 2015. Available at: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf.

[10] The Centers for Medicare & Medicaid Services published weekly Open Enrollment snapshots that provided preliminary point-in-time estimates for weekly data that could fluctuate based on consumers changing or 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.

Section II of the report focuses on the 14 states (including the District of Columbia) that are operating their own Marketplace platforms for 2015 (see page 20). Most of the 14 states include activity for the period 11-15-2014 to 2-15-2015 (including activity associated with individuals who qualified for a SEP that was reported through 2-21-2015, except for California where data on SEP activity extend through 2-22-2015). These 14 states account for 24 percent (2.8 million) of plan selections through the Marketplaces in this report. The data available for these states include new consumers and reenrollees (please see Appendix Table D2 for additional information on the data on plan selections through the Marketplaces that are available for various states). Data are available for certain states relating to completed applications, eligibility determinations, website visitors, call center activity; and the overall distribution of plan selections through the Marketplaces by gender, age, metal level, financial assistance status, and reenrollment status (See Appendix Table D3 for a summary of which additional metrics are available for each state).

Key Highlights:

National plan selection data show that as of the end of the second Open Enrollment period, nearly 11.7 million[11] Americans selected or were automatically reenrolled[12] into a 2015 health insurance plan through the Health Insurance Marketplaces, specifically:

- More than 8.84 million people selected or were automatically reenrolled in 2015 plans through the Marketplaces in the 37 states that are using the HealthCare.gov platform. This includes:
  - More than 4.6 million new consumers, 2.2 million active reenrollees, and nearly 2.0 million automatic reenrollees; and
  - 3.2 million (36 percent) people with plan selections who are under the age of 35.
- Nearly 2.85 million people selected or were automatically reenrolled into 2015 plans through the Marketplaces in the 14 states (including DC) that are using their own Marketplace platforms in 2015.

Additionally, updated premium and tax credit information show that in the 37 States using the HealthCare.gov platform:

- More than 8 in 10 individuals (nearly 7.7 million, or 87 percent) with a 2015 plan selection through the Marketplaces in the HealthCare.gov states qualify for an advance premium tax credit[13] with an average value of $263 per person per month (Table 6).
- The average advance premium tax credit covers about 72 percent of the gross premium for individuals who qualify for an advance premium tax credit.
- The average net premium is $101 per month among individuals with 2015 plan selections through the Marketplaces who qualify for an advance premium tax credit.
- Overall, more than half (55 percent) of the 8.8 million individuals with 2015 plan selections through the Marketplaces in the HealthCare.gov states have 2015 plan selections through the Marketplaces with a monthly premium of $100 or less after applying the advance premium tax credit; about 8 in 10 had the option of selecting such a plan.

[11] It is important to note that these data generally represent the number of individuals who have selected, or been automatically reenrolled into a 2015 plan through the Marketplaces, with or without payment of premium. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Data on effectuated enrollment are not yet available.

[12] It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-15-15 (including SEP activity through 2-22-15), but who may ultimately decide not to retain Marketplace coverage for the remainder of 2015 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP). The plan selection data in future reports will exclude these individuals (e.g., due to the subsequent cancellation or termination of their coverage).

[13] For purposes of this analysis, an individual qualifying for an advance premium tax credit was defined as any individual with an APTC amount >$0.

Table 1

Key Statistics Relating to the Marketplaces	Reporting Period: 11-15-14 to 2-15-15 *(including SEP Activity Thru 2-22-15)*
Total 2015 Plan Selections in the Marketplaces	11,688,074
2015 Plan Selections in the Marketplaces in States Using the HealthCare.gov Platform (1)	8,838,291
2015 Plan Selections in the Marketplaces in State-Based Marketplaces Using Their Own Marketplace Platforms (2)	2,849,783

Notes:

(1) The data for the States using the HealthCare.gov platform are for 11-15-2014 to 2-15-2015, including SEP activity through 2-22-15.

(2) The data for most of the States using their own Marketplace platforms are for 11-15-2014 to 2-15-2015, including SEP activity through 2-21-15 (however, the data for CA include SEP activity through 2-22-15).

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

- ***More Than 4.6 Million People Who Did Not Have Marketplace Coverage at the Beginning of the 2015 Open Enrollment Period Selected Plans Through the Marketplaces.***

  More than 8.84 million individuals have selected or been automatically reenrolled into a 2015 plan through the Marketplaces as of 2-15-15 in HealthCare.gov states (see Table 2). Of that total, 53 percent (more than 4.6 million) are plan selections by new consumers who did not have a plan selection through the Marketplaces as of November 2014,[14] and 47 percent (nearly 4.2 million) are plan selections for consumers who are reenrolling in coverage through the Marketplaces.

- ***Many of the Consumers Who Were Reenrolling in Coverage in the HealthCare.gov States Returned to the Marketplaces and Selected a Plan.***

  Within the HealthCare.gov states, in addition to the 4.6 million new consumers who selected 2015 coverage through the Marketplaces, 2.2 million active reenrollees also returned to the Marketplaces and selected a 2015 plan as of 2-15-15 (see Table 2).

[14] The nearly 4.7 million new consumers in HealthCare.gov states includes a small number of individuals who previously had 2014 coverage through the Marketplaces in Nevada and Oregon, which switched from using their own Marketplace platforms for the 2014 coverage year to using the HealthCare.gov Marketplace platform for the 2015 coverage year.

The 2.2 million active reenrollees who shopped for coverage represented more than half (53 percent) of the nearly 4.2 million consumers who had an active plan selection through the Marketplaces as of November 2014 and have been reenrolled in 2015 coverage through the Marketplaces. The remaining 47 percent (nearly 2 million) have been automatically reenrolled (see Table 2).

- ***More Than Half of the Reenrollees Who Shopped for Coverage in the HealthCare.gov States Switched Marketplace Plans.***

  More than half (1.2 million or 54 percent) of the 2.2 million active reenrollees who selected 2015 plans through the Marketplaces in the HealthCare.gov states switched plans between the 2014 and 2015 coverage years (see Table 2). The remaining 1.0 million (46 percent) remained in the same Marketplace plan (including those who remained in a similar crosswalked plan).[15]

  Overall, the 1.2 million active reenrollees, who shopped for coverage and switched plans, represented 29 percent of the nearly 4.2 million consumers who reenrolled in 2015 coverage through the Marketplaces (including the automatic reenrollees). (See Appendix Table B2 for state-level data on active reenrollees who switched Marketplace plans).

  The 29 percent of reenrollees who switched plans is higher than that seen in other programs. For example, studies show that approximately 13 percent of Medicare Part D enrollees change plans in a given year;[16] 12 percent of those active employees with Federal Employee Health Benefit Plan coverage switch plans each year,[17] and only about 7.5 percent of those with employer sponsored coverage[18] switch plans for reasons other than a job change during a given year.

[15] Some consumers' 2014 plans were no longer active for 2015 but the insurer offered a plan with similar benefits, known as a "crosswalk plan." For purposes of this report, active reenrollees who selected the crosswalk plan for the 2015 coverage year (identified based on the information provided by the insurance companies) are not included in the total number who switched plans.

[16] Hoadley, J. et. al., "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?" Kaiser Family Foundation, October 2013, accessed at http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/.

[17] Atherley, A. et. al., "Health Plan Switching Among Members of the Federal Employees Health Benefits Program," *Inquiry* 42:255-265 (Fall 2005), Accessed at http://www.jstor.org/discover/10.2307/29773204?sid=21106062471743&uid=2&uid=3739584&uid=4&uid=3739256.

[18] Cunningham, P., "Few Americans Switch Employer Health Plans for Better Quality, Lower Costs," NIHCR Research Brief No. 12, January 2013, accessed at http://www.nihcr.org/Health-Plan-Switching.

Table 2

2015 Plan Selections Through the Marketplaces in States Using the HealthCare.gov Platform By Enrollment Type	Cumulative 11-15-14 to 2-15-15 *(Including SEP Activity thru 2-22-15)*			
	Number	Plan Selection Data by Enrollment Type as a % of:		
		Total Plan Selections *n=8.84m*	All Consumers Reenrolling in Coverage *n=4.17m*	Active Reenrollees *n=2.21m*
Total 2015 Plan Selections through the Marketplaces in HealthCare.gov States (1)	8.84 million	100%	N/A	N/A
New Consumers (2)	4.67 million	53%	N/A	N/A
Consumers Reenrolling in 2015 Coverage through the Marketplaces (3)	4.17 million	47%	100%	N/A
Active Reenrollees (4)	2.21 million	25%	53%	100%
Active Reenrollees Who Remained in the Same Marketplace Plan (2)	*1.01 million*	*11%*	*24%*	*46%*
Active Reenrollees Who Switched Marketplace Plans (3)	*1.20 million*	*14%*	*29%*	*54%*
Automatic Reenrollees (5)	1.96 million	22%	47%	N/A

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 or been automatically reenrolled into 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 issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP).

(2) New Consumers includes data on 2015 Marketplace plan selections for individuals who did not have an active Marketplace plan selection in HealthCare.gov as of November 2014. This includes consumers who were entirely new to the Marketplace (e.g., those who had not previously submitted a completed application for 2014 coverage through HealthCare.gov, including some individuals who may have previously had experience with a State-Based Marketplace that was using its own Marketplace platform in 2014); as well as those who had previously submitted a completed application to the Marketplace during the 2014 coverage year (including those whose previous 2014 Marketplace plan selection was cancelled or terminated before November 2014, those who were determined eligible to enroll in a QHP, but did not select a Marketplace plan during the 2014 Coverage Year, and those who submitted a completed application to the Marketplace but were not determined eligible to enroll in a QHP during the 2014 coverage year).

(3) Consumers reenrolling in coverage through the Marketplaces includes data for consumers who had an active Marketplace plan selection in HealthCare.gov as of November 2014 and selected or were automatically reenrolled into a 2015 Marketplace plan (e.g., including data for both active reenrollees and automatic reenrollees). It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-15-15 (including SEP activity through 2-22-15), but who may ultimately decide not to retain Marketplace coverage for the remainder of 2015 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP). The plan selection data in future reports will exclude these individuals (e.g., due to the subsequent cancellation or termination of their coverage).

(4) Active Reenrollees represents the number of consumers reenrolling in coverage through the Marketplaces who returned to the Marketplace and selected a 2015 plan through the Marketplaces, including some individuals who were initially automatically reenrolled by the Marketplace and subsequently returned to the Marketplaces to select a plan.

(5) Automatic Reenrollees represents the number of consumers reenrolling in coverage through the Marketplaces whose plan selections have a current status of automatically renewed because they have not returned to the Marketplaces to select a plan.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

- ***Nearly 1.7 Million Consumers in the HealthCare.gov States Selected a Marketplace Plan During the Last Month of the 2015 Open Enrollment Period***

  The Marketplaces in the HealthCare.gov states experienced additional enrollment as the close of the 2015 Open Enrollment period approached.

  Table 3 shows that nearly 1.7 million of the more than 8.8 million plan selections (19 percent) for consumers in the HealthCare.gov states during the 2015 Open Enrollment period occurred during the last month of the Open Enrollment period (between 1-16-15 and 2-15-15, including SEP activity through 2-22-15). By comparison, 51 percent of those who selected a plan in the 2014 Open Enrollment Period in the HealthCare.gov states (nearly 3.0 million out of 5.4 million) did so between 3-2-14 and 3-31-14 (including SEP activity through 4-19-14).[19] Note that in 2014, all consumers were new consumers and there was no renewal process. When looking only at new consumers for the 2015 Open Enrollment Period, a greater proportion waited until the end. Specifically, about 36 percent of the more than 4.6 million new consumers who selected 2015 plans through the Marketplaces in the HealthCare.gov states did so during the last month of the open enrollment period (including SEP activity through 2-22-15).

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

Table 3

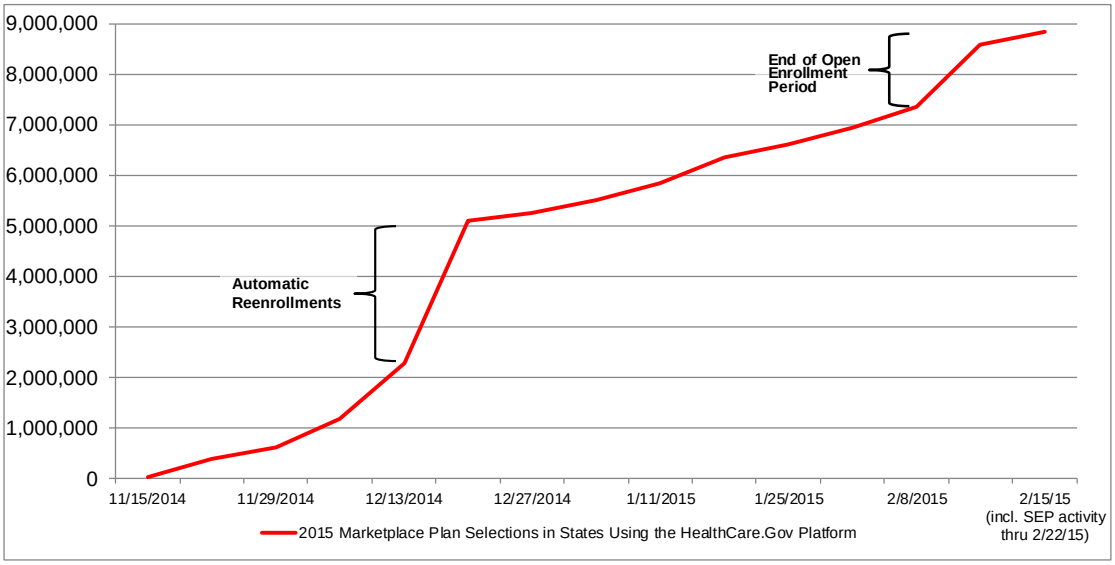
2015 Plan Selections through the Marketplaces in States Using the HealthCare.gov Platform By Plan Selection Date	Total Plan Selections		Plan Selections By New Consumers (1)	
	Number	% of Total	Number	% of Total
Total 2015 Plan Selections through the Marketplaces in HealthCare.gov States, 11-14-14 to 2-15-15 *(including SEP activity through 2-22-15)* (2) (3)	8.84 million	100%	4.67 million	100%
Number With Plan Selection Dates During the First Two Months of the Open Enrollment Period (11-15-14 to 1-16-15)	7.16 million	81%	3.00 million	64%
Number Who Selected a Plan Through the Marketplaces During the Last Month of the Open Enrollment Period Period *(including SEP activity through 2-22-15)*	1.68 million	19%	1.67 million	36%

Notes: Numbers may not add to totals due to rounding
(1) New Consumers includes data on 2015 Marketplace plan selections for individuals who did not have an active Marketplace plan selection in HealthCare.gov as of November 2014. This includes consumers who were entirely new to the Marketplace (e.g., those who had not previously submitted a completed application for 2014 coverage through HealthCare.gov, including some individuals who may have previously had experience with a State-Based Marketplace that was using its own Marketplace platform in 2014); as well as those who had previously submitted a completed application to the Marketplace during the 2014 coverage year (including those whose previous 2014 Marketplace plan selection was cancelled or terminated before November 2014, those who were determined eligible to enroll in a QHP, but did not select a Marketplace plan during the 2014 Coverage Year, and those who submitted a completed application to the Marketplace but were not determined eligible to enroll in a QHP during the 2014 coverage year).
(2) Total 2015 Marketplace Plan Selections represents cumulative data on the number of unique individuals who have selected or been automatically reenrolled into 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 issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP).
(3) Special Enrollment Period (SEP) activity includes plan selections that were made between 2-16-15 and 2-22-15 by those who qualified for an SEP because they were "in line" on 2-15-15, as well as those who experienced a qualifying life event or a complex situation related to applying for coverage in the Marketplace with coverage effective on March 1, 2015.
Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

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 2-15-15 *(including SEP Activity thru 2-22-15)*

The number of 2015 Marketplace plan selections increased by 1.7 million between 1-16-15 and 2-15-15, including SEP activity thru 2-22-15 (from more than 7.1 million to 8.8 million)



Notes: Represents cumulative sums of weekly data (Sunday to Saturday) on the 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 3-6-15

- ***Interest in the Marketplaces in HealthCare.gov States Has Been High.*** – During the 2015 Open Enrollment period:
  - ***o*** 35.2 million visitors used the HealthCare.gov and CuidadoDeSalud.gov websites;
  - ***o*** 16.8 million calls were made to the Marketplace call center for the HealthCare.gov states;
  - ***o*** 9.2 million completed applications for 2015 coverage were submitted; and
  - ***o*** 12.4 million individuals were included in these completed applications.[20]

[20] A single completed application form that is submitted to the Marketplace can include multiple individual applicants from the same household.

Characteristics of 2015 Plan Selections Through the Marketplaces in the HealthCare.gov States Compared to 2014 and Characteristics of New Consumers and Reenrollees in 2015

Generally, the demographic characteristics of consumers selecting plans through the Marketplaces in the HealthCare.gov states during the 2014 and 2015 Open Enrollment Periods were quite similar (see Table 4).

There were also some demographic differences between new consumers in 2015 and consumers reenrolling in coverage through the Marketplaces. Most notably, new consumers were more likely to be young adults, less likely to select a silver plan, more likely to be African-American or Latino, and less likely to be White.

As noted in the 2014 summary enrollment report,[21] the data on race and ethnicity should be interpreted with great caution since more than one-third of enrollees do not provide these data.

[21] 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.

Table 4

Comparison of Selected Characteristics of Plan Selections through the Marketplaces in States Using the HealthCare.gov Platform	2014 Open Enrollment Period (2)	2015 Open Enrollment Period (3)			
	Total Plan Selections	Total Plan Selections	By Reenrollment Status		
			New Consumers	Active Reenrollees	Automatic Reenrollees
Total Number of Individuals Who Have Selected a 2015 Plan Through the Marketplaces in the HealthCare.gov States (1)	5.44 million	8.84 million	4.67 million	2.21 million	1.96 million
Males who have selected a Marketplace plan (5)	*45%*	*46%*	*47%*	*43%*	*46%*
Females who have selected a Marketplace plan (5)	*55%*	*54%*	*53%*	*57%*	*54%*
0 to 34 year olds who have selected a Marketplace plan (5)	*35%*	*36%*	*40%*	*28%*	*36%*
18 to 34 year olds who have selected a Marketplace plan (5)	*28%*	*28%*	*31%*	*21%*	*29%*
Individuals who have selected a Silver Marketplace plan (5)	*69%*	*69%*	*66%*	*72%*	*72%*
Individuals who have selected a Marketplace plan with Financial Assistance (5)	*86%*	*87%*	*86%*	*91%*	*84%*
African-Americans who have selected a Marketplace plan (5)	*17%*	*14%*	*16%*	*11%*	*15%*
Latinos who have selected a Marketplace plan (5)	*11%*	*11%*	*12%*	*10%*	*10%*
Whites who have selected a Marketplace plan (5)	*63%*	*65%*	*63%*	*69%*	*66%*
Individuals in ZIP Codes designated as Rural who have selected a Marketplace Plan (5)	*N/A*	*17%*	*17%*	*18%*	*18%*

Notes:

(1) Represents the cumulative number of unique individuals who have selected or been automatically reenrolled into 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 issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). See Appendix D for additional technical notes.

(2) Data for the 2014 Open Enrollment Period are for the following reporting period: 10-1-13 to 3-31-14 (including SEP activity through 4-19-14). 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) Data for the 2015 Open Enrollment Period are for the following reporting period: 11-15-14 to 2-15-15 (including SEP activity through 2-22-15). 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) The data for the 2014 Open Enrollment period correspond with the reporting period for the 2015 Open Enrollment Period.

(5) 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 A1.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

Distribution of 2015 Plan Selections Through the Marketplaces in the HealthCare.gov States By Household Income

Most (80 percent) of the consumers who selected 2015 plans through the Marketplaces in the HealthCare.gov states during the 2015 Open Enrollment period (11-15-14 to 2-15-15, including SEP activity through 2-22-15) had household incomes that were between 100 percent and 250 percent of the Federal Poverty Level (FPL). However, the observed household income distributions differed between HealthCare.gov states that have and have not expanded Medicaid under the Affordable Care Act (see Table 5).[22]

[22] As of December 2014, 14 HealthCare.gov states had implemented the expansion of Medicaid under the Affordable Care Act to cover adults under age 65 with incomes up to 133 percent of the Federal Poverty Level. Additionally, Pennsylvania implemented the Medicaid expansion on January 1, 2015 and Indiana the implemented Medicaid expansion on February 1, 2015.

Table 5

2015 Plan Selections Through the Marketplaces in States Using the HealthCare.gov Platform by Household Income and Medicaid Expansion Status, 11-15-14 to 2-15-15 *(including SEP activity thru 2-22-15)*						
Household Income *(% of the Federal Poverty Level (FPL))*	**Total Plan Selections**			**Plan Selections for Consumers Renewing Coverage**		
	All States Using the HealthCare.gov Platform for the 2015 Coverage Year *(37 States)*	**HealthCare.gov States That Have Implemented the Medicaid Expansion (1)** *(16 States)*	**HealthCare.gov States That Have Not Implemented the Medicaid Expansion** *(21 States)*	**All States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	**HealthCare.gov States That Have Implemented the Medicaid Expansion (1)** *(16 States)*	**HealthCare.gov States That Have Not Implemented the Medicaid Expansion** *(21 States)*
Total 2015 Plan Selections Through the Marketplaces (2)	8.84 million	2.56 million	6.28 million	4.17 million	1.28 million	2.89 million
Plan Selections With Available Data on Household Income (3)	8.31 million	2.35 million	5.97 million	3.93 million	1.18 million	2.75 million
Plan Selections by Household Income (% of Total with Available Data):						
<100% of FPL	3%	2%	3%	2%	2%	2%
≥100% - ≤150% of FPL	40%	22%	47%	39%	25%	45%
>150% - ≤200% of FPL	25%	32%	23%	26%	31%	24%
>200% - ≤250% of FPL	15%	19%	13%	15%	18%	13%
>250% - ≤300% of FPL	8%	11%	7%	8%	11%	7%
>300% - ≤400% of FPL	8%	11%	6%	7%	10%	6%
> 400% of FPL	2%	3%	2%	2%	3%	2%

Notes:

(1) As of December 2014, 14 HealthCare.gov states had implemented the expansion of Medicaid under the Affordable Care Act to cover adults under age 65 with incomes up to 133 percent of the Federal Poverty Level. Additionally, Pennsylvania implemented the Medicaid expansion on January 1, 2015 and Indiana the implemented Medicaid expansion on February 1, 2015. See Appendix D for additional technical notes.

(2) Represents the cumulative number of unique individuals who have selected or been automatically reenrolled into 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 issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP).

(3) Household Income represents the individual's household income as a percentage of the Federal Poverty Level. The 2014 Federal Poverty Guidelines, which are used in determining premium tax credits for 2015 coverage, can be accessed at http://aspe.hhs.gov/poverty/14poverty.cfm.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

Impact of the Advance Premium Tax Credit on Monthly Premiums

Under the Affordable Care Act, advance premium tax credits are available to reduce premium costs for qualified individuals.[23]

- More than 8 in 10 individuals (nearly 7.7 million, or 87 percent) who selected or were automatically enrolled in a 2015 plan through the Marketplaces in the HealthCare.gov states qualify for an advance premium tax credit[24] with an average value of $263 per person per month[25] (Table 6).
- The average advance premium tax credit covers about 72 percent of the gross premium for individuals who qualify for an average advance premium tax credit.
- The average net premium after advance premium tax credit is $101 per month among individuals with 2015 plan selections through the Marketplaces in the HealthCare.gov states who qualify for an advance premium tax credit.

Table 6

Reduction in Average Monthly Premiums from Advance Premium Tax Credits (APTC) in States Using the HealthCare.gov Platform (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)	Percent of Plan Selections with APTC	Average Monthly Premium before APTC	Average Monthly APTC	Average Monthly Premium After APTC	Average Percent Reduction in Premium after APTC
TOTAL – States Using the HealthCare.gov Platform	8.84 million	87%	$364	$263	$101	72%

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

[23] The premium tax credit ("PTC") is calculated as the difference between the cost of the adjusted monthly premium of the second-lowest cost silver plan with respect to the applicable taxpayer and the applicable contribution percentage that a person is statutorily required to pay deter-mined by household income. An individual may choose to have all or a portion of the PTC paid in advance (advance premium tax credit or "APTC") to an issuer of a qualified health plan in order to reduce the cost of monthly insurance premiums. APTCs are generally available for individuals with a projected household income between 100 percent (133 percent in states that have chosen to expand their Medicaid programs) and 400 percent of the Federal Poverty Level (FPL). For 2015, the percentage of household income that a qualified individual or family will pay toward a health insurance premium ranges from 2.01 percent of household income at 100 percent of the FPL to 9.56 percent of income at 400 percent of FPL. For more information on the required contribution percentage, see http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

[24] For purposes of this analysis, an individual qualifying for an advance premium tax credit was defined as any individual with an APTC amount >$0.

[25] Averages in this brief refer to plan-selection-weighted averages across individuals with plan selections with advance premium tax credits in the 37 HealthCare.gov states. For more information, see the ASPE Issue Brief "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using the HealthCare.gov Platform," accessed at http://www.aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf.

Many Consumers Took Advantage of the Availability of 2015 Plans with Premiums of $100 or Less Through the Marketplaces in the HealthCare.gov States

- Overall, more than half (55 percent) of the 8.8 million total individuals with 2015 plan selections through the Marketplaces in the HealthCare.gov states have a monthly premium of $100 or less after applying the advance premium tax credit. About 8 in 10 of these individuals had the option of selecting such a plan (see Table 7).
- Meanwhile, more than 3 in 10 of the 8.8 million total individuals with 2015 plan selections through the Marketplaces in the HealthCare.gov states have a monthly premium of $50 or less after applying any applicable advance premium tax credit. About 7 in 10 of eligible individuals had the option of selecting such a plan

Table 7

Availability and Selection of Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) through the Marketplaces in States Using the HealthCare.gov Platform (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)	Availability of Plans With Monthly Premiums of $100 or Less		Selection of Plans With Monthly Premiums of $100 or Less	
		Percent Who Could Have Selected a Plan with a Monthly Premium of $50 or Less after APTC	Percent Who Could Have Selected a Plan with a Monthly Premium of $100 or Less after APTC	Percent Who Selected or Were Automatically Reenrolled in a Plan With a Monthly Premium of $50 or Less after APTC	Percent Who Selected or Were Automatically Reenrolled in a Plan With a Monthly Premium of $100 or Less after APTC
Total Number of Individuals With 2015 Plan Selections Through the Marketplaces	8.84 million	66%	77%	33%	55%
Individuals With 2015 Plan Selections With APTC through the Marketplaces	7.65 million	77%	89%	38%	63%

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

Distribution of 2015 Plan Selections Through the Marketplaces in the HealthCare.gov States by Monthly Premium After Tax Credit and Reenrollment Status

- Consumers who shopped for coverage were more likely to have a 2015 plan selection through the Marketplaces with a monthly premium of $100 or less after applying the advance premium tax credit – 58 percent for new consumers and 55 percent for reenrollees who returned to the Marketplaces and selected a plan, compared with 46 percent for automatic reenrollees who did not return to the Marketplaces (see Table 8).

Table 8

2015 Plan Selections Through the Marketplaces in States Using the HealthCare.gov Platform By Monthly Premium After Tax Credit	Cumulative 11-15-14 to 2-15-15 *(Including SEP Activity thru 2-22-15)*			
	Total Individuals With 2015 Marketplace Plan Selections	By Reenrollment Status		
		New Consumers	Active Reenrollees	Automatic Reenrollees
Total 2015 Plan Selections Through the Marketplaces in HealthCare.gov States, 11-14-14 to 2-15-15 *(including SEP activity through 2-22-15)* (3)	8.84 million	4.67 million	2.21 million	1.96 million
Plan Selections by Monthly Premium After the Advance Premium Tax Credit (APTC):				
Less Than or Equal to $100	55%	58%	55%	46%
≥$0 and ≤ $50	33%	37%	33%	22%
>$50 and ≤ $100	22%	21%	22%	24%
Greater Than $100	45%	42%	45%	54%

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

Table 9

2015 Plan Selections Through the Marketplaces in States Using the HealthCare.gov Platform By Monthly Premium After Tax Credit	Cumulative 11-15-14 to 2-15-15 *(Including SEP Activity thru 2-22-15)*			
	Total Individuals With 2015 Marketplace Plan Selections With APTC	By Reenrollment Status		
		New Consumers	Active Reenrollees	Automatic Reenrollees
Total 2015 Plan Selections Through the Marketplaces in HealthCare.gov States, 11-14-14 to 2-15-15 *(including SEP activity through 2-22-15)* (3)	7.65 million	4.01 million	2.01 million	1.63 million
Plan Selections by Monthly Premium After the Advance Premium Tax Credit (APTC):				
Less Than or Equal to $100	63%	67%	60%	55%
≥$0 and ≤ $50	38%	43%	37%	27%
>$50 and ≤ $100	25%	24%	23%	28%
Greater Than $100	37%	33%	40%	45%

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

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 2015 Open Enrollment period, with more than 35 million visitors to the Marketplace websites, 15 million calls to the Marketplace call center, and 9 million completed applications in the HealthCare.gov states as of 2-15-15 (including SEP activity through 2-22-15) (see Table 10).

Table 10

Cumulative Enrollment-Related Information Relating to the Marketplaces in States Using The HealthCare.gov Platform	**Reporting Period: 11-15-14 to 2-15-15** *(including SEP Activity Thru 2-22-15)* **(1)**
Visitors to the Marketplace Websites (2)	35,175,531
Calls to the Marketplace Call Center (3)	16,806,861
Number of Completed Applications	9,197,913
Number of Individuals Included in Completed Applications	12,410,323
Number of Individuals Determined Eligible to Enroll in a 2015 Plan Through the Marketplaces	10,721,940

Notes:

(1) The data in this table are for the 11-15-14 to 2-15-15 reporting period. See Appendix D for technical notes.

(2) Visitors to the Marketplace Websites includes 33,845,038 unique visitors on HealthCare.gov and 1,330,493 unique visitors on CuidadoDeSalud.gov between 11-15-14 and 2-15-15, including additional SEP activity through 2-22-15. 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 1,471,607 calls with Spanish-speaking representatives and 15,324,491 other calls between 11-15-14 and 2-15-15, including additional SEP activity through 2-22-15.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

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

Nearly 2.85 million individuals have selected 2015 plans through the Marketplace s in the 14 states (including DC) that are using their own Marketplace platforms for the 2015 coverage year as of 2-15-15 (including SEP activity through 2-21-15).[26] Several states (Maryland, Massachusetts, and Idaho) are unable to separate out data for new consumers and consumers reenrolling in coverage through the Marketplaces due to system vendor changes or other information technology system issues. This includes:

- 357,764 plan selections through the Marketplaces in 3 states reporting all enrollees as new consumers because of systems issues. (Idaho,[27] Maryland, and Massachusetts); and
- 2,492,019 plan selections through the Marketplaces in 11 states reporting data on new consumers, consumers actively reenrolling in Marketplace coverage, and automatic reenrollees (California, Colorado, Connecticut, District of Columbia, Hawaii, Kentucky, Minnesota, New York, Rhode Island, Vermont, and Washington).

Consistent with experience during the 2014 Open Enrollment period, the Marketplaces in the states using their own Marketplace platforms experienced additional plan selections as the close of the 2015 Open Enrollment period approached. Table 11 shows that 16 percent of the nearly 2.85 million plan selections for consumers who selected or were automatically enrolled in Marketplace plans in these states during the 2015 Open Enrollment period (including SEP activity through 2-21-15) occurred during the last month of the Open Enrollment period (between 1-18-15 and 2-15-15, including SEP activity through 2-21-15).

[26] Data for California are for 11-15-14 to 2-22-15.

[27] Data for Idaho include some automatic reenrollees from their previous HealthCare.gov platform (Idaho used the HealthCare.gov platform during the 2014 coverage year); however, Idaho is treating all plan selections as new in 2015.

Table 11

2015 Plan Selections Through the Marketplaces in States Using Their Own Marketplace Platforms By Plan Selection Date	Total Plan Selections	
	Number	**% of Total**
Total 2015 Plan Selections Through the Marketplaces in States Using Their Own Marketplace Platforms, 11-14-14 to 2-15-15 *(including SEP activity through 2-22-15)* (2) (3)	2.85 million	100%
Number With Plan Selection Dates During the First Two Months of the Open Enrollment Period (11-15-14 to 1-17-15)	2.38 million	84%
Number Who Selected a Marketplace Plan During the Last Month of the Open Enrollment Period *(including SEP activity through 2-22-15)*	0.47 million	16%

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 or been automatically reenrolled into 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 issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data.
(2) Special Enrollment Period (SEP) activity includes plan selections that were made between 2-15-15 and 2-21-15 by those who qualified for an SEP because they were "in line" on 2-15-15, as well as those who experienced a qualifying life event or a complex situation related to applying for coverage in the Marketplace with coverage effective on March 1, 2015.
Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

This report also includes available data relating to completed applications, eligibility determinations, website visitors, and call center activity (see Table 12); as well as the overall distribution of Marketplace plan selections by gender, age, metal level, and financial assistance status. (See Appendix Table A3 for a summary of available data on the characteristics of Marketplace plan selections in these states, and Appendix Table D3 for a summary of which data are available for each state. Additionally, Appendix Tables C1, C2, C3, C4, and C5 include state-level data for several metrics).

Table 12

Cumulative Enrollment-Related Information on the Marketplaces in States Using Their Own Marketplace Platforms	Reporting Period: 2015 Open Enrollment Period (1)
Visitors to the Marketplace Websites *Number of States Reporting: 13*	13,011,171
Calls to the Marketplace Call Centers *Number of States Reporting: 14*	8,110,152
Number of Completed Applications *Number of States Reporting: 12*	1,886,934
Number of Individuals Included in Completed Applications *Number of States Reporting: 12*	3,525,757
Number of Individuals Determined Eligible to Enroll in a 2015 Plan through the Marketplaces *Number of States Reporting: 14*	3,694,776
Number of Individuals Who Have Selected a 2015 Plan through the Marketplaces (2) *Number of States Reporting: 14*	2,849,783

Notes:

(1) Most of the data in this table are for the 11-15-14 to 2-15-15 (including SEP activity through 2-21-15) reporting period with the following exceptions: data for California are for 11-15-14 to 2-15-15 (including SEP activity through 2-22-15).

(2) Total 2015 Marketplace Plan Selections generally 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 issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated (however, one state, Washington, has reported data on effectuated enrollment). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data. These data do not include a count of the number of individuals who have selected a standalone dental plan. They also generally do not include data for individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP).

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

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 platforms. 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 2015 Open Enrollment period – which generally corresponds with data from 11-15-14 to 2-15-15 (including SEP activity through 2-22-15) for the 37 HealthCare.gov states; and from 11-15-14 to 2-15-15 (including SEP activity through 2-22-15) in states that are using their own Marketplace platforms for the 2015 coverage (see Table 13 below).

Table 13

Marketplace Type	Reporting Period
States Using the HealthCare.gov Marketplace Platform (37 states)	11-15-14 to 2-15-15 (including SEP activity thru 2-22-15)
States Using Their Own Marketplace Platform (14 states)	
California	11-15-14 to 2-15-15 (including SEP activity thru 2-22-15)
Other 13 States (including DC)	11-15-14 to 2-15-15 (including SEP activity thru 2-21-15)

Data for certain metrics are not available for several of the states that are using their own Marketplace platforms.

It is important to note that some of the 14 states that are using their own Marketplace platforms are not separately reporting data for new consumers and consumers who are reenrolling in coverage through the Marketplaces. Please refer to Appendix D for additional technical notes.

This report also includes available data on the characteristics of individuals who have selected a plan through the Marketplaces for the 37 states that are using the HealthCare.gov platform for 2015, and the 14 states that are using their own Marketplace platforms. 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 2015 Open Enrollment period because the data for the various metrics are counted using comparable definitions for data elements across states and Marketplace types.

SECTION IV: APPENDICES

APPENDIX TABLE A1

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance, Marketplaces Total *11-15-14 to 2-15-15 (including SEP activity through 2-22-15) (1)*		
Characteristics	**Marketplaces Total** *(States Using the HealthCare.gov Platform and States Using Their Own Marketplace Platforms)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-22-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan		
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2015 Marketplace Plan	11,688,074	n/a
By Gender		
Female	6,281,662	54%
Male	5,398,069	46%
Subtotal: Plan Selections With Available Data on Gender	11,679,731	100%
Unknown Gender	8,343	n/a
By Age		
Age < 18	890,017	8%
Age 18-25	1,269,792	11%
Age 26-34	1,982,477	17%
Age 35-44	1,940,164	17%
Age 45-54	2,559,338	22%
Age 55-64	2,947,749	25%
Age ≥65	74,824	1%
Subtotal: Plan Selections With Available Data on Age (2)	11,664,361	100%
Unknown Age	3,001	n/a
Ages 18 to 34	3,252,269	28%
Ages 0 to 34	4,142,286	36%
By Metal Level		
Bronze	2,574,807	22%
Silver	7,801,379	67%

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance, Marketplaces Total *11-15-14 to 2-15-15 (including SEP activity through 2-22-15) (1)*		
Characteristics	**Marketplaces Total** *(States Using the HealthCare.gov Platform and States Using Their Own Marketplace Platforms)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-22-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Gold	794,853	7%
Platinum	381,989	3%
Catastrophic	110,304	1%
Subtotal: Plan Selections With Available Data on Metal Level (4)	11,663,332	100%
Standalone Dental	1,402,616	n/a
Unknown Metal Level	75,060	n/a
By Financial Assistance Status		
With Financial Assistance	9,941,820	86%
Without Financial Assistance	1,682,145	14%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	11,623,965	100%
Unknown Financial Assistance Status	0	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). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections for all but three states (Minnesota, DC and New York). These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). Data for the 37 HealthCare.gov States include SEP activity through 2-22-15; data for the 15 States using their own Marketplace platforms include SEP activity through 2-21-15 (with the exception of CA, which includes SEP activity through 2-22-15). For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(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 multiple 2015 Marketplace plan selections in the system that will be resolved through data cleanup processes. 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 3-6-15.

APPENDIX TABLE A2

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, and Rural Status in States Using the HealthCare.gov Platform (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*		
Characteristics	**States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-22-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan		
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2015 Marketplace Plan	8,838,291	n/a
By Gender		
Female	4,798,629	54%
Male	4,034,320	46%
Subtotal: Plan Selections With Available Data on Gender	8,832,949	100%
Unknown Gender	5,342	n/a
By Age		
Age < 18	726,305	8%
Age 18-25	990,751	11%
Age 26-34	1,479,091	17%
Age 35-44	1,474,514	17%
Age 45-54	1,912,050	22%
Age 55-64	2,182,380	25%
Age ≥65	52,488	1%
Subtotal: Plan Selections With Available Data on Age (2)	8,817,579	100%
Unknown Age	n/a	n/a
Ages 18 to 34	2,469,842	28%
Ages 0 to 34	3,196,147	36%
By Metal Level		
Bronze	1,872,457	21%
Silver	6,090,199	69%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, and Rural Status in States Using the HealthCare.gov Platform (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*		
Characteristics	**States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-22-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Gold	573,641	6%
Platinum	225,074	3%
Catastrophic	76,920	1%
Subtotal: Plan Selections With Available Data on Metal Level (4)	8,838,291	100%
Standalone Dental	1,377,874	n/a
Unknown Metal Level	0	n/a
By Financial Assistance Status		
With Financial Assistance	7,690,911	87%
Without Financial Assistance	1,147,380	13%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	8,838,291	100%
Unknown Financial Assistance Status	n/a	n/a
By Self-Reported Race/Ethnicity		
American Indian / Alaska Native	26,314	0%
Asian	460,293	8%
Native Hawaiian / Pacific Islander	5,145	0%
African-American	789,498	14%
Latino	613,053	11%
White	3,649,620	65%
Multiracial	76,609	1%
Subtotal: Plan Selections With Available Data on Self-Reported Race/Ethnicity	5,620,532	100%
Unknown Race/Ethnicity	3,217,759	n/a
By Rural Status		
In ZIP Codes Designated as Rural	1,542,970	17%
In ZIP Codes Designated as Urban	7,295,321	83%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, and Rural Status in States Using the HealthCare.gov Platform (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*		
Characteristics	**States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-22-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Subtotal: Plan Selections With Available Data on Rural Status	8,838,291	100%
Unknown Rural Status	n/a	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). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(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 multiple 2015 Marketplace plan selections in the system that will be resolved through data cleanup processes. 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 3-6-15.

APPENDIX TABLE A3

Marketplace Plan Selections by Gender and Age; Gender and Metal Level; Financial Assistance Status and Metal Level; and Metal Level and Age in States Using the HealthCare.gov Platform (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	HealthCare.gov States Total			Females – HealthCare.gov States			Males – HealthCare.gov States		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	8,838,291	n/a	n/a	4,798,629	n/a	n/a	4,034,320	n/a	n/a
By Gender and Age	**Number**	**% of Gender Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Gender Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Gender Total (4)**	**% of Age Group Total (5)**
Age < 18	726,305	8%	100%	354,662	7%	49%	371,374	9%	51%
Age 18-25	990,751	11%	100%	528,623	11%	53%	461,501	11%	47%
Age 26-34	1,479,091	17%	100%	787,537	16%	53%	690,799	17%	47%
Age 35-44	1,474,514	17%	100%	791,804	17%	54%	681,786	17%	46%
Age 45-54	1,912,050	22%	100%	1,049,934	22%	55%	860,837	21%	45%
Age 55-64	2,182,380	25%	100%	1,244,747	26%	57%	936,186	23%	43%
Age ≥65	52,488	1%	100%	29,418	1%	56%	23,038	1%	44%
Subtotal: Plan Selections With Available Data on Age	8,817,579	100%	100%	4,786,725	100%	54%	4,025,521	100%	46%
Unknown Age	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ages 18 to34	2,469,842	28%	100%	1,316,160	27%	53%	1,152,300	29%	47%
Ages 0 to 34	3,196,147	36%	100%	1,670,822	35%	52%	1,523,674	38%	48%
By Gender and Metal Level	**Number**	**% of Gender Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Gender Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Gender Total (4)**	**% of Metal Level Total (5)**
Bronze	1,872,457	21%	100%	950,185	20%	51%	921,300	23%	49%
Silver	6,090,199	69%	100%	3,393,112	71%	56%	2,693,099	67%	44%
Gold	573,641	6%	100%	301,753	6%	53%	271,621	7%	47%
Platinum	225,074	3%	100%	116,818	2%	52%	108,158	3%	48%
Catastrophic	76,920	1%	100%	36,761	1%	48%	40,142	1%	52%
Subtotal: Plan Selections With Available Data on Metal Level	8,838,291	100%	100%	4,798,629	100%	54%	4,034,320	100%	46%
Standalone Dental	1,377,874	n/a	n/a	751,805	n/a	n/a	625,307	n/a	n/a
Unknown Metal Level	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Description	HealthCare.gov States Total			With Financial Assistance - HealthCare.gov States			Without Financial Assistance - HealthCare.gov States		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	8,838,291	n/a	n/a	7,690,911	n/a	n/a	1,147,380	n/a	n/a
By Financial Assistance Status and Metal Level (6)	**Number**	**% of Financial Assistance Status Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Financial Assistance Status Total (4)**	**% of Metal Level Total (5)**	**Number**	**% of Financial Assistance Status Total (4)**	**% of Metal Level Total (5)**
Bronze	1,872,457	21%	100%	1,471,197	19%	79%	401,260	35%	21%
Silver	6,090,199	69%	100%	5,725,012	74%	94%	365,187	32%	6%
Gold	573,641	6%	100%	360,353	5%	63%	213,288	19%	37%
Platinum	225,074	3%	100%	134,354	2%	60%	90,720	8%	40%
Catastrophic	76,920	1%	100%	0	0%	0%	76,920	7%	100%
Subtotal: Plan Selections With Available Data on Metal Level	8,838,291	100%	100%	7,690,911	100%	87%	1,147,380	100%	13%
Standalone Dental	1,377,874	n/a	n/a	0	n/a	n/a	0	n/a	n/a
Unknown Metal Level	0	n/a	n/a	0	n/a	n/a	0	n/a	n/a

Description	HealthCare.gov States Total			Bronze Plan Selections			Silver Plan Selections		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	8,838,291	n/a	n/a	1,872,457	n/a	n/a	6,090,199	n/a	n/a
By Metal Level and Age (6)	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**
Age < 18	726,305	8%	100%	168,300	9%	23%	429,614	7%	59%
Age 18-25	990,751	11%	100%	194,316	10%	20%	705,264	12%	71%
Age 26-34	1,479,091	17%	100%	316,319	17%	21%	989,441	16%	67%
Age 35-44	1,474,514	17%	100%	288,780	15%	20%	1,044,435	17%	71%
Age 45-54	1,912,050	22%	100%	402,611	22%	21%	1,353,224	22%	71%
Age 55-64	2,182,380	25%	100%	487,546	26%	22%	1,515,303	25%	69%
Age ≥65	52,488	1%	100%	9,540	1%	18%	39,722	1%	76%
Subtotal: Plan Selections With Available Data on Age	8,817,579	100%	100%	1,867,412	100%	21%	6,077,003	100%	69%
Unknown Age	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ages 18 to34	2,469,842	28%	100%	510,635	27%	21%	1,694,705	28%	69%
Ages 0 to 34	3,196,147	36%	100%	678,935	36%	21%	2,124,319	35%	66%

Description	Gold Plan Selections			Platinum Plan Selections			Catastrophic Plan Selections		
	Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)		Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan									
Number of Individuals Who Have Selected a Marketplace Plan	573,641	n/a	n/a	225,074	n/a	n/a	76,920	n/a	n/a
By Metal Level and Age (6)	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**
Age < 18	89,511	16%	12%	35,230	16%	5%	3,650	5%	1%
Age 18-25	45,992	8%	5%	19,500	9%	2%	25,679	34%	3%
Age 26-34	92,832	16%	6%	42,376	19%	3%	38,123	50%	3%
Age 35-44	93,299	16%	6%	43,676	19%	3%	4,324	6%	0%
Age 45-54	110,297	19%	6%	42,789	19%	2%	3,129	4%	0%
Age 55-64	137,900	24%	6%	39,890	18%	2%	1,741	2%	0%
Age ≥65	2,245	0%	4%	978	0%	2%	3	0%	0%
Subtotal: Plan Selections With Available Data on Age	572,076	100%	6%	224,439	100%	3%	76,649	100%	1%
Unknown Age	1,565	n/a	n/a	n/a	n/a	n/a	267	n/a	n/a
Ages 18 to34	138,824	24%	6%	61,876	28%	3%	63,802	83%	3%
Ages 0 to 34	228,335	40%	7%	97,106	43%	3%	67,452	88%	2%

Description	Standalone Dental Plan Selections		
	Number (2)	% of Available Data, Excluding Unknown (3)	
Total Who Have Selected a Marketplace Plan			
Number of Individuals Who Have Selected a Marketplace Plan	1,377,874	n/a	n/a
Number Who Have Selected a Standalone Dental Plan By Metal Level and Age	**Number**	**% of Metal Level Total (4)**	**% of Age Group Total (5)**
Age < 18	99,744	7%	14%
Age 18-25	159,052	12%	16%
Age 26-34	302,134	22%	20%
Age 35-44	260,498	19%	18%
Age 45-54	277,464	20%	15%
Age 55-64	269,468	20%	12%
Age ≥65	6,391	0%	12%
Subtotal: Plan Selections With Available Data on Age	1,374,751	100%	16%
Unknown Age	n/a	n/a	n/a
Ages 18 to34	461,186	34%	19%
Ages 0 to 34	560,930	41%	18%

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). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(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) Represents the vertical percentage for the data that are being shown based on a given set of metrics. For example, if the rows show Age Groups and the columns show Gender, then this percentage represents the data for a given Age Group / Gender combination as a percentage of the comparable Gender total for all Age Groups (e.g., Persons between the ages of 18 and 34 represent X percent of the all of the Female Marketplace Plan selections).

(5) Represents the horizontal percentage of the data that are being shown based on a given set of metrics. For example, if the rows show Age Groups and the columns show Gender, then this percentage represents the data for a given Age Group / Gender combination as a percentage of the comparable Age Group total for all Genders (e.g., Females represent X percent of the Marketplace Plan selections for persons between the ages of 18 and 34).

(6) 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 multiple 2015 Marketplace plan selections in the system that will be resolved through data cleanup processes. 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.

APPENDIX TABLE A4

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance Status in State-Based Marketplaces Using Their Own Marketplace Platforms (1) *11-15-14 to 2-15-15 (including SEP activity through 2-21-15)*		
Characteristics	**State-Based Marketplaces Using Their Own Marketplace Platforms for the 2015 Coverage Year** *(14 States)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-21-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan *(14 States Reporting)*		
Total Number of Individuals Who Have Selected or Been Automatically Reenrolled Into a 2015 Marketplace Plan	2,849,783	100%
By Gender *(10 States Reporting)*		
Female	1,483,033	52.1%
Male	1,363,749	47.9%
Subtotal: Plan Selections With Available Data on Gender	2,846,782	100%
Unknown Gender	3,001	n/a
By Age *(10 States Reporting)*		
Age < 18	163,712	5.8%
Age 18-25	279,041	9.8%
Age 26-34	503,386	17.7%
Age 35-44	465,650	16.4%
Age 45-54	647,288	22.7%
Age 55-64	765,369	26.9%
Age ≥65	22,336	0.8%
Subtotal: Plan Selections With Available Data on Age (2)	2,846,782	100%
Unknown Age	3,001	n/a
Ages 18 to 34	782,427	27.5%
Ages 0 to 34	946,139	33.2%

Marketplace Plan Selections by Gender, Age, Metal Level, and Financial Assistance Status in State-Based Marketplaces Using Their Own Marketplace Platforms (1) *11-15-14 to 2-15-15 (including SEP activity through 2-21-15)*		
Characteristics	**State-Based Marketplaces Using Their Own Marketplace Platforms for the 2015 Coverage Year** *(14 States)*	
	Number 11-15-14 to 2-15-15 *(including SEP activity through 2-21-15)* **(2)**	**% of Available Data, Excluding Unknown (3)**
By Metal Level *(10 States Reporting)*		
Bronze	702,350	24.9%
Silver	1,711,180	60.6%
Gold	221,212	7.8%
Platinum	156,915	5.6%
Catastrophic	33,384	1.2%
Subtotal: Plan Selections With Available Data on Metal Level (4)	2,825,041	100%
Standalone Dental	24,742	n/a
Unknown Metal Level	75,060	n/a
By Financial Assistance Status *(9 States Reporting)*		
With Financial Assistance	2,250,909	80.8%
Without Financial Assistance	534,765	19.2%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	2,785,674	100%
Unknown Financial Assistance Status	64,109	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 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 eligible for a Special Enrollment Period (SEP). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data. For additional technical notes, please refer to Appendix D of this report.

All states except DC, Minnesota, New York, and Washington removed cancellations and terminations from all total plan selection data. DC removed cancellations and terminations from its auto reenrollee data. New York removed cancellations and terminations from all of its reenrollee data, active and automatic, but did not remove them from the "new" plan selections. Washington removed terminations from all of their plan selection data. Minnesota did not remove cancellations and terminations from its plan selection data.

(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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. (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 multiple 2015 Marketplace plan selections in the system that will be resolved through data cleanup processes. 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 3-6-15.

APPENDIX TABLE B1

Marketplace Plan Selection by Enrollment Type in States Using the HealthCare.gov Platform, by State, 2015 (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*					
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (1)**	**Distribution By Enrollment Type (2)**			
		New Consumers (3)	**Consumers Reenrolling in Marketplace Coverage (4)**		
			Total Reenrollees	**Active Reenrollees (5)**	**Automatic Reenrollees (6)**
	Number	**% of Total**	**% of Total**	**% of Total**	**% of Total**
States Using the HealthCare.gov Platform (7)					
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (8)					
Nevada (9)	73,596	100%	0%	0%	0%
New Mexico	52,358	51%	49%	18%	31%
Oregon (9)	112,024	100%	0%	0%	0%
Subtotal - SBMs Using the HealthCare.gov Platform	237,978	89%	11%	4%	7%
Federally-Facilitated Marketplace (FFM) States					
Alabama	171,641	54%	46%	25%	21%
Alaska	21,260	52%	48%	35%	13%
Arizona	205,666	48%	52%	25%	27%
Arkansas	65,684	44%	56%	20%	37%
Delaware	25,036	51%	49%	22%	27%
Florida	1,596,296	55%	45%	30%	15%
Georgia	541,080	55%	45%	21%	23%
Illinois	349,487	50%	50%	21%	29%
Indiana	219,185	50%	50%	26%	25%
Iowa	45,162	53%	47%	28%	19%
Kansas	96,197	52%	48%	24%	24%
Louisiana	186,277	58%	42%	21%	21%
Maine	74,805	47%	53%	34%	19%
Michigan	341,183	42%	58%	24%	34%
Mississippi	104,538	56%	44%	15%	29%
Missouri	253,430	52%	48%	26%	22%
Montana	54,266	41%	59%	29%	30%
Nebraska	74,152	53%	47%	33%	14%
New Hampshire	53,005	40%	60%	31%	29%
New Jersey	254,316	48%	52%	30%	23%
North Carolina	560,357	51%	49%	31%	18%
North Dakota	18,171	45%	55%	33%	23%
Ohio	234,341	47%	53%	25%	28%
Oklahoma	126,115	54%	46%	21%	25%
Pennsylvania	472,697	41%	59%	24%	34%
South Carolina	210,331	58%	42%	19%	23%
South Dakota	21,393	47%	53%	25%	28%
Tennessee	231,440	53%	47%	26%	21%

Marketplace Plan Selection by Enrollment Type in States Using the HealthCare.gov Platform, by State, 2015 (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*					
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (1)**	**Distribution By Enrollment Type (2)**			
		New Consumers (3)	**Consumers Reenrolling in Marketplace Coverage (4)**		
			Total Reenrollees	**Active Reenrollees (5)**	**Automatic Reenrollees (6)**
	Number	**% of Total**	**% of Total**	**% of Total**	**% of Total**
Texas	1,205,174	57%	43%	21%	22%
Utah	140,612	49%	51%	24%	27%
Virginia	385,154	54%	46%	26%	20%
West Virginia	33,421	49%	51%	24%	26%
Wisconsin	207,349	44%	56%	32%	24%
Wyoming	21,092	48%	52%	28%	24%
TOTAL – States Using the HealthCare.gov Platform	**8,838,291**	**53%**	**47%**	**25%**	**22%**

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 these tables represent cumulative data on the number of unique individuals who have selected or have been automatically reenrolled into a 2015 Marketplace medical plan for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix D 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 coverage through the Marketplaces.

(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 issuer) as of the reporting date, and did not have a Marketplace plan selection as of November 2014. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP).

(4) "Consumers reenrolling in coverage through the Marketplaces" 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 have been automatically reenrolled in coverage through the Marketplaces – with or without the first premium payment having been received directly by the issuer). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-15-15 (including SEP activity through 2-22-15), but who may ultimately decide not to retain Marketplace coverage for the remainder of 2015 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP). The plan selection data in future reports will exclude these individuals (e.g., due to the subsequent cancellation or termination of their coverage).

(5) Active reenrollees are indviduals 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.

(6) Automatic Reenrollees are individuals who had a Marketplace plan selection as of November 2014, and retain coverage without returning to the Marketplace and selecting a plan. A consumer was automatically reenrolled into their 2014 plan or a plan with similar benefits from their same issuer if they were enrolled in a Marketplace plan in 2014 and did not select a plan ahead of the 12-15-14 deadline. If the consumer realized after the deadline that there was a better plan for their family or needed

to update their information, the consumer could make that change before 2-15-15, and would at that point be considered as having actively selected a plan.

(7) For the HealthCare.gov states, the data on 2015 Marketplace plan selections includes data for new consumers and consumers who reenrolling in Marketplace coverage (including data for consumers who actively reenrolled in coverage through the Marketplaces, and data for automatic reenrollees).

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

(9) 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 coverage through the Marketplaces 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 3-6-15.

APPENDIX TABLE B2

Plan Switching by Active Reenrollees Who Selected Plans Through the Marketplaces in States Using the HealthCare.gov Platform, By State (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (1)	Total Consumers Reenrolling in Coverage Through the Marketplaces (2)	Total Active Reenrollees (3)	Active Reenrollees Who Switched Plans (4)	Proportion Who Switched Plans:		
					Switchers as a % of Total Plan Selections	Switchers as a % of Total Reenrollees	Switchers as a % of Active Reenrollees
	Number	Number	Number	Number	%	%	%
States Using the HealthCare.gov Platform							
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)							
Nevada (6)	73,596	216	216	216	0%	100%	100%
New Mexico	52,358	25,398	9,195	4,542	9%	18%	49%
Oregon (6)	112,024	279	279	278	0%	100%	100%
Subtotal - SBMs Using the HealthCare.gov Platform	237,978	25,893	9,690	5,036	2%	19%	52%
Federally-Facilitated Marketplace (FFM) States							
Alabama	171,641	78,631	43,040	9,535	6%	12%	22%
Alaska	21,260	10,214	7,376	4,422	21%	43%	60%
Arizona	205,666	107,435	51,017	34,965	17%	33%	69%
Arkansas	65,684	37,092	12,986	5,180	8%	14%	40%
Delaware	25,036	12,321	5,526	2,307	9%	19%	42%
Florida	1,596,296	718,276	481,215	294,847	18%	41%	61%
Georgia	541,080	242,228	116,062	62,038	11%	26%	53%
Illinois	349,487	174,463	73,066	32,388	9%	19%	44%
Indiana	219,185	110,569	55,906	37,253	17%	34%	67%
Iowa	45,162	21,152	12,598	9,266	21%	44%	74%
Kansas	96,197	46,393	23,398	13,922	14%	30%	60%
Louisiana	186,277	78,662	39,107	22,649	12%	29%	58%
Maine	74,805	39,765	25,509	7,550	10%	19%	30%
Michigan	341,183	197,398	80,865	41,072	12%	21%	51%
Mississippi	104,538	46,450	16,065	9,715	9%	21%	60%
Missouri	253,430	122,027	66,032	39,066	15%	32%	59%
Montana	54,266	32,054	15,841	8,167	15%	25%	52%
Nebraska	74,152	34,845	24,757	19,741	27%	57%	80%
New Hampshire	53,005	31,805	16,220	10,833	20%	34%	67%
New Jersey	254,316	133,215	75,712	45,197	18%	34%	60%
North Carolina	560,357	274,227	174,352	76,409	14%	28%	44%
North Dakota	18,171	10,080	5,969	3,121	17%	31%	52%
Ohio	234,341	123,258	58,806	35,541	15%	29%	60%
Oklahoma	126,115	57,486	26,378	14,275	11%	25%	54%
Pennsylvania	472,697	276,746	115,773	55,830	12%	20%	48%
South Carolina	210,331	88,749	40,650	22,315	11%	25%	55%
South Dakota	21,393	11,425	5,416	3,612	17%	32%	67%
Tennessee	231,440	108,241	59,091	35,674	15%	33%	60%

Plan Switching by Active Reenrollees Who Selected Plans Through the Marketplaces in States Using the HealthCare.gov Platform, By State (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (1)	Total Consumers Reenrolling in Coverage Through the Marketplaces (2)	Total Active Reenrollees (3)	Active Reenrollees Who Switched Plans (4)	Proportion Who Switched Plans:		
					Switchers as a % of Total Plan Selections	Switchers as a % of Total Reenrollees	Switchers as a % of Active Reenrollees
	Number	Number	Number	Number	%	%	%
Texas	1,205,174	523,653	258,760	133,710	11%	26%	52%
Utah	140,612	71,959	33,840	17,931	13%	25%	53%
Virginia	385,154	176,642	98,822	43,555	11%	25%	44%
West Virginia	33,421	16,981	8,150	3,062	9%	18%	38%
Wisconsin	207,349	115,755	66,759	40,303	19%	35%	60%
Wyoming	21,092	10,964	5,877	3,431	16%	31%	58%
TOTAL – States Using the HealthCare.gov Platform	**8,838,291**	**4,167,054**	**2,210,631**	**1,203,918**	**14%**	**29%**	**54%**

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 these tables represent cumulative data on the number of unique individuals who have selected or have been automatically reenrolled into a 2015 Marketplace medical plan for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix D of this report.

(2) "Consumers reenrolling in coverage through the Marketplaces" 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 have been automatically reenrolled in coverage through the Marketplaces – with or without the first premium payment having been received directly by the issuer). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-15-15 (including SEP activity through 2-22-15), but who may ultimately decide not to retain Marketplace coverage for the remainder of 2015 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP). The plan selection data in future reports will exclude these individuals (e.g., due to the subsequent cancellation or termination of their coverage).

(3) "Active reenrollees" are indviduals 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.

(4) "Active reenrollees who switched plans" are active reenrollees who have not selected the same plan as for the 2014 coverage year, or a similar "crosswalked" plan with similar benefits that is offered by the same issuer as their 2014 plan.

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

(6) 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 coverage through the Marketplaces 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 3-6-15.

APPENDIX TABLE B3

Total Completed Applications and Individuals Who Completed Applications in States Using the HealthCare.gov Platform, By State, 2015 *11-15-2014 to 2-15-2015 (including SEP activity through 2-22-15)*		
Description	**Total Number of Completed Applications for 2015 Coverage (2)**	**Total Individuals Applying for 2015 Coverage in Completed Applications (3)**
	Number	**Number**
States Using the HealthCare.gov Platform		
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (4)		
Nevada	82,700	122,001
New Mexico	58,738	79,360
Oregon	175,126	258,030
Subtotal - SBMs Using the HealthCare.gov Platform	316,564	459,391
Federally-Facilitated Marketplace (FFM) States		
Alabama	192,777	244,632
Alaska	22,435	30,969
Arizona	194,343	299,153
Arkansas	88,255	119,770
Delaware	25,913	36,179
Florida	1,619,814	2,061,154
Georgia	549,560	734,954
Illinois	373,220	500,406
Indiana	242,230	322,822
Iowa	56,117	74,220
Kansas	95,844	132,595
Louisiana	206,463	245,015
Maine	68,633	94,722
Michigan	352,323	474,323
Mississippi	121,401	144,733
Missouri	259,690	354,475
Montana	50,771	69,867
Nebraska	66,671	100,254
New Hampshire	53,730	71,101

Total Completed Applications and Individuals Who Completed Applications in States Using the HealthCare.gov Platform, By State, 2015
11-15-2014 to 2-15-2015 (including SEP activity through 2-22-15)

Description	Total Number of Completed Applications for 2015 Coverage (2)	Total Individuals Applying for 2015 Coverage in Completed Applications (3)
	Number	Number
New Jersey	309,870	423,205
North Carolina	551,595	721,700
North Dakota	15,812	25,199
Ohio	268,617	362,214
Oklahoma	121,751	171,584
Pennsylvania	539,463	671,675
South Carolina	221,364	280,564
South Dakota	21,428	30,705
Tennessee	292,069	390,237
Texas	1,159,040	1,703,147
Utah	107,675	195,563
Virginia	363,579	511,789
West Virginia	37,617	50,452
Wisconsin	211,488	273,135
Wyoming	19,791	28,419
TOTAL – States Using the HealthCare.gov Platform	**9,197,913**	**12,410,323**

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 2-15-15 (including SEP activity through 2-22-15). 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 eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix D 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) Nevada, New Mexico, and Oregon are using the HealthCare.gov platform for 2015.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX TABLE B4

Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using the HealthCare.gov Platform, By State, 2015 (1) *11-15-2014 to 2-15-2015 (including SEP activity through 2-22-15)*				
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 Plan Selections Through the Marketplaces (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	90,696	77,228	28,290	73,596
New Mexico	62,905	49,378	15,522	52,358
Oregon	140,994	111,139	61,828	112,024
Subtotal - SBMs Using the HealthCare.gov Platform	294,595	237,745	105,640	237,978
Federally-Facilitated Marketplace (FFM) States				
Alabama	222,610	166,768	10,408	171,641
Alaska	27,056	21,779	3,613	21,260
Arizona	245,307	192,805	49,814	205,666
Arkansas	78,948	65,808	23,006	65,684
Delaware	29,682	23,992	5,985	25,036
Florida	1,909,132	1,632,571	126,181	1,596,296
Georgia	664,646	528,944	63,083	541,080
Illinois	408,019	323,657	86,560	349,487
Indiana	252,834	209,754	66,539	219,185
Iowa	57,110	47,154	15,474	45,162
Kansas	121,007	89,471	10,512	96,197
Louisiana	228,809	180,933	7,915	186,277
Maine	88,598	73,370	5,327	74,805
Michigan	387,618	333,890	82,135	341,183
Mississippi	132,596	106,478	10,699	104,538
Missouri	316,984	248,697	34,679	253,430

Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using the HealthCare.gov Platform, By State, 2015 (1)
11-15-2014 to 2-15-2015 (including SEP activity through 2-22-15)

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 Plan Selections Through the Marketplaces (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	64,632	52,823	2,683	54,266
Nebraska	90,915	73,371	7,218	74,152
New Hampshire	60,664	44,068	9,294	53,005
New Jersey	307,849	245,148	60,757	254,316
North Carolina	668,702	557,164	47,920	560,357
North Dakota	21,313	18,129	2,013	18,171
Ohio	279,722	229,459	79,963	234,341
Oklahoma	156,795	118,248	12,946	126,115
Pennsylvania	539,023	433,287	126,853	472,697
South Carolina	257,282	205,800	21,106	210,331
South Dakota	27,626	22,496	2,861	21,393
Tennessee	306,785	222,782	40,373	231,440
Texas	1,535,857	1,177,520	146,548	1,205,174
Utah	164,262	141,539	29,017	140,612
Virginia	470,998	355,017	36,569	385,154
West Virginia	40,358	33,409	5,063	33,421
Wisconsin	237,426	205,697	27,628	207,349
Wyoming	26,180	21,633	847	21,092
TOTAL – States Using the HealthCare.gov Platform	**10,721,940**	**8,641,406**	**1,367,229**	**8,838,291**

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 2-15-15 (including SEP activity through 2-22-15). 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 eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes information, please refer to Appendix D 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. Note: This number only includes data for individuals who applied for 2015 Marketplace coverage in completed applications. It does not include individuals who were automatically reenrolled. Thus, the number determined eligible for 2015 coverage may be lower than the total number of 2015 plan selections (which includes reenrollees).

(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. Note: This number only includes data for individuals who applied for 2015 Marketplace coverage in completed applications. It does not include individuals who were automatically reenrolled. Thus, the number determined eligible for 2015 coverage may be lower than the total number of 2015 plan selections with financial assistance (which includes reenrollees).

(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 December 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 coverage through the Marketplaces (with or without the first premium payment having been received directly by the issuer) during the reference period. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for 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 3-6-15.

APPENDIX TABLE B5

Marketplace Plan Selections by Financial Assistance Status in States Using the HealthCare.gov Platform, By State (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*						
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)**	**Plan Selections With Available Data on Financial Assistance Status (3)**	**By Financial Assistance Status (4)** *(% of Available Data, Excluding Unknown)*			
			With Financial Assistance	**Without Financial Assistance**	**With APTC** *(non-add)*	**With CSR** *(non-add)*
	Number	**Number**	**%**	**%**	**%**	**%**
States Using the HealthCare.gov Platform (4)						
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)						
Nevada	73,596	73,596	89%	11%	89%	55%
New Mexico	52,358	52,358	76%	24%	74%	47%
Oregon	112,024	112,024	79%	21%	77%	47%
Subtotal - SBMs Using the HealthCare.gov Platform	237,978	237,978	81%	19%	80%	49%
Federally-Facilitated Marketplace (FFM) States						
Alabama	171,641	171,641	89%	11%	89%	71%
Alaska	21,260	21,260	90%	10%	89%	54%
Arizona	205,666	205,666	76%	24%	75%	54%
Arkansas	65,684	65,684	88%	12%	88%	56%
Delaware	25,036	25,036	84%	16%	83%	45%
Florida	1,596,296	1,596,296	93%	7%	93%	70%
Georgia	541,080	541,080	90%	10%	89%	67%
Illinois	349,487	349,487	78%	22%	78%	46%
Indiana	219,185	219,185	88%	12%	87%	50%
Iowa	45,162	45,162	86%	14%	85%	48%
Kansas	96,197	96,197	80%	20%	80%	55%
Louisiana	186,277	186,277	89%	11%	89%	57%
Maine	74,805	74,805	89%	11%	89%	58%
Michigan	341,183	341,183	88%	12%	88%	55%
Mississippi	104,538	104,538	94%	6%	93%	76%
Missouri	253,430	253,430	88%	12%	88%	58%
Montana	54,266	54,266	85%	15%	84%	51%
Nebraska	74,152	74,152	88%	12%	87%	50%
New Hampshire	53,005	53,005	71%	29%	70%	37%
New Jersey	254,316	254,316	83%	17%	83%	51%
North Carolina	560,357	560,357	92%	8%	92%	65%
North Dakota	18,171	18,171	86%	14%	86%	42%
Ohio	234,341	234,341	84%	16%	84%	44%
Oklahoma	126,115	126,115	81%	19%	79%	59%
Pennsylvania	472,697	472,697	81%	19%	80%	57%
South Carolina	210,331	210,331	88%	12%	88%	63%
South Dakota	21,393	21,393	88%	12%	86%	63%
Tennessee	231,440	231,440	83%	17%	82%	62%
Texas	1,205,174	1,205,174	86%	14%	85%	59%

Marketplace Plan Selections by Financial Assistance Status in States Using the HealthCare.gov Platform, By State (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)	Plan Selections With Available Data on Financial Assistance Status (3)	By Financial Assistance Status (4) *(% of Available Data, Excluding Unknown)*			
			With Financial Assistance	Without Financial Assistance	With APTC *(non-add)*	With CSR *(non-add)*
	Number	Number	%	%	%	%
Utah	140,612	140,612	88%	12%	88%	60%
Virginia	385,154	385,154	84%	16%	83%	55%
West Virginia	33,421	33,421	86%	14%	86%	54%
Wisconsin	207,349	207,349	90%	10%	89%	58%
Wyoming	21,092	21,092	91%	9%	91%	52%
TOTAL – States Using the HealthCare.gov Platform	**8,838,291**	**8,838,291**	**87%**	**13%**	**87%**	**60%**

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: Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(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) Data on Marketplace plan selections with financial assistance includes plan selections for individuals who are receiving a premium tax credit and/or cost-sharing subsidy.

(5) 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 (including data for consumers who actively reenrolled in coverage through the Marketplaces, and data for automatic reenrollees).

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

Source: Centers for Medicare & Medicaid Services, as of 3-6-15; ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

APPENDIX TABLE B6

Marketplace Plan Selection by Age in States Using the HealthCare.gov Platform, By State (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Number of Plan Selections With Available Data on Age (2) (3)	By Age (% of Available Data, Excluding Unknown)								
		Age < 18	Age 18-25	Age 26-34	Age 35-44	Age 45-54	Age 55-64	Age ≥65	Ages 18-34	Ages 0-34
	Number	%	%	%	%	%	%	%	%	%
States Using the HealthCare.gov Platform (4)										
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)										
Nevada	73,411	13%	9%	15%	16%	20%	26%	1%	24%	36%
New Mexico	52,216	8%	7%	14%	14%	22%	34%	1%	21%	29%
Oregon	111,743	7%	8%	17%	16%	19%	33%	1%	24%	31%
Subtotal - SBMs Using the HealthCare.gov Platform	237,370	9%	8%	16%	16%	20%	31%	1%	24%	32%
Federally-Facilitated Marketplace (FFM) States										
Alabama	171,371	3%	13%	19%	19%	22%	24%	0%	32%	35%
Alaska	21,198	10%	8%	20%	16%	19%	26%	1%	28%	39%
Arizona	205,063	23%	9%	14%	14%	17%	23%	1%	23%	45%
Arkansas	65,604	7%	9%	16%	16%	21%	30%	1%	25%	32%
Delaware	24,983	13%	8%	15%	15%	22%	26%	1%	23%	36%
Florida	1,592,786	6%	13%	15%	18%	24%	23%	1%	28%	33%
Georgia	540,095	6%	13%	18%	19%	22%	21%	1%	31%	37%
Illinois	348,559	7%	10%	18%	15%	21%	28%	1%	28%	35%
Indiana	218,631	9%	9%	16%	16%	20%	29%	0%	25%	35%
Iowa	45,041	5%	9%	17%	15%	22%	32%	0%	26%	31%
Kansas	95,977	9%	11%	19%	16%	19%	25%	0%	31%	40%
Louisiana	185,924	4%	12%	20%	18%	22%	23%	0%	33%	37%
Maine	74,704	10%	8%	15%	14%	22%	31%	0%	23%	33%
Michigan	340,006	9%	9%	16%	15%	21%	28%	0%	26%	35%
Mississippi	104,354	3%	14%	17%	18%	22%	25%	0%	31%	34%
Missouri	252,945	9%	11%	19%	16%	20%	25%	0%	30%	39%
Montana	54,186	7%	10%	20%	16%	19%	29%	0%	29%	36%
Nebraska	73,982	14%	11%	18%	16%	18%	23%	0%	29%	43%
New Hampshire	52,869	8%	9%	16%	14%	23%	30%	0%	24%	32%
New Jersey	253,197	8%	10%	15%	15%	24%	26%	1%	25%	34%
North Carolina	559,615	8%	11%	17%	18%	22%	23%	0%	28%	37%
North Dakota	18,114	23%	8%	19%	13%	15%	22%	0%	27%	50%
Ohio	233,636	11%	8%	15%	14%	20%	31%	0%	24%	34%
Oklahoma	125,868	10%	11%	18%	17%	20%	24%	0%	29%	39%
Pennsylvania	471,056	6%	10%	18%	16%	22%	29%	0%	28%	34%
South Carolina	210,020	7%	11%	17%	17%	23%	26%	0%	28%	34%
South Dakota	21,320	11%	10%	20%	15%	17%	26%	0%	30%	41%
Tennessee	231,090	6%	10%	18%	17%	22%	27%	0%	28%	34%

Marketplace Plan Selection by Age in States Using the HealthCare.gov Platform, By State (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Number of Plan Selections With Available Data on Age (2) (3)	By Age (% of Available Data, Excluding Unknown)								
		Age < 18	Age 18-25	Age 26-34	Age 35-44	Age 45-54	Age 55-64	Age ≥65	Ages 18-34	Ages 0-34
	Number	%	%	%	%	%	%	%	%	%
Texas	1,202,044	10%	13%	17%	17%	22%	21%	1%	29%	39%
Utah	140,343	22%	11%	21%	16%	14%	16%	0%	33%	54%
Virginia	384,487	11%	12%	18%	17%	20%	22%	1%	30%	40%
West Virginia	33,322	6%	7%	13%	15%	21%	37%	0%	20%	26%
Wisconsin	206,769	6%	9%	17%	15%	21%	32%	0%	26%	32%
Wyoming	21,050	13%	9%	20%	15%	17%	26%	0%	29%	42%
TOTAL – States Using the HealthCare.gov Platform	**8,817,579**	**8%**	**11%**	**17%**	**17%**	**22%**	**25%**	**1%**	**28%**	**36%**

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). Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(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 (including data for consumers who actively reenrolled in coverage through the Marketplaces, and data for automatic reenrollees).

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

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX TABLE B7

Reduction in Average Monthly Premiums from Advance Premium Tax Credits in States Using the HealthCare.gov Platform (1) *11-15-14 to 2-15-15 (including SEP activity through 2-22-15)*						
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)**	**Percent of Plan Selections with APTC**	**Average Monthly Premium before APTC**	**Average Monthly APTC**	**Average Monthly Premium After APTC**	**Average Percent Reduction in Premium after APTC**
States Using the HealthCare.gov Platform (4)						
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)						
Nevada	73,596	89%	$361	$242	$119	67%
New Mexico	52,358	74%	$323	$196	$127	61%
Oregon	112,024	77%	$334	$198	$136	59%
Subtotal - SBMs Using the HealthCare.gov Platform	237,978	80%	$341	$213	$128	62%
Federally-Facilitated Marketplace (FFM) States						
Alabama	171,641	89%	$354	$266	$88	75%
Alaska	21,260	89%	$639	$534	$105	84%
Arizona	205,666	75%	$278	$155	$123	56%
Arkansas	65,684	88%	$389	$280	$109	72%
Delaware	25,036	83%	$404	$264	$140	65%
Florida	1,596,296	93%	$376	$294	$82	78%
Georgia	541,080	89%	$346	$273	$73	79%
Illinois	349,487	78%	$336	$208	$128	62%
Indiana	219,185	87%	$438	$319	$120	73%
Iowa	45,162	85%	$371	$260	$111	70%
Kansas	96,197	80%	$301	$211	$90	70%
Louisiana	186,277	89%	$416	$319	$97	77%
Maine	74,805	89%	$425	$332	$93	78%
Michigan	341,183	88%	$366	$236	$130	64%
Mississippi	104,538	93%	$405	$353	$52	87%
Missouri	253,430	88%	$363	$281	$82	77%
Montana	54,266	84%	$346	$230	$116	66%
Nebraska	74,152	87%	$354	$250	$104	70%
New Hampshire	53,005	70%	$385	$244	$141	63%
New Jersey	254,316	83%	$470	$306	$164	65%
North Carolina	560,357	92%	$410	$315	$95	77%
North Dakota	18,171	86%	$369	$228	$141	62%
Ohio	234,341	84%	$389	$244	$145	63%
Oklahoma	126,115	79%	$295	$206	$89	70%
Pennsylvania	472,697	80%	$355	$226	$129	64%
South Carolina	210,331	88%	$365	$278	$86	76%
South Dakota	21,393	86%	$358	$228	$130	64%
Tennessee	231,440	82%	$316	$213	$102	68%

Reduction in Average Monthly Premiums from Advance Premium Tax Credits in States Using the HealthCare.gov Platform (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)	Percent of Plan Selections with APTC	Average Monthly Premium before APTC	Average Monthly APTC	Average Monthly Premium After APTC	Average Percent Reduction in Premium after APTC
Texas	1,205,174	85%	$328	$239	$89	73%
Utah	140,612	88%	$248	$159	$89	64%
Virginia	385,154	83%	$348	$259	$89	74%
West Virginia	33,421	86%	$448	$311	$137	69%
Wisconsin	207,349	89%	$440	$315	$125	72%
Wyoming	21,092	91%	$550	$420	$130	76%
TOTAL – States Using the HealthCare.gov Platform	**8,838,291**	**87%**	**$364**	**$263**	**$101**	**72%**

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

APPENDIX TABLE B8

Availability and Selection of Marketplace Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) For Individuals With 2015 Marketplace Plan Selections With APTC in States Using the HealthCare.gov Platform (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Number of Individuals With 2015 Marketplace Plan Selections with APTC (2)	Data For Individuals Who Have 2015 Marketplace Plan Selections With APTC			
		Availability of Plans With Monthly Premiums of $100 or Less		Selection of Plans With Monthly Premiums of $100 or Less	
		Percent Who Could Have Selected a Plan with a Monthly Premium of $50 or Less after APTC	Percent Who Could Have Selected a Plan with a Monthly Premium of $100 or Less after APTC	Percent Who Selected a Plan With a Monthly Premium of $50 or Less after APTC	Percent Who Selected a Plan With a Monthly Premium of $100 or Less after APTC
States Using the HealthCare.gov Platform (4)					
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)					
Nevada	65,326	100%	100%	19%	53%
New Mexico	38,848	64%	84%	22%	49%
Oregon	86,444	100%	100%	17%	44%
Subtotal - SBMs Using the HealthCare.gov Platform	190,618	93%	97%	19%	48%
Federally-Facilitated Marketplace (FFM) States					
Alabama	152,498	80%	90%	43%	70%
Alaska	18,839	75%	86%	40%	57%
Arizona	153,335	65%	86%	24%	52%
Arkansas	57,797	67%	85%	24%	58%
Delaware	20,876	58%	78%	18%	45%
Florida	1,479,439	84%	93%	51%	72%
Georgia	484,073	83%	92%	51%	74%
Illinois	271,763	63%	83%	21%	49%
Indiana	191,586	71%	85%	26%	53%
Iowa	38,532	68%	85%	27%	56%
Kansas	76,504	72%	87%	40%	67%
Louisiana	165,786	85%	93%	41%	63%
Maine	66,616	71%	85%	40%	65%
Michigan	298,774	70%	87%	21%	48%
Mississippi	97,606	91%	96%	60%	80%
Missouri	222,559	80%	91%	46%	69%
Montana	45,432	60%	78%	26%	54%
Nebraska	64,656	76%	90%	34%	59%
New Hampshire	37,242	66%	82%	21%	43%
New Jersey	211,158	51%	71%	15%	38%
North Carolina	512,975	80%	91%	40%	65%
North Dakota	15,569	58%	80%	17%	42%
Ohio	196,714	62%	82%	16%	41%
Oklahoma	100,039	82%	93%	40%	66%
Pennsylvania	379,607	62%	81%	23%	51%

Availability and Selection of Marketplace Plans With Monthly Premiums of $100 or Less After the Advance Premium Tax Credit (APTC) For Individuals With 2015 Marketplace Plan Selections With APTC in States Using the HealthCare.gov Platform (1)
11-15-14 to 2-15-15 (including SEP activity through 2-22-15)

Description	Number of Individuals With 2015 Marketplace Plan Selections with APTC (2)	Data For Individuals Who Have 2015 Marketplace Plan Selections With APTC			
		Availability of Plans With Monthly Premiums of $100 or Less		Selection of Plans With Monthly Premiums of $100 or Less	
		Percent Who Could Have Selected a Plan with a Monthly Premium of $50 or Less after APTC	Percent Who Could Have Selected a Plan with a Monthly Premium of $100 or Less after APTC	Percent Who Selected a Plan With a Monthly Premium of $50 or Less after APTC	Percent Who Selected a Plan With a Monthly Premium of $100 or Less after APTC
South Carolina	185,276	82%	92%	43%	69%
South Dakota	18,503	53%	76%	17%	47%
Tennessee	190,418	81%	92%	32%	60%
Texas	1,030,138	80%	92%	43%	68%
Utah	123,088	69%	90%	33%	67%
Virginia	320,525	80%	91%	42%	68%
West Virginia	28,719	57%	77%	21%	47%
Wisconsin	184,822	68%	83%	26%	50%
Wyoming	19,152	59%	77%	26%	49%
TOTAL – States Using the HealthCare.gov Platform	**7,651,234**	**77%**	**89%**	**38%**	**63%**

Source: ASPE computation of CMS data for 37 states using the HealthCare.gov platform as of 2-15-15 (including SEP activity through 2-22-15).

APPENDIX TABLE C1

Marketplace Plan Selection by Enrollment Type in State-Based Marketplaces Using Their Own Marketplace Platforms, By State, 2015 (1)
11-15-2014 to 2-15-2015 (including SEP activity through 2-21-15)

Description	Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (1)	Distribution By Enrollment Type (2)			
		New Consumers (3)	Consumers Reenrolling in Marketplace Coverage (4)		
			Total Reenrollees	Active Reenrollees	Automatic Reenrollees
	Number	% of Total	% of Total	% of Total	% of Total
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms					
California (5)	1,412,200	35%	65%	37%	28%
Colorado (6)	140,327	28%	72%	34%	38%
Connecticut (7)	109,839	38%	61%	20%	41%
District of Columbia (8)	18,465	26%	74%	15%	60%
Hawaii (9)	12,625	75%	25%	1%	24%
Idaho (16)	97,079	100%	N/A	N/A	N/A
Kentucky (10)	106,330	26%	73%	39%	35%
Maryland (16)	120,145	100%	N/A	N/A	N/A
Massachusetts (16)	140,540	100%	N/A	N/A	N/A
Minnesota (11)	59,704	60%	40%	26%	14%
New York (12)	408,841	35%	66%	N/A	N/A
Rhode Island (13)	31,337	32%	68%	68%	N/A
Vermont (14)	31,619	14%	87%	17%	69%
Washington (15)	160,732	37%	63%	N/A	N/A
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms	**2,849,783**	**43%**	**57%**	**24%**	**20%**

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 these tables represent cumulative data on the number of unique individuals who have selected or have been automatically reenrolled into a 2015 Marketplace medical plan for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the issuer). This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix D 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 coverage through the Marketplaces.

(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 issuer) as of the reporting date, and did not have a Marketplace plan selection as of November 2014. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP).

(4) "Consumers reenrolling in coverage through the Marketplaces" are those individuals who had a Marketplace plan selection during coverage year 2014, and have either actively submitted a 2015 application and selected a 2015 Marketplace medical plan or have been automatically reenrolled in coverage through the Marketplaces – with or without the first premium payment having been received directly by the issuer). These data also do not include: standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP). It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-15-15 (including SEP activity through 2-21-15), but who may ultimately decide not to retain Marketplace coverage for the remainder of 2015 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP).

(5) California reports represent data through 2/22/15. California began its automatic renewal process in December 2014 and periodically cancels individuals not paying their premiums during ongoing data cleaning processes. If an individual had effectuated enrollment by 11/12/14 and did not actively re-enroll, he/she was automatically re-enrolled by 12/15/14.

(6) Colorado automatically renewed eligible individuals December 15, 2014 for coverage beginning January 1, 2015 and periodically cancels individuals not paying their premiums during ongoing data cleaning processes.

(7) Connecticut automatically renewed eligible individuals during December 2014 for coverage beginning January 1, 2015. Connecticut individuals not paying their premiums are removed from enrollment counts upon receipt of cancelation notice from insurers. If an individual had effectuated coverage as of December 2014, he/she was eligible for automatic re-enrollment.

(8) DC aligned its automatic renewal process with the Federal 2015 open enrollment process. Individuals automatically renewed needed to effectuate enrollment by December 15, 2014 to be considered enrolled, otherwise DC canceled their coverage. DC removed terminations and cancellations from their data for automatic re-enrollees, but did not remove them for new enrollees or active re-enrollees.

(9) Hawaii began its automatic renewal process November 15, 2014 and canceled individuals for non-payment by January 31, 2015. If an individual had effectuated enrollment by 11/1/2014, did not actively reenroll, and selected "auto-renewal," he/she was automatically reenrolled by 12/31/2014 for the 2015 plan year.

(10) Kentucky notified individuals eligible for automatic renewal November 1, 2014 they would be automatically renewed for coverage effective January 1, 2015. Kentucky periodically cancels individuals not paying their premiums during ongoing data cleaning processes. Any individual who was actively receiving benefits as of 11/14/2014 was considered eligible for automatic re-enrollment and was re-enrolled on 11/15/14. Kentucky's report of unknown individuals in 2015 plan selection breakouts represents the count of individuals converted from a legacy system (KAMES) to KYHBE.

(11) Minnesota began its automatic renewal process in January 2015.

(12) New York's renewal process began November 15, 2014. New York removed terminations and cancellations from their data for active and automatic re-enrollees, but did not remove them for new enrollees. New York's re-enrollment data does not distinguish between active and automatic reenrollment. In New York, individuals who were enrolled in October 2014, with an end date of December 31, 2014, were eligible for automatic re-enrollment if their program eligibility stayed the same from 2014 to 2015, and their plan was available in 2015. If an individual's 2014 coverage was cancelled/terminated after October 2014, they were removed from the 2015 coverage that they were automatically renewed into. Additionally, if individuals voluntarily cancel or terminate their coverage, they are removed from the enrollment count at the time they cancel or terminate their coverage. If an individual's coverage is cancelled or terminated for non-payment, they are removed from the enrollment count when the issuer transmits that transaction to the Marketplace.

(13) Rhode Island does not have any automatic re-enrollments for its 2015 plan selection data, as Rhode Island required all individuals to undergo active re-enrollment. Individuals are canceled from the system if they do not make payment on the 23rd day of the month prior to the coverage month.

(14) Vermont automatically renewed all Marketplace consumers for coverage beginning January 1, 2015, with payment for coverage due 21 days after automatically renewed consumers were sent an invoice.

(15) Washington reports only individuals who have both enrolled and paid for coverage (effectuated enrollment) for its report of plan selection, thereby undercounting the true total of plan selections in Washington. Washington began its renewal process November 15, 2014, with payment deadlines the 23rd day of the month prior to the coverage month. Washington defines renewals as the number of QHP enrollees with coverage in December 2014 and coverage in 2015 as of February 21, 2015. Washington is not able to provide automatic and active renewal breakouts for 2015 plan selection data due to system issues. Their system counts some re-enrollees as both automatic and active re-enrollees, which may lead to double counting re-enrollee breakouts. Washington removed enrollees who terminated their coverage from their plan selection data for new enrollees and re-enrollees, but retained individuals in the count until issuers confirmed that the coverage was terminated for nonpayment.

(16) 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.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX TABLE C2

Total Completed Applications and Individuals Who Completed Applications in State-Based Marketplaces Using Their Own Marketplace Platforms, By State, 2015 (1)
11-15-2014 to 2-15-2015 (including SEP activity through 2-21-15)

Description	Total Number of Completed Applications for 2015 Coverage (2)	Total Individuals Applying for 2015 Coverage in Completed Applications (3)
	Number	Number
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms		
California (4)	N/A	NA
Colorado	94,088	134,931
Connecticut	131,627	226,266
District of Columbia	14,521	19,570
Hawaii	16,159	25,314
Idaho	89,460	203,577
Kentucky (5)	94,447	153,920
Maryland (6)	263,035	N/A
Massachusetts	334,410	522,457
Minnesota	127,978	201,920
New York	N/A	502,616
Rhode Island	71,995	120,771
Vermont (7)	33,155	59,451
Washington	616,059	1,354,964
TOTAL - SBMs Using Their Own Marketplace Platforms	**1,886,934**	**3,525,757**

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 2-15-15 (including SEP activity through 2-21-15). 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 eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix D 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) California reports data through 2/22/15. California's system does not specifically track the total number of completed applications or individuals applying for coverage.

(5) Kentucky data for "completed applications" includes data for the 2014 special enrollment period from 11-15-14 to 12-31-14, 2015 open enrollment, and 2015 SADP enrollment, as its system is not able to differentiate these data at the application level.

(6) Maryland's system cannot provide the number of individuals applying for coverage through the Marketplace, as records may be removed from this count after eligibility determinations.

(7) Vermont data for application numbers include withdrawn cases, but do not include test cases.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX TABLE C3

Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in State-Based Marketplaces Using Their Own Marketplace Platforms, By State, 2015 (1)
11-15-2014 to 2-15-2015 (including SEP activity through 2-21-15)

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 Plan Selections Through the Marketplaces (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
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms				
California (6) (7)	1,138,456	535,032	1,056,164	1,412,200
Colorado (7) (8)	132,077	N/A	85,432	140,327
Connecticut (9)	167,193	124,803	277,336	109,839
District of Columbia	7,539	1,714	9,355	18,465
Hawaii	24,568	12,306	32,854	12,625
Idaho	215,145	163,829	314,398	97,079
Kentucky	223,335	138,320	152,529	106,330
Maryland	120,632	85,345	154,194	120,145
Massachusetts	246,397	164,849	276,060	140,540
Minnesota (10)	71,451	38,382	106,654	59,704
New York (11)	1,006,505	498,707	357,456	408,841
Rhode Island	44,097	33,604	65,396	31,337
Vermont	57,533	22,660	16,922	31,619
Washington	239,848	176,295	818,697	160,732
TOTAL - SBMs Using Their Own Marketplace Platforms	**3,694,776**	**1,995,846**	**3,723,447**	**2,849,783**

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 2-15-15 (including SEP activity through 2-22-15). 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 eligible for a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes information, please refer to Appendix D 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. Note: With the exception of states that treated all of the individuals who selected 2015 coverage through the Marketplaces, this number only includes data for individuals who applied for 2015 Marketplace coverage in completed applications. It does not include individuals who were automatically reenrolled. Thus, the number determined eligible for 2015 coverage may be lower than the total number of 2015 plan selections (which includes reenrollees).

(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 December 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 issuer) during the reference period. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. These data do not include 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). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data.

(6) California reports data through 2/22/15.

(7) Reported Medicaid + CHIP eligibility assessment totals may be underreported, as CA and CO employ processes that do not capture all Medicaid + CHIP eligibility assessments.

(8) Colorado data for individuals applying and those eligible for a QHP does not include individuals automatically reenrolled. Therefore, the number of individuals completing applications, and those eligible for a QHP, is less than the total number of individuals enrolled. Colorado's Marketplace, Connect for Health Colorado, and the Medicaid Agency, use the Shared Eligibility System to determine eligibility for Medicaid, APTC/CSR, and CHIP. Therefore, the data provided by Colorado for "Individuals Assessed Eligible for Medicaid/CHIP" only include new individual determinations for the Medicaid and CHIP programs processed between 11/15/14 – 2/21/15. These data do not include redeterminations, recertifications, and renewals for Medicaid and CHIP.

(9) Connecticut's number of individuals assessed eligible for Medicaid/CHIP is greater than the number of individuals applying. This results from Medicaid redeterminations for individuals who already have an initial application with the exchange.

(10) Minnesota data for number of individuals assessed eligible for Medicaid/MinnesotaCare represents data through 2/22/15.

(11) New York eligibility data represent individuals who have an active eligibility determination on or after 11/15/14. The number of individuals applying represents individuals in accounts that were created on or after 11/15/14. This figure does not include renewals, or other eligibility determinations for accounts created before 11/15/14.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX TABLE C4

Marketplace Plan Selections by Financial Assistance Status in State-Based Marketplaces Using Their Own Marketplace Platforms, By State, 2015 (1) *11-15-2014 to 2-15-2015 (including SEP activity through 2-21-15)*				
Description	**Total Number of Individuals With 2015 Plan Selections Through the Marketplaces (2)**	**Plan Selections With Available Data on Financial Assistance Status (3)**	**By Financial Assistance Status (4)** *(% of Available Data, Excluding Unknown)*	
			With Financial Assistance	**Without Financial Assistance**
	Number	**Number**	**%**	**%**
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms				
California (5)	1,412,200	1,407,795	90.3%	9.7%
Colorado	140,327	140,327	54.2%	45.8%
Connecticut	109,839	109,839	77.4%	22.6%
District of Columbia (7)	18,465	18,465	10.8%	89.2%
Hawaii	12,625	12,625	76.7%	23.3%
Idaho (9)	97,079	97,079	84.2%	15.8%
Kentucky	106,330	106,330	69.3%	30.7%
Maryland (9)	120,145	120,145	70.8%	29.2%
Massachusetts (9)	140,540	140,540	65.6%	34.4%
Minnesota (6) (7)	59,704	N/A	N/A	N/A
New York (7)	408,841	408,841	73.5%	26.5%
Rhode Island	31,337	31,337	88.2%	11.8%
Vermont	31,619	31,619	62.2%	37.8%
Washington (7)	160,732	160,732	78.8%	21.2%
TOTAL – SBMs Using Their Own Marketplace Platforms	**2,849,783**	**2,785,674**	**80.8%**	**19.2%**

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 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). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data. For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(3) In some cases, the data for certain characteristics of Marketplace plan selections are not 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) Data on Marketplace plan selections with financial assistance includes plan selections for individuals who are receiving a premium tax credit and/or cost-sharing subsidy.

(5) California reports represent data through 2/22/15. California's plan selection breakouts result in roughly 4,000 unknowns due to total plan selection and plan selection breakout reports having been run at different times.

(6) Minnesota tracks plan selection by financial assistance at the household level; it cannot report it at the individual level.

(7) All states except DC, Minnesota, New York, and Washington removed cancellations and terminations from all total plan selection data. DC removed cancellations and terminations from it automatic reenrollee data. New York removed cancellations and terminations from all of its reenrollee data, active and automatic, but did not remove them from the "new" plan selections. Washington removed terminations from all of their plan selection data. Minnesota did not remove cancellations and terminations from its plan selection data.

(8) Washington reports only individuals who have both enrolled and paid for coverage (effectuated enrollment) for its report of plan selection, thereby undercounting the true total number of plan selections in Washington.

(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.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX TABLE C5

Marketplace Plan Selection by Age in State-Based Marketplaces Using Their Own Marketplace Platforms, By State, 2015 (1)
11-15-2014 to 2-21-2015

Description	Number of Plan Selections With Available Data on Age (2) (3)	By Age (% of Available Data, Excluding Unknown)								
		Age < 18	Age 18-25	Age 26-34	Age 35-44	Age 45-54	Age 55-64	Age ≥65	Ages 18-34	Ages 0-34
	Number	%	%	%	%	%	%	%	%	%
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms										
California (4)	1,408,352	5.2%	10.8%	16.9%	16.0%	24.2%	26.8%	0.9%	27.5%	32.7%
Colorado	140,327	11.6%	7.6%	18.9%	16.1%	18.9%	26.5%	0.3%	26.6%	38.2%
Connecticut	109,839	7.3%	10.2%	15.4%	13.7%	23.4%	30.0%	1.4%	25.3%	32.5%
District of Columbia (5)	18,465	7.8%	6.1%	37.2%	21.4%	14.5%	13.0%	0.6%	43.1%	50.9%
Hawaii	12,625	14.5%	9.4%	17.3%	16.3%	16.7%	25.8%	1.4%	26.3%	40.6%
Idaho (8)	97,079	12.7%	11.0%	18.1%	16.6%	17.8%	23.8%	0.2%	29.0%	41.7%
Kentucky	106,330	10.6%	7.8%	14.8%	16.1%	21.5%	29.2%	0.5%	22.4%	33.0%
Maryland (8)	120,145	5.7%	10.7%	19.0%	17.6%	22.4%	24.6%	1.7%	29.2%	34.8%
Massachusetts (8)	140,540	5.6%	8.8%	21.8%	17.2%	21.8%	24.8%	1.0%	30.3%	35.8%
Minnesota (5)	59,704	9.0%	7.1%	17.2%	14.9%	19.0%	32.7%	0.5%	24.2%	33.2%
New York (5)	408,841	2.6%	9.2%	20.2%	18.4%	23.5%	25.6%	0.5%	29.4%	32.0%
Rhode Island	31,337	5.0%	10.0%	17.3%	17.5%	22.7%	27.5%	0.9%	27.1%	32.1%
Vermont	31,619	6.4%	9.1%	13.0%	14.2%	22.4%	34.5%	0.5%	22.0%	28.4%
Washington (5)	160,732	3.7%	7.9%	16.5%	16.4%	21.4%	33.9%	0.7%	24.2%	27.9%
TOTAL - SBMs Using Their Own Marketplace Platforms	**2,849,783**	5.7%	9.8%	17.7%	16.4%	22.7%	26.9%	0.8%	27.5%	33.2%

Notes:

"N/A" means that the data for the respective metric is not 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 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 eligible for a Special Enrollment Period (SEP). Except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data. For additional technical notes, please refer to Appendix D 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 issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated.

(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) California reports represent data through 2/22/15. California's plan selection breakouts result in roughly 4,000 unknowns due to total plan selection and plan selection breakout reports run at different times.

(5) All states except DC, Minnesota, New York, and Washington removed cancellations and terminations from all total plan selection data. DC removed cancellations and terminations from it auto reenrollee data. New York removed cancellations and terminations from all of its reenrollee data, active and automatic, but did not remove them from the "new" plan selections. Washington removed terminations from all of their plan selection data. Minnesota did not remove cancellations and terminations from its plan selection data.

(7) Washington reports only individuals who have both enrolled and paid for coverage (effectuated enrollment) for its report of plan selection, thereby undercounting the true total of plan selections in Washington.

(8) 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.

Source: Centers for Medicare & Medicaid Services, as of 3-6-15.

APPENDIX D: TECHNICAL NOTES

We believe that the information contained in this issue brief provides the most systematic summary of enrollment-related activity in the Marketplaces during 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 have been included in weekly enrollment updates 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 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 2-15-15 (including SEP activity through 2-22-15) 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 2015 Open Enrollment period – which generally corresponds with data from 11-15-14 to 2-15-15 (including SEP activity through 2-22-15) for the 37 HealthCare.gov states, and from 11-15-14 to 2-15-15 (including SEP activity through 2-21-15) for the states that are using their own Marketplace platforms for the 2015 coverage, except California. 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 D1

Marketplace Type	Reporting Period	
	2015 March Enrollment Report	Week 14 Weekly Enrollment Snapshot
States Using the HealthCare.gov Marketplace Platform (37 states)	11-15-14 to 2-22-15 (including SEP activity thru 2-22-15)	11-15-14 to 2-22-15 (including SEP activity thru 2-22-15)
States Using Their Own Marketplace Platform (14 states)		
California	11-15-14 to 2-22-15 (including SEP activity thru 2-22-15)	Not Included
Other 13 States (including DC)	11-15-14 to 2-21-15 (including SEP activity thru 2-22-15)	Not Included

2015 Plan Selections Through the Marketplaces (also known as Marketplace Plan Selections) – Represents cumulative data on the number of unique individuals who have selected a 2015 plan through the Marketplaces for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the issuer) during the reference period. This is also known as pre-effectuated enrollment, because enrollment is not considered effectuated until the first premium payment is made, and this figure includes plan selections for which enrollment has not yet been effectuated. These data represent the number of individuals with active plan selections for a Marketplace medical plan as of the reporting date. These data 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 eligible for a Special Enrollment Period (SEP).

Additionally, in the data for the HealthCare.gov states, individuals whose Marketplace coverage has been cancelled or terminated are not included in the total number of Marketplace plan selections.[28] The data for the HealthCare.gov states also do not include plan selection data for coverage with an effective date beginning after 3-1-15. This table only reflects data for the individual market Marketplaces. Among the SBMs that are using their own Marketplace platforms, except for three states, the data for total number of plan selections removes cancellations and terminations. Minnesota does not remove either from its total plan selection data, whereas DC removes cancellations and terminations from its automatic reenrollment data and New York removes cancellations and terminations from its active and automatic reenrollee data.

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.

This report includes data on SEP activity through 2-22-15. It is important to note that this report does not include data on effectuated enrollment (that the number of people who have paid monthly premiums to the insurer). Additionally, this report does not include data relating to any individuals who enroll through an SEP after 2-22-15, including any upcoming SEP for individuals who were unaware of, or did not understand the implications of the fee for not enrolling in health insurance coverage.

This report does not include data relating to any individuals who enroll through an SEP after 2-22-15, including any upcoming SEP for individuals who were unaware of, or did not understand the implications of the fee for not enrolling in health insurance coverage.

[28] For example, coverage has been terminated for approximately 90,000 consumers who had 2014 coverage were not able to continue their Marketplace coverage in 2015 because they did not provide the necessary documentation of their citizenship or immigration status, and these individuals are no longer included in the cumulative total.

In-Line Special Enrollment Period – The SEP for individuals who were "in-line" on 2-15-15 ended on 2-22-15 for the states that are using the HealthCare.gov platform. Most of the SBMs that are using their own Marketplace platforms allowed individuals who started the process before 2-15-15, but could not finish, to complete the application and select a plan by varying dates, mostly within February, with the exception of Colorado, which allowed applicants through March 2 to complete their applications, and Washington, which allowed applicants to enroll through April 17. Vermont has indicated that the state will assist consumers with enrollment if they report a problem trying to enroll, but did not provide for a formal extension period.

Tax Season Special Enrollment Period – CMS recently announced a special enrollment period (SEP) for tax season. For individuals and families in the HealthCare.gov states who did not have health coverage in 2014 and are subject to the fee or "shared responsibility payment" when they file their 2014 taxes. For those who were unaware or did not understand the implications of the fee for not enrolling in coverage, CMS will provide consumers with an opportunity to purchase health insurance coverage from March 15 to April 30, 2015. (For additional information, see http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-02-20.html). Most of the SBMs that are using their own Marketplace platforms followed the federal guidelines regarding the SEP for tax season.

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 plan through the Marketplaces (with or without the first premium payment having been received directly by the issuer) and did not have an active 2014 Marketplace plan selection as of November 1, 2014. These data do not include stand-alone dental plan selections. These data also generally do not include any individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for a Special Enrollment Period (SEP);. Additionally, in the data for the HealthCare.gov states and most states using their own platforms, individuals who have cancelled or terminated their Marketplace plans are not included in the total number of Marketplace plan selections. 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 coverage through the Marketplaces"*** 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 have been automatically reenrolled in coverage through the Marketplaces – with or without the first premium payment having been received directly by the issuer. Individuals who have cancelled or terminated their Marketplace plans are not included in the total number of plan selections. These data also do not include: standalone dental plan selections; or

individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been eligible for 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 coverage through the Marketplaces 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. A consumer is considered to have actively selected a plan, if they are a consumer with coverage in 2014 who came back, updated their application and selected a plan. The consumer could have actively selected their 2014 plan, decided to choose a new plan from their existing insurer or selected a new plan from a different insurer. A consumer could have actively selected a plan prior to the 12-15-14 deadline or could have come back after being automatically reenrolled and decided to update their information and select a plan; and

- ***Consumers who have been 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. A consumer was automatically reenrolled into their 2014 plan or a plan with similar benefits from their same issuer[29] if they were enrolled in a Marketplace plan in 2014 and did not select a plan ahead of the 12-15-14 deadline. If the consumer realized after the deadline that there was a better plan for their family or needed to update their information, the consumer could make that change before 2-15-15, and would at that point be considered as having actively selected a plan.

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

[29] Some consumers' 2014 plans were no longer active for 2015 but the insurer offered a plan with similar benefits. Based on the information provided by the insurance companies, consumers were "crosswalked" and automatically re-enrolled into that similar plan. No consumer was automatically re-enrolled into a plan with a different issuer.

Appendix Table D2

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 *	Included in this report**
Consumers Who Are Being Automatically Reenrolled into Marketplace Coverage	Included in this report for the following 10 states: CA, CO, CT, DC, HI, KY, MN, NY, VT, and WA	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).

Automatic Reenrollments – In this report, data on automatic reenrollments are included in the overall Marketplace plan selection totals for Consumers Who Are Actively Reenrolling in Marketplace Coverage for the 37 HealthCare.gov states and 10 of the SBMs that are using their own Marketplace platforms for 2015 (see Appendix Table D2 for a list of these states). These data represent consumers who had a Marketplace plan selection as of November 2014, and retain coverage without returning to the Marketplace and selecting a plan because the applicable Marketplace has passively reenrolled them in 2015 Marketplace coverage. It is important to note that the reenrollment data in this report may include some individuals who were reenrolled in coverage through the Marketplaces as of 2-15-15 (including SEP activity through 2-22-15), but who may ultimately decide not to retain Marketplace coverage for the remainder of 2015 (for example, because they have obtained coverage through another source such as an employer or Medicaid/CHIP). The plan selection data in future reports will exclude these individuals (e.g., due to the subsequent cancellation or termination of their coverage).

Definition of Active Reenrollees Who Switched Plans – For purposes of this report, active reenrollees who switched plans are active reenrollees who have not selected the same plan as for the 2014 coverage year, or a similar "crosswalked" plan with similar benefits that is offered by the same issuer as their 2014 plan.[30]

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

[30] Some consumers' 2014 plans were no longer active for 2015 but the insurer offered a plan with similar benefits, known as a "crosswalk plan." For purposes of this report, active reenrollees who selected the crosswalk plan for the 2015 coverage year (identified based on the information provided by the insurance companies) are not included in the total number who switched plans.

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, people who select 2015 Marketplace plans in Nevada and Oregon are generally treated as new consumers for operational enrollment and reporting purposes because the system cannot identify or automatically reenroll individuals 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 coverage through the Marketplaces 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 Marketplace Plan Selections with Financial Assistance – Marketplace plan selections with financial assistance includes plan selections for individuals who are receiving a premium tax credit and/or cost-sharing reduction.

Data on Premium Tax Credits – The Affordable Care Act specifies that an individual or family who is eligible for premium tax credits will be required to pay no more than a fixed percentage of their income based on the second-lowest cost silver plan available in the Marketplace in their coverage area. This applicable percentage varies only by household income as a percentage of the Federal Poverty Level (FPL) and does not depend on household members' ages, the number of people within the household covered through the Marketplace, or Marketplace premiums. The applicable percentage is converted into a maximum dollar amount the household is required to pay annually for the benchmark plan, and the premium tax credit is applied to make up the difference between the maximum dollar amount and the actual premium, if any. The exact dollar amount of the premium tax credit depends on the premium of the second-lowest cost silver plan available to the household and the cost of covering the family members who are seeking Marketplace coverage.

For purposes of this report, an individual qualifying for an advance premium tax credit was defined as any individual with an APTC amount >$0. Averages in this brief refer to plan-selection-weighted averages across individuals with plan selections with advance premium tax credits in the 37 HealthCare.gov states.[31]

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. Data for standalone dental plan selections are shown separately.

[31] For additional methodological information, see the ASPE Issue Brief "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using the HealthCare.gov Platform," accessed at http://www.aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf.

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 types (see Appendix Tables A1 and A2).

Data on Additional Characteristics of Marketplace Plan Selections – This report also includes data on the characteristics of individuals 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,[32] but lower than that reported in administrative data sources in the healthcare industry.[33] 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 individuals 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.[34]

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

[33] 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.

[34] 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

- ***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.

Metrics Reported by SBMs Using Their Own Marketplace Platforms -- It is important to note that some of the 14 states that are using their own Marketplace platforms are not separately reporting data for new consumers and consumers who are reenrolling in Marketplace coverage.

Appendix Table D3

Metric	Number of States Reporting Data for this Metric
Visitors to the Marketplace Websites	13 States – California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Minnesota, New York, Rhode Island, Vermont, Washington
Calls to the Marketplace Call Centers	14 States – California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
Completed Applications	12 States – Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Rhode Island, Vermont, Washington
Individuals Applying for Coverage in Completed Applications	12 States – Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
Number of Individuals Determined Eligible to Enroll in a Marketplace Plan	14 States – Colorado, California, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
Number of Individuals Determined Eligible to Enroll in a Marketplace Plan with Financial Assistance	13 States –California, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
Number of Individuals Determined or	14 States – California, Colorado, Connecticut, DC, Hawaii, Idaho,

Enrollment Report, which can be accessed at http://www.aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

Metric	Number of States Reporting Data for this Metric
Assessed Eligible for Medicaid/CHIP by the Marketplace	Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
Number of Individuals with 2015 Marketplace Plan Selections	14 States – California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
2015 Marketplace Plan Selections by Financial Assistance Status	13 States – California, Colorado, Connecticut, DC, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, New York, Rhode Island, Vermont, Washington
2015 Marketplace Plan Selections by Age	14 States –California, Colorado, Connecticut, DC, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
2015 Marketplace Plan Selections by Gender	14 States – California, Colorado, Connecticut, DC, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
2015 Marketplace Plan Selections by Metal Level	14 States –California, Colorado, Connecticut, DC, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington

Effectuated Enrollment – Data on effectuated enrollment for the 2015 Open Enrollment period are not yet available. Therefore, the enrollment data in this report are generally based on pre-effectuated enrollment (plan selections). However, one state, Washington, has reported data on effectuated enrollment.

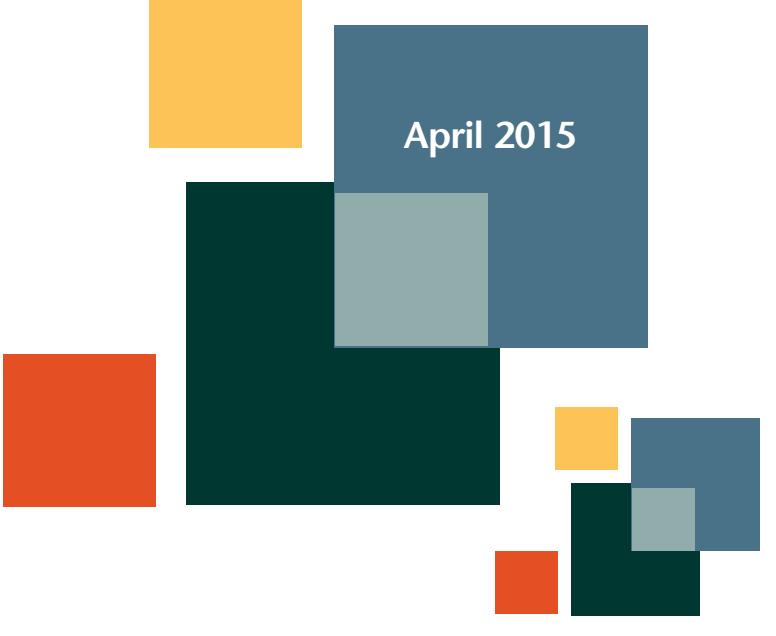
Additional Data Validation – CMS has been taking steps to enhance the processes for generating and validating Marketplace data. As such, some of the numbers in this report could be updated in future reports.

NATIONAL ACADEMY OF SOCIAL INSURANCE

Addressing Pricing Power in Health Care Markets:

Principles and Policy Options to Strengthen and Shape Markets

The Final Report of the Academy's Panel on Pricing Power in Health Care Markets



NATIONAL ACADEMY OF SOCIAL INSURANCE

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The Academy convenes steering committees and study panels that are charged with conducting research, issuing findings and, in some cases, reaching recommendations based on their analyses. Members of these groups are selected for their recognized expertise and with due consideration for the balance of disciplines and perspectives appropriate to the project.

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Addressing Pricing Power in Health Care Markets:

Principles and Policy Options to Strengthen and Shape Markets

The Final Report of the Academy's Panel on Pricing Power in Health Care Markets

April 2015

Study Panel on Addressing Pricing Power in Health Care Markets

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Dedication

In memory of Andrew Hyman, without whose vision, passion, and dedication to social insurance and universal coverage this project would not have been possible.

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Executive Summary

In June 2013, the National Academy of Social Insurance (NASI) convened a diverse study panel of economists, antitrust experts, researchers, and hospital and insurance executives to examine the role and impact of pricing power in the U.S. health care system. While the public sector sets prices administratively, the private sector relies on market-based pricing. In the private sector, pricing power, also known as market power, is defined as the ability of a seller to raise and maintain prices above the level that would prevail if the market were competitive.

Primarily interested in the role of prices and their contribution to spending growth, the panel set out to think systematically about market power and the shifting balance of negotiating power from private purchasers to health care providers over the last 20 years.

Despite spending nearly double the share of gross domestic product on health care as other developed nations, care in the United States is uneven at best and ranks poorly by many critical measures compared to other countries. U.S. spending differs from other developed countries for two main reasons: substantially higher private prices paid for medical care and higher administrative costs related to health insurance.

Concerns about the lack of price competition are longstanding in health care, and the role of market power in the conduct of both health insurers and health care providers is a significant policy issue. Primarily interested in the role of prices and their contribution to spending growth, the panel set out to think systematically about market power and the shifting balance of negotiating power from private purchasers to health care providers over the last 20 years.

Health Care Markets Differ from Other Goods and Services

The market for medical care is different from other markets in at least two significant ways: third-party payment for insured consumers and a fundamental imbalance in information and clinical knowledge between patients and clinicians.

If insured consumers are able to fulfill their cost-sharing obligations, third-party payment often insulates them from the further costs of their health care decisions and removes the primary incentive for them to be price conscious and shop for an acceptable level of quality at the lowest price. Health care consumers also face difficulties in assessing the value of health care services because they typically lack both clinical knowledge and access to widespread, useable health care price and quality information.

While most experts acknowledge that health care is different from other goods and services to some degree, there is a major division between those who think competition can significantly improve the situation and those who think health care is fundamentally different in ways that are likely to thwart attempts to create competitive markets.

The former group believes that reasonably well-functioning markets can be created through greater transparency of performance on quality and costs, relaxed barriers to entry of potential competitors, increased consumer financial responsibility for the health care choices they make, and supported by antitrust or other pro-market regulatory approaches. Those who think health care is fundamentally different emphasize unique characteristics that seem fixed and unamenable to pro-market policies: asymmetry of information between buyers and sellers, inherent uncertainty and variation in clinical decision-making, desirable insurance protection that society wants but that makes patients relatively indifferent to costs, and the intermingling of patient care with other activities that benefit society as a whole, including research, education, and care for the uninsured.

The Shifting Balance of Power Between Health Plans and Providers

Over the last two decades, the balance of power between health plans and providers has shifted significantly, albeit to different degrees in different local health care markets. Following a serious recession and the failure of government health care reform in the early 1990s, managed care emerged as a market-based response to rapidly rising private health care costs. Employers shifted large numbers of workers to managed care products that relied on restrictive provider networks and greater utilization management.

Armed with a credible threat of excluding providers from their networks and the resulting loss of patient volume, health plans gained negotiating leverage over hospitals and physicians and obtained significant price discounts. About the same time, however, hospital consolidation picked up speed through mergers and acquisitions as hospitals tried to reduce excess capacity, cut expenses, and increase their clout with insurers.

By the late1990s, a significant backlash against tightly managed care developed and, aided by the booming economy and tight labor markets, negotiating leverage began to swing back to providers, particularly dominant hospitals. Focused more on recruiting and retaining workers, employers abandoned cost controls in favor of broad provider networks, denying health plans an important bargaining chip with providers — the credible threat of exclusion from plan networks if provider price demands were too high.

Not surprisingly, spending growth for employer-sponsored insurance accelerated as insurers abandoned narrow-provider networks and tight utilization management controls. Initially, increased volume of services played a larger role in private-sector spending growth, but higher prices ultimately became a greater factor. Lacking support from employers to hold the line against provider demands, health plans in many cases effectively called a truce with providers, leading to the existing environment where higher provider payment rates are passed on to employers — and ultimately to employees — through higher premiums.

Insurer and Provider Market Power

As the intermediary between health care providers and insurance purchasers, insurers with market power can potentially leverage negotiations in both directions. On one hand, insurers with market power have the ability to obtain greater price discounts from providers who need to be in the

dominant insurer's provider network; on the other hand, such insurers do not have to actually use this market power because they do not face effective competition in selling their insurance products to employers. Evidence is mixed on the net impact of these two factors on hospital prices.

While concerns about insurer market power exist, most recent attention has focused on the market power of health care providers — primarily the ability of dominant hospitals and large physician group practices to negotiate higher prices. Growing evidence shows that private insurers pay widely varying prices both across and within local health care markets — sometimes double and triple or more — for the same medical services.

Reasons for Provider Market Power

Market power and negotiating leverage are derived from a number of complex and mutually reinforcing factors, including provider size, reputation, location, and unique service offerings. Despite the complexity of factors contributing to provider market power, much of the policy discussion about negotiating leverage has focused on the size of the provider.

Mergers among hospitals to create a single hospital system — horizontal integration — and/or integration of physician practices and hospitals into larger health systems — vertical integration — recently have garnered attention. Over the last two decades, there has been a steep increase in hospital mergers and in market concentration. The trend toward consolidation in health care markets continues to accelerate and now includes the absorption of physician practices into hospital systems.

Key Emerging Trends and Market Power

Increased scrutiny of high and widely varying prices for health care services, especially hospital care, has helped raise public awareness of the lack of price competition and focus policy attention on the role of provider market power in negotiating prices with insurers. Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have also been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular. The array of emerging trends related to market power includes:

Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have also been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular.

- Fostering consumer price-sensitivity through greater cost sharing and health plan benefit structures that guide patients to more efficient providers;
- Launching payment reforms that move from piecemeal fee-for-service methods that reward volume regardless of quality to methods placing more risk on providers for the cost and quality of care;
- Shifting care from inpatient hospital settings to outpatient care;

- Encouraging health plan competition in the individual and small-group markets through state health insurance exchanges; and
- Intervening in markets through state and federal regulatory and antitrust enforcement actions.

Policy Principles

With a diverse group of national experts participating, the Academy study panel developed a set of policy principles to provide a starting point for crafting policy that would address market power in health care markets (see Chapter 2 for the complete principles). Substantively, these principles reflect a preference for market solutions and for targeted regulation in markets that lack competition — in some cases because of provider consolidation — or where new competitors are unlikely to enter the market. These principles recognize the need for policy to address broader societal goals — for example, around issues of access and quality — but the panel believes that meeting these societal goals should explicitly recognize the potential impact on prices and competition. Finally, the principles reflect the important role of competition in generating new ideas about institutions and mechanisms for innovative ways to deliver care that can increase both quality and efficiency.

Policy Principles

- Market competition is often the best way to motivate providers to increase efficiency, improve quality, and ensure that health care prices reflect the value of services provided to consumers. Where unfettered market competition is ineffective, public policy can enhance market competition or, if that is not likely to be successful, regulate prices directly.
  - When they work well, competitive markets weed out providers that fail to efficiently deliver services that are valued by consumers. While some inefficient providers may lose business or even exit the market, consumers benefit from the overall improvements in efficiency and quality that emerge from competition.
  - Competitive markets generate prices that reflect the cost and value of services and promote innovations in health care delivery, including the development of new institutional mechanisms for the delivery and organization of care. In the long run, these innovations may provide substantial benefits to patients.
  - Health care markets are local, and policy interventions that address market failures should be tailored to local markets. In many markets, there has been significant hospital consolidation to the degree that unregulated markets are unlikely to generate competition that will lead to efficient prices or innovation.

Policy Principles continued

- There is a broad scope of regulatory interventions to foster competition, including targeting more aggressive antitrust enforcement, prohibiting providers from demanding favorable treatment as a condition of contracting, and directly limiting prices through administrative means.
- However, all regulation risks so-called capture — or undue influence —by regulated entities. Just as markets may not work in every situation, regulation has costs and benefits that vary by context. Regulatory capture has in some situations led price regulation to be only marginally effective, if at all.
- Along with care for patients, hospitals and physicians often provide additional services with significant social value, including research, medical training, and uncompensated care. In a competitive market, prices are unlikely to support these public goods. Increased competition leads to the additional need for specific policies to support such activities.

- Greater transparency that provides consumers with accurate and timely information about price, quality, costs, and provider networks likely can help them make better choices and, in some cases, make markets more competitive. Greater transparency also may improve the functioning of markets by exposing market conditions and market behavior to public scrutiny. At the same time, policymakers must guard against providers or plans using price information for collusive purposes.
- The benefits of emerging payment reforms and delivery systems, such as ACOs and other provider configurations, may improve quality but also can contribute to excessive market consolidation. Policymakers should carefully evaluate known costs and benefits before making exceptions to competition laws to encourage new but unproved payment and delivery systems. Forcing highly integrated systems to divest if they do not deliver value is a formidable challenge.
- Significant variations in provider prices should reflect real differences in costs related to their missions or to consumer preferences in well-functioning markets, not vagaries of negotiating leverage that might produce inequitable prices of services, placing providers in very different financial circumstances unrelated to their own performance.

Policy Options

Recognizing that no single policy option would be applicable to all local markets — that there is no "silver bullet" to address the lack of price competition — the study panel produced a range of policy options. The policy options assume that laws and regulations can help foster competition by imposing rules of conduct and by addressing barriers to competition.

The policy options should not be seen as either a packaged set or as competing alternatives. Where feasible, policy solutions should be crafted to reflect local health care market conditions. The policy options follow a continuum based on how vigorously they intervene in the market from least to most:

Policy Options

- Policy Option A: Encouraging Market Entry of Competitors
- Policy Option B: Greater Price Transparency
    1. Collecting and Reporting All-Payer Claims Data
    2. Supporting Price-Conscious Consumers
- Policy Option C: Limiting Anticompetitive Health Plan-Provider Contracting Provisions
- Policy Option D: Harmonizing Network-Adequacy Requirements with the Development of Limited-Provider Networks
- Policy Option E: Active Purchasing by Public Payers
- Policy Option F: Improved Antitrust Enforcement
    1. Scrutiny of Hospitals and Insurers with Market Power and the Foreclosure of Markets to New Entrants
    2. Active Review of Vertical Mergers
    3. Conduct Remedies and Post-Merger Monitoring
- Policy Option G: Additional Public Oversight and Review
- Policy Option H: Regulating Premium Increases through Strengthened Rate Review
- Policy Option I: Limiting Out-of-Network Provider Charges
- Policy Option J: Setting Upper Limits on Permissible, Negotiated Provider Payment Rates
- Policy Option K: Expanding the Use of All-Payer and Private-Payer Rate Setting

CHAPTER ONE
Assessing the Problem of Pricing Power in Health Care Markets

The Role of Prices in Health Care Spending Growth

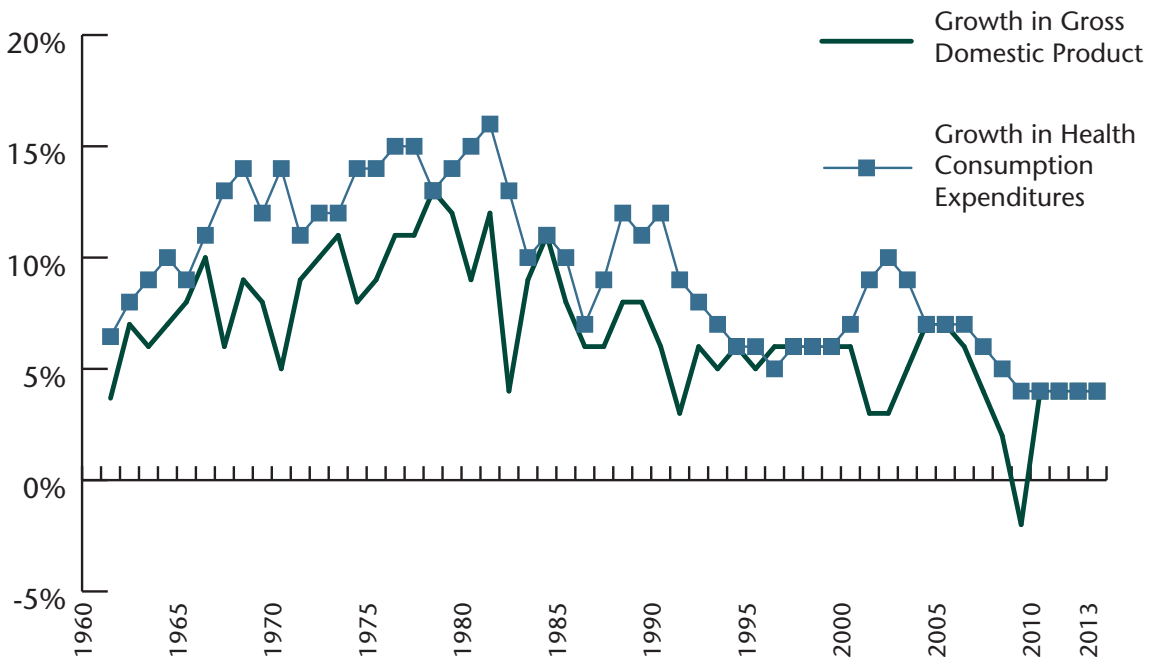
Although U.S. health care spending growth has moderated in recent years, rising health care costs remain a critical domestic policy issue, especially as more Americans gain health insurance. Maintaining the significant coverage gains under the Affordable Care Act (ACA), in large part, depends on keeping health care affordable. In 2011, the United States spent 17.7 percent of gross domestic product (GDP), or $2.7 trillion, on health care, compared to an average of 9.4 percent of GDP for other developed nations in the Organization for Economic Cooperation and Development (OECD).[1]

The United States stands out because of two major factors: substantially higher prices paid for medical care and higher administrative costs related to health insurance.

Higher U.S. spending does not produce better quality care — care in the United States is uneven at best and ranks poorly by many measures. The United States also has fewer hospital admissions and fewer physician visits per capita than most other countries,[2] as well as a younger population and comparable or lower rates of chronic conditions.[3] The United States stands out because of two major factors: substantially higher prices paid for medical care[4] and higher administrative costs related to health insurance.[5] Financing of the U.S. health care system is split about evenly between the public and private sectors, with the public sector largely setting prices for health care and the private sector relying on market-based pricing.

On average, annual U.S. health care spending growth has outpaced growth in the overall economy by about two percentage points since 1960 (see Exhibit 1).[6] Simply put, spending growth consists of two main components: 1) the volume and intensity of services and 2) the price of services. The share of spending growth attributable to higher volume or higher prices shifts over time and is affected by many factors, including levels of insurance coverage, economic conditions, advances in medical technology, the population's health status, and demographics, such as aging of the population. In recent years, health care spending growth has slowed — a turn of events many have attributed to the 2007-09 recession, stagnant incomes, declining employer-sponsored health insurance, greater cost sharing for insured people, and cost-containment efforts by Medicare and state Medicaid programs.[7] While these are important factors, the NASI study panel is primarily interested in the role of prices and their contribution to private health care spending growth.

Exhibit 1: U.S. Health Care Spending and GDP Growth Trends, 1960-2013



Source: From National Health Expenditure Accounts, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

When spending growth is caused primarily by rising prices for the same services, consumers are worse off because they must spend more to maintain their health. Rising prices may reflect increased resource costs, less competition, ineffective regulation, or costly new technologies. Several studies point to medical prices as significantly contributing to overall health care spending growth, accounting for 50 percent to 80 percent of growth in any given year.[8]

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Though health care spending growth in 2013 reached historic lows not seen since 1998, analysts point to spending growth accelerating in the near future as economic growth picks up and more people are insured under the ACA.[9] Actuaries at the Centers for Medicare and Medicaid Services (CMS) estimate that health spending growth will increase from 3.6 percent in 2013 to about 5.7 percent annually through 2023, when health spending will account for an estimated 19.3 percent of GDP.[10]

What is Pricing Power?

In simple economic terms, pricing power — or market power — is the ability of a seller to raise and maintain prices above the level that would prevail if the market were competitive. High prices can be maintained, for example, if there are no substitutes available to consumers or if new firms cannot enter the market. The exercise of market power imposes high costs on consumers and society, resulting not only in higher prices but also in greater inefficiencies. Concerns about the lack of price competition are longstanding in health care, and the role of market power in the conduct of both health insurers and health care providers is a significant policy issue.

Why Health Care Differs from Other Goods and Services

The market for medical care is different from other markets in at least two significant ways: third-party payment for insured consumers and a fundamental imbalance in information, clinical knowledge, and understanding between patients and clinicians. Third-party payment leads consumers to be less sensitive to prices than would otherwise be the case. Standard economic theory holds that when well-informed consumers pay the full cost of services, they will make a conscious trade-off between the price and quality of goods and services and purchase those that provide the best value — or the combination of highest quality and lowest price acceptable to the consumer.

Once insured consumers have fulfilled their cost-sharing obligations, however, third-party payment largely insulates them from the costs of their health care decisions and removes the incentive for them to be price-conscious and shop for an acceptable level of quality at the lowest price. Typically, consumers would respond to high prices by purchasing less, but in health care, insurance allows consumers to continue paying high prices and demand greater quantities of care.

In addition to the effects of third-party payment, health care consumers often face difficulties in assessing the value of health care services for two main reasons:

- The fundamental imbalance in information, clinical knowledge, and understanding between patients and clinicians, coupled with the emotionally laden nature of life-threatening serious illnesses.
- The lack of widespread, useable consumer price and quality information. This lack of information may make consumers less able to judge whether higher-priced services deliver higher quality.

…there is a major division between those who think competition can significantly improve the situation and those who think health care is fundamentally different in ways that cannot and should not be subject to attempts to create competitive markets.

While most acknowledge that health care purchasing is different from other goods and services to some degree, there is a major division between those who think competition can significantly improve the situation and those who think health care is fundamentally different in ways that cannot and should not be subject to attempts to create competitive markets. The former group believes that reasonably well-functioning markets can be created through greater transparency of performance on quality and costs, relaxed barriers to entry of potential competitors, increased consumer financial responsibility for the health care choices they make, and supported by antitrust or other pro-market regulatory approaches.

Those who think health care is fundamentally different emphasize unique characteristics — well articulated in a seminal article by Kenneth Arrow[11] more than 50 years ago — symmetry of information between buyers and sellers, inherent uncertainty and variation in clinical decision-making, desirable insurance protection that society wants but that makes patients relatively indifferent to costs at the time of service, and the intermingling of patient care with other activities that benefit society as a whole, including research, education, and care for the uninsured.

Those who think current market failures can be improved or even perfected tend naturally to support public policies that would make markets function better. Those skeptical of market solutions for health care tend to favor more overtly regulatory approaches. And some would see complementary interaction between regulation and competition, for example, regulating prices as a way to promote competition over quality and service use. Regardless of one's viewpoint, current law assumes competitive markets in health care.

The Shifting Balance of Power Between Health Plans and Providers

Over the last two decades, the balance of power between health plans and providers has shifted significantly, albeit to different degrees in different local health care markets. Following a serious recession and the failure of government health care reform in the early 1990s, managed care emerged as the market-based response to rapidly rising health care costs. Employers shifted large numbers of workers to managed care products, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), which relied on restrictive provider networks and greater utilization management.

Armed with a credible threat of excluding providers from their networks and the resulting loss of patient volume, health plans gained negotiating leverage over hospitals and physicians and obtained significant price discounts. About the same time, however, hospital consolidation picked up speed through mergers and acquisitions as hospitals tried to reduce excess capacity, cut expenses, and increase their clout with insurers.

By the late-1990s, a significant backlash against tightly managed care developed and, aided by the booming economy and tight labor markets, negotiating leverage began to swing back to providers, particularly dominant hospitals. Focused more on recruiting and retaining workers, employers abandoned cost controls in favor of broad provider networks, denying health plans an important bargaining chip with providers — the credible threat of exclusion from plan networks if provider price demands were too high.

A wave of health plan-provider showdowns occurred in the early 2000s, with providers threatening to drop out of plan networks unless they received higher payment rates and other favorable contract terms. About the same time, hospitals shifted competitive strategies from a nascent "wholesale approach — vying for managed care contracts — to a retail approach — marketing directly to patients and physicians on the basis of the latest technology and amenities."[12]

Not surprisingly, spending growth for employer-sponsored insurance accelerated as insurers abandoned narrow-provider networks and tight utilization management controls. Initially, increased

volume of services played a larger role in spending growth, but higher prices ultimately became a greater factor in spending growth. Lacking support from employers to hold the line against provider demands, health plans in many cases effectively called a truce with providers, leading to the existing "pass-through" environment where higher provider payment rates are passed on to employers through higher premiums. In turn, employers have responded to higher premiums by steadily increasing patient cost sharing at the point of service and, more recently, by asking workers to pay a slightly larger share of premiums.[13]

Insurer Market Power

As the intermediary between health care providers and insurance purchasers, insurers with market power can potentially leverage negotiations in both directions.

As the intermediary between health care providers and insurance purchasers, insurers with market power can potentially leverage negotiations in both directions. Insurer market power largely is derived from market share — the number of covered lives — in either the fully insured individual and group markets or in the self-insured market where carriers provide only administrative services to employers.[14] Large insurers typically can obtain greater price discounts from providers that agree to be in the insurer's network because of the promise of increased patient volume.[15] Insurers also can gain market power by offering products with narrower provider networks.

Historically, the health insurance market has been relatively concentrated, in large part, because of the legacy dominance in many areas of local Blue Cross Blue Shield plans. And, health plan consolidation has increased in the last decade through mergers and acquisitions and as regional and local non-Blue plans became less attractive to national and multi-state employers.[16] As a result, the health insurance market has become more concentrated over time. In 2004, the largest insurers controlled more than half the market in 16 states and at least one-third of the market in 38 states. Between 1998 and 2006, the fraction of health care markets that were concentrated to levels high enough to raise antitrust concerns, according to the U.S. Department of Justice's Horizontal Merger Guidelines, increased from 68 percent to 99 percent.[17]

The outcome of price negotiations between dominant insurers and dominant providers — also known as a bilateral monopoly — is difficult to predict.

Data on the impact of health plan concentration on prices is limited but developing.[18] The outcome of price negotiations between dominant insurers and dominant providers — also known as a bilateral monopoly — is difficult to predict. In theory, an increase in a health plan's market power may strengthen bargaining power with hospitals and other providers, which may in turn lead to reduced payment rates and reduced premiums. The dominant health plan could more effectively threaten exclusion from the network to negotiate lower prices.[19]

But at the same time, increased concentration in the insurer market may allow the merged entity to simply increase premiums to employers.[20] There is some evidence to support both arguments. One study found that hospital prices in the most concentrated health plan markets are approximately 12 percent lower than in more competitive markets.[21] Another study shows that concentration in the insurance market produces a

greater reduction in prices than concentration in hospital markets raises prices — although that result may be skewed because of the particular geographic markets examined.[22]

There also is evidence that increased insurance market concentration leads to higher premiums, not lower, even if only by a modest amount.[23] Nonetheless, insurer concentration, while a factor, has not been a driving force of rapid growth in private health insurance premiums.[24] One study shows that health plan concentration explained 12 percent of the premium increase among a large set of employer-based health plans.

Provider Market Power

While concerns about insurer market power exist, most recent attention has focused on the market power of health care providers — primarily the ability of dominant hospitals and large physician group practices to negotiate higher prices.

The market power of providers varies across regional and metropolitan markets.[25,26] One study of 10 markets found hospital payment rates ranged from 134 percent above Medicare to 193 percent of Medicare.[27] Another study of eight different markets found that payment rates for inpatient care in 2010 averaged 205 percent of Medicare in Milwaukee and 147 percent in Miami.[28] The differential was even greater for outpatient rates, which ranged from 234 percent of Medicare in Cleveland to 366 percent in San Francisco.[29]

Another study of eight different markets found that payment rates for inpatient care in 2010 averaged 205 percent of Medicare in Milwaukee and 147 percent in Miami. The differential was even greater for outpatient rates, which ranged from 234 percent of Medicare in Cleveland to 366 percent in San Francisco.

Another study, based on claims data from current and retired autoworkers using 110 hospitals in 10 metropolitan markets, identified private plan prices that ranged from 34 percent above Medicare to 93 percent above Medicare, including adjustments for the facility's case-mix, status as a teaching hospital, and local wages.[30] In a few extreme cases, private insurers paid hospitals five times what Medicare pays for inpatient services and seven times what Medicare pays for outpatient care.[31,32]

In competitive markets, hospitals would not be able to sustain such high prices over time because purchasers would shift to lower-price hospital competitors.[33] Hospitals are unlikely to ever be pure substitutes for one another; their location alone confers some market power based on convenience if nothing else. But if competition in other markets is characterized by a drive to innovate and improve processes to drive down costs and improve quality, then health care is far different.[34]

Currently, wide price variations exist even within a single geographic area.

Currently, wide price variations exist even within a single geographic area. The landmark report by the Massachusetts Attorney General in 2010 documented the ability of some hospitals and physicians to charge as much as 100 percent more for similar services. These prices did

not correlate to quality of care, the acuity of the population served, the payer mix, or status as an academic teaching hospital or research facility.[35] Instead, variation among private payment rates was explained by differences in negotiating leverage among regional hospitals and physician groups.

A study of hospitals serving autoworkers found little meaningful correlation between higher prices and quality; higher-price hospitals did much better than lower-price hospitals on reputation-based measures of quality but had a much more mixed record on outcome-based quality measures.[36]

For physicians, market power may depend heavily on the type of specialty, since prices for specialists vary far more than for primary care. In part that may be due to the complexity of services provided by specialists and surgeons. But it is more likely due to the greater market power of specialists—their smaller numbers in any market and their tendency to form larger single-specialty practices allow them to more easily walk away from negotiations with insurers and command higher prices.

Reasons for Provider Market Power

Market power and negotiating leverage are derived from a number of complex and mutually reinforcing factors, including reputation, location, and unique service offerings. Some hospitals and physicians can demand higher prices based on a reputation for quality, regardless of whether that reputation is correlated with objective measures of higher quality. Others benefit from their prominence as a well-known, research-oriented, academic health center. Insurers often believe that without these so-called must-have providers their networks will not be attractive to employers and consumers.

Hospitals also can command must-have status through their dominance in a fairly isolated or sparsely populated geographic area where access to a broad range of health care providers is limited.[37] Likewise, hospitals and physicians can gain market power and higher prices by virtue of offering unique and highly specialized services, such as neonatal intensive care, organ transplants, or specialized cancer care.[38,39]

The negotiating leverage of these large hospitals and physician practices is reinforced by the reluctance of many employers to adopt benefit structures with limited-provider networks, which weakens insurers' negotiating power and undermines their ability to rebuff provider price demands.[40]

Consolidated Provider Markets

Despite the complexity of factors contributing to provider market power, much of the policy discussion about negotiating leverage has focused on the size of the provider. Mergers among hospitals to create a single hospital system — horizontal integration — and/or integration of physician practices and hospitals into larger health systems — vertical integration — have garnered much attention. Over the last two decades, there has been a steep increase in hospital mergers and in market concentration, as measured by the Herfindahl-Hirschman Index (HHI).

What is the Herfindahl–Hirschman Index (HHI)?

The Herfindahl–Hirschman Index is a commonly accepted measure of market concentration used by antitrust enforcement agencies and scholars in the field. The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20, and 20 percent, the HHI is 2,600 ($30^2 + 30^2 + 20^2 + 20^2 = 2{,}600$). The HHI takes into account the relative size distribution of the firms in a market. It approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The HHI increases both as the number of firms in the market decreases and as the disparity in size among those firms increases. The agencies generally consider markets where the HHI is between 1,500 and 2,500 points to be moderately concentrated and markets where the HHI exceeds 2,500 points to be highly concentrated. Transactions that increase the HHI by more than 200 points in highly concentrated markets are presumed likely to enhance market power under the *Horizontal Merger Guidelines* issued by the Department of Justice and the Federal Trade Commission.

Excerpt from U.S. Department of Justice. Available at http://www.justice.gov/atr/public/guidelines/hhi.html.

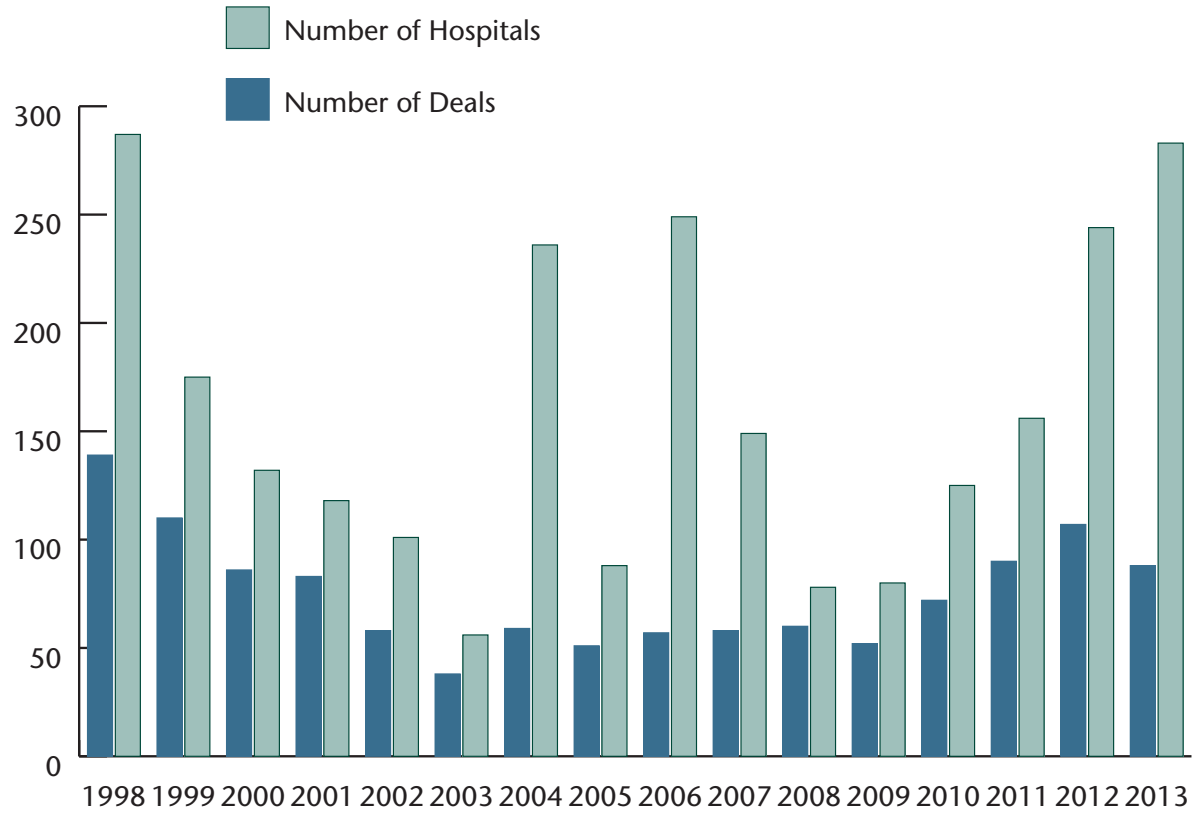
Over the last two decades, there has been a 40 percent increase in hospital market concentration. While much of the merger activity slowed by the early 2000s, the HHI increased from a national average of 2,340 — the level just under where the Federal Trade Commission (FTC) and Department of Justice (DOJ) consider a market highly concentrated — to 3,261 over this time.[41] This is equivalent to a market with five hospitals of equal size becoming a market with three hospitals of equal size.[42] Moreover, using the HHI as the yardstick, most of the metropolitan statistical areas in the United States are now considered highly concentrated hospital markets.[43]

Over the last two decades, there has been a 40 percent increase in hospital market concentration.

This is equivalent to a market with five hospitals of equal size becoming a market with three hospitals of equal size….most of the metropolitan statistical areas in the United States are now considered highly concentrated hospital markets.

Hospital consolidation appears to be accelerating. Between 2009 and 2012, there were 314 hospital mergers, with the number increasing every year within that period (see Exhibit 2). The true volume of consolidation is likely to be greater since this description of transactions does not include affiliations and joint ventures.[44]

Exhibit 2: Hospital Mergers & Acquisition, 1998-2013



Sources: American Hospital Association (2014) Trendwatch Chartbook, Organizational Trends, Chart 2.9. Available at http://www.aha.org/research/reports/tw/chartbook/ch2.shtml. See also A Wave of Hospital Mergers (Business Day), New York Times, August 12, 2013. Available at http://www.nytimes.com/interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0.

Many of the most significant hospitals in major markets today are not free-standing facilities, but part of Integrated Delivery Networks (IDNs) that also include physician groups, post-acute providers such as home health agencies, and in some cases, health plans. The managements of the entities claim that consolidation is not a strategic market move but rather to further the goal of improving population health. Others note that consolidation may allow smaller hospitals better access to capital and the ability to bargain for higher payment rates by merging with a larger hospital; larger hospitals may be able to invest in new technologies and spread fixed costs over a larger base.[45] Some providers may consolidate out of fear — of being the last independent provider standing, of needing to adapt in an increasingly coordinated and integrated health care system, or of stagnating margins from Medicare and Medicaid patients.[46]

Consolidation among hospitals may also provide the new entity with bargaining leverage with health plans that might otherwise play hospitals against each other.[47] Moreover, large health systems may be able to increase the quality of care because there is a clear positive relationship between higher volume and outcomes for many procedures. Thus, consolidation may allow the new entity to increase the volume of specialized services and improve quality. Ultimately, larger health systems potentially could be beneficial, by improving health care quality and reducing costs through improved clinical integration.

However, relatively little is known about the economics of these complex IDNs. To this end, the Academy commissioned a team of researchers led by Jeff Goldsmith and Lawton R. Burns to see what could be learned about IDNs from their publicly disclosed financial and quality information; the researchers focused particularly on the financial role of the IDNs' hospital assets and how their hospital holdings affect their overall performance.[48] Although publicly available data are scarce and two to three years old, the study found little evidence in the literature of any comparative advantage accruing to providers from forming IDNs. Nor does there appear to be a relationship between hospital market concentration and IDN operating profit. Looking at the performance of the flagship hospital in the IDN's portfolio—either the original hospital that created the system or one that is located in its principal metropolitan or regional market—the study found that they appear to be more expensive, both on a cost-per-case and on a total cost-of-care-basis, than the services of their most significant in-market competitor. Further, the flagship facilities of IDNs operating health plans or having significant capitated revenues are more expensive per case (Medicare case-mix adjusted) than their in-market competitors.[49]

And there is little evidence that integrating hospital and physician care promotes quality or reduces cost. Indeed, there is growing evidence that hospital-physician integration has raised physician costs and the total cost of care. The evidence further suggests that the more providers invest in IDN development, the lower their operating margins and return on capital. Thus there appear to be no economies of scale (savings from being a larger entity overall) and no economies of scope (savings from having different services — health plan, hospital, and physician—delivered by a single IDN).[50]

…there is little evidence that integrating hospital and physician care promotes quality or reduces cost. Indeed, there is growing evidence that hospital-physician integration has raised physician costs and the total cost of care.

Most studies find that hospital consolidation is associated with price increases. Evidence also shows that there is strength in numbers: just being part of a system, regardless of whether it is small or large, can help secure higher prices. Hospitals in both small systems and large systems were able to obtain much higher prices than hospitals that were not part of a system (17 percent and 34 percent more, respectively).[51] According to a comprehensive review, consolidation in the 1990s among hospitals in proximity to each other consistently led to price increases that range between 4 percent and 53 percent.[52] While factors that contribute to increased negotiating leverage in health care markets are complex, the result appears clear: higher prices that bear little relation to the cost of production.

Evidence also shows that there is strength in numbers: just being part of a system, regardless of whether it is small or large, can help secure higher prices. Hospitals in both small systems and large systems were able to obtain much higher prices than hospitals that were not part of a system (17 percent and 34 percent more, respectively).

However, others caution that several hospital competition and merger studies are from the 1990s or early 2000s and may not reflect current market realities.[53] While the studies may be dated, an important market dynamic remains: insurers still rely on network structures to pit hospitals against one another in price

negotiations, a strategy that can only work when competition is robust. Another important takeaway from prior studies is that health care markets are local, and that judgments about market power should be made at the local level.

Other Aspects of Provider Consolidation

The trend toward consolidation in health care markets continues to accelerate and now includes the absorption of physician practices into hospital systems.[54] Physicians who sell their practices to hospitals typically become hospital employees. While most physicians remain either self-employed or work in independent, physician-owned practices, the share of physicians employed by hospitals is substantial and growing rapidly.

Many factors make such acquisitions attractive to hospitals and physicians. Employment of primary care and specialty physicians can help hospitals expand their referral base.[55] For physicians, hospital employment or affiliation allows them to share the complexity and cost of running a practice — especially the cost of new information technology — and reduces the financial pressure of stagnant payment rates.[56] Hospital employment also provides a stable salary and a better work-life balance, which is increasingly attractive to younger physicians.[57]

For some physicians, another benefit is higher compensation.[58] Hospitals often negotiate with insurers on behalf of employed physicians, gaining substantially higher rates than small practices are able to garner. Likewise, larger physician groups may be able to command higher payments from private insurers, while solo or small practices often are price takers.

Generally, most health care competition occurs in local markets. However, large multi-hospital systems operating in different geographic markets also can use size to their advantage. They may seek to negotiate on behalf of the entire health system,[59] pursuing an "all-or-none" strategy that ensures that all facilities in the system receive higher payment rates.

Though studies have not yet borne this out, the idea is that even system hospitals with relatively small market shares can obtain higher prices because of the cumulative influence of a large system on the network of a particular plan. Thus, these multi-facility hospital systems can use their dominance in a major geographic market (such as the San Francisco Bay Area) as leverage in more competitive geographic markets (such as the less populous Central Valley). Through geographically dispersed mergers, such systems may be able to extend their bargaining leverage even in markets where they do not have significant market share and, therefore, without raising concerns under existing antitrust guidelines.[60]

Market Power and Antitrust Enforcement

Antitrust laws are intended to foster competition, discourage anticompetitive monopolistic practices, and prevent inefficient consolidation. The major pieces of federal law that frame antitrust policy are the Sherman Act, the Clayton Act, and the Federal Trade Commission Act. Briefly, section 1 of the Sherman Act bars cartel behavior, such as price fixing, group boycotts, market division, and similar

collusive agreements; section 2 of the Sherman Act prohibits firms from exploiting monopoly power to stifle market entry or inhibit competition. The Clayton Act prohibits mergers, tying, and exclusive dealing arrangements that lessen competition or lead to a monopoly. Finally, the FTC Act created an independent agency to work with DOJ to enforce federal antitrust laws.

Federal regulators, state attorneys general, and private plaintiffs, including consumers, all contribute to antitrust enforcement. Most actions under federal antitrust law are brought by private parties. While both federal agencies and private parties can bring suit to enforce civil penalties, only federal agencies can enforce criminal provisions.

Because the two federal enforcement agencies are relatively small and litigating cases can be expensive and protracted, considerable emphasis has been placed on preliminary reviews of announced mergers. Pre-merger review under the Hart-Scott-Rodino Act allows the agencies to assess any anticompetitive consequences of a merger before it is consummated.

To specify and clarify when agencies are likely to challenge proposed mergers, both the FTC and the DOJ Antitrust Division have disseminated a variety of materials that offer some enforcement predictability to would-be merging parties: merger guidelines, public statements upon closing investigations where there is no enforcement, advisory opinions, amicus briefs in court cases, and, in the case of health care, a set of Statements on Antitrust Enforcement Policy in Health Care. The Statements outline the types of hospital mergers, joint ventures, multi-provider networks, and information-sharing agreements between physicians and purchasers that are likely to trigger further antitrust scrutiny.

The basics of antitrust doctrine are no different when applied to health care than to other industries, yet certain circumstances of health care — widespread third-party payment that creates so-called moral hazard, or how behavior changes when people are insured against losses; extensive regulation; the large role of government purchasers; and a rapid pace of technological change — make the analysis of competition and monopoly power unique.

Currently, federal agencies operate under the assumption that consolidation among providers is not justified simply to exercise countervailing power in geographic areas where health plans also are consolidated. The agencies have explicitly stated that enforcement against unlawful consolidation of health plans is preferable to permitting providers to accrue market power simply to counter health plans' negotiating power.

Horizontal review includes not only mergers but also such transactions as physician network joint ventures in which competitors collaborate. The inquiry in each of these transactions compares the losses in competition against the purported gains in efficiencies, including clinical efficiencies. Under current guidelines, transactions that involve significant financial risk for patient care, such as global fees, are more likely than other financial arrangements to avoid enforcement. Finally, the agencies pay particular attention to whether transactions lead to joint pricing, which preempts price competition, and whether collaborative pricing is necessary to achieve the proposed efficiencies.

The FTC successfully argued that courts should look at how the merger affects bargaining over networks with health plans, in addition to changes in patient flows.

In recent years, the FTC has aggressively challenged a number of horizontal mergers by hospitals and health systems that substantially reduce competition. Perhaps the pivotal case was *FTC v. Evanston*, in which the FTC not only ended a seven-case losing streak but laid out a blueprint for successful litigation going forward. The FTC successfully argued that courts should look at how the merger affects bargaining over networks with health plans in addition to changes in patient flows.[61,62] In the last year, the agency successfully blocked mergers in *Pro-Medica Health v. FTC* and *FTC v. St. Luke's* and undid a merger in *FTC v. Phoebe Putney*.

Many local geographic markets are already highly concentrated, with either a dominant hospital system or a small number of competitors that each has pricing power. Even with the courts taking a different view of horizontal mergers, cases are time and resource intensive, and the government is able to challenge few mergers. Consequently, antitrust policy also should consider actions to constrain the exercise of pricing power where providers have achieved monopoly power.

High Prices and Cost Shifting?

One argument for why prices have been rising is that hospitals are simply cost shifting by demanding higher private payment rates to make up for lower payment rates from Medicare and Medicaid. Price differences alone are not evidence of cost shifting because different payers may have a different willingness to pay for services. At issue is whether one set of payers (usually private insurers) is paying more because someone else (usually public payers) is paying less.[63]

Historically, the evidence of whether and to what extent cost shifting actually occurs in hospitals has been quite mixed.[64] A review of the early literature by the Congressional Budget Office in 2008 found evidence on cost shifting varies over time, depending on the payment system and competitiveness of the market.[65] In the early 1980s, there was evidence of cost shifting as hospitals were paid based on their charges, price negotiations with plans were less intense, and there was little selective contracting. But evidence of cost shifting seemed quite weak after that when health plans aggressively negotiated payments and established provider networks.[66]

The notion that high private payment rates are efforts to cost shift assumes that hospitals operate under a structure so that any reduction in payment rates from public programs like Medicare must be made up by increases in private payment rates. There is an alternative theory, advanced by staff at the Medicare Payment Advisory Committee (MedPAC), that hospitals in concentrated markets with high private payment rates have negative Medicare margins as a result of higher costs. Weak cost controls could be caused by the lack of competition in these markets.[67] In this scenario, higher payments from private payers compensate for higher costs rather than for lower payments from public programs. This MedPAC theory is consistent with findings from the Massachusetts' Attorney General that higher prices for health care in the state reflected the hospitals' higher cost structures but were not necessarily *caused* by them.

This alternative theory advanced by MedPAC is consistent with recent studies demonstrating that private payment rates and market conditions are related to hospital cost structure. Hospitals in markets with less competition appear to be less efficient and thus have higher cost structures; this reduces their overall margins and necessitates higher commercial rates. A study of 61 hospitals participating in the value-based purchasing initiative of the Integrated Healthcare Association demonstrated that hospitals in concentrated markets are more likely to focus on revenue enhancement from private payers — cost shifting — while hospitals in competitive markets are more likely to focus on cost moderation.[68] A review of inpatient payment rates across hospital markets between 1995 and 2009 found that the hospitals most adversely impacted by Medicare cuts — that presumably had the highest Medicare volumes — did not make up the shortfall with increased prices from other payers, while those affected the least actually increased revenues.[69] These studies find that what looks like cost shifting may be inefficient behavior related to markets lacking competition.

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Key Emerging Trends and Market Power

Increased scrutiny of high and widely varying prices for health care services, especially hospital care, has helped raise public awareness of the lack of price competition and focus policy attention on the role of provider market power in negotiating prices with insurers. Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular.

Although public policy is only now coming to grips with the importance of high prices as a major driver of U.S. health care spending growth, payers and purchasers have been adopting strategies permitted under current market and regulatory conditions to try to restrain health care cost growth in general and high provider prices in particular.

Understanding emerging trends in health care financing and delivery can help policymakers identify how best to counteract market power and foster price competition in health care markets. The array of emerging trends related to market power includes:

- Fostering consumer price-sensitivity through greater cost sharing and health plan benefit structures that guide patients to more efficient providers;
- Launching payment reforms that move from piecemeal fee-for-service methods that reward volume regardless of quality to methods placing more risk on providers for the cost and quality of care;
- Shifting care from inpatient hospital settings to outpatient care;
- Encouraging health plan competition in the individual and small-group markets through state health insurance exchanges; and
- Intervening in markets through state and federal regulatory and antitrust enforcement actions.

Fostering Consumer Price-Sensitivity

For more than a decade, consumer out-of-pocket costs for health care have increased steadily as purchasers and payers resorted to higher deductibles, coinsurance, and copayments to buy down premium increases. A secondary goal has been to encourage consumers to actively shop among alternative providers based on price considerations and, in some cases, forgo care they don't really need.

Since many insured consumers are insulated to a large degree from high and rising health care prices, they have little reason to care about health care prices if they are able to fulfill their cost-sharing obligations. Increasingly, however, purchasers and payers are trying to raise consumer awareness and knowledge of the prices they pay for their care.

Providing transparent and useful information about provider prices remains a challenge, but recently purchasers and payers have invested in price-transparency tools to raise consumer awareness of wide price variations among providers for the same or similar services and to help them find lower-price providers. And, some purchasers and payers have tentatively turned to benefit structures, including tiered-provider networks, designed to raise consumer awareness of differential prices at the point of service.

Consumer Out-of-Pocket Costs.

Insured consumers face two types of out-of-pocket costs for medical care: contributions toward health insurance premiums and patient cost sharing at the point of service in the form of deductibles, coinsurance, and copayments. Over time, while the average share of premium contributions for people with employer coverage has increased slightly, for the most part, worker contributions have remained relatively stable at about 28 percent for family coverage and 18 percent for single coverage.[70]

…patient cost sharing at the point of services has increased steadily over the last decade or longer. For example, the average general deductible for single employer-sponsored coverage was $1,217 in 2014 compared to $836 in 2009. The proportion of workers covered by high-deductible health plans has increased from 4 percent in 2006 to 20 percent in 2014.

In contrast, patient cost sharing at the point of services has increased steadily over the last decade or longer. For example, the average general deductible for single employer-sponsored coverage was $1,217 in 2014 compared to $836 in 2009. The proportion of workers covered by high-deductible health plans has increased from 4 percent in 2006 to 20 percent in 2014. In an era of stagnant wage growth for large parts of the workforce, these increases in cost sharing have the potential to significantly reduce access to care. At a time of growing disparity in wealth, these averages may mask even larger increases for workers who have less bargaining power or in sectors where there is greater slack in the labor market.

Limited-Provider Networks.

Emerging payer strategies to counter provider pricing power include developing limited-provider networks that either exclude high-price providers or require greater patient cost sharing to use non-preferred, in-network providers. Narrow-network plans exclude certain providers entirely, while tiered-provider networks

use quality/efficiency metrics to assign providers to cost-sharing tiers, with the goal of directing patients toward more cost-effective providers through financial incentives. A primary goal of limited-provider networks is to motivate providers in non-preferred tiers to reduce prices or improve quality in exchange for preferred status.

By limiting network providers, health plans can bargain with providers for lower prices in exchange for greater patient volume. They potentially can exclude high-price providers entirely. While employers have moved tentatively to offer narrow-network plans, the ACA exchanges have turned out to be the epicenter of this trend, with about half of the plans offered having narrow networks.[71] Ultimately, insurers and employers contend that health plans must have the flexibility to form restrictive networks to balance negotiating leverage with providers and encourage competition on price and quality.

Payment Reform

Experimentation with and adoption of alternative public and private payment methods increasingly is impacting health care prices. This trend reflects the wide recognition that under the existing fee-for-service payment system, providers are rewarded primarily for the volume of care delivered with little regard for quality or efficiency. Many believe this piecemeal payment approach contributes to fragmented care delivery and an emphasis on acute, episodic care rather than care coordination for people with chronic conditions, such as diabetes and high-blood pressure, which if treated improperly contribute to poor quality and high costs.

Many private payers and purchasers, even before enactment of the ACA, were experimenting with and implementing new payment and delivery models, including private versions of accountable care organizations (ACOs), where a group of providers is rewarded for successfully taking greater responsibility for the cost and quality of care of a defined group of patients. The precise payment method adopted affects whether providers have a direct incentive to restrain their prices or not. For example, the most widely adopted approach — shared savings — typically sets targets for an ACO based on the organization's historic spending for patients attributed to the ACO to determine whether the ACO has met quality and spending targets. In short, this approach accepts the baseline per capita spending of the ACO but discourages further price increases. Physician-based ACOs have incentives to create referral arrangements with hospitals and other providers with lower prices to help meet spending targets.

The ACA has also led to a series of initiatives and demonstrations of new payment and delivery models in Medicare, including shared-savings ACOs, bundled payments for particular procedures involving hospitalization, and patient-centered medical homes.

The major provision that potentially affects provider pricing power is encouraging providers to form ACOs. At its most basic level, the ACO program encourages providers to integrate care delivery, and if they are successful in meeting certain cost and quality goals, share a percentage of the savings with the government. ACOs are seen as a positive step toward preparing providers to assume financial risk for the cost of care because they move payment incentives away from fee-for-service methods that reward high volume toward payments based on quality and efficiency. A potential downside of promoting Medicare ACOs is that these bigger, more integrated provider organizations may also command increased bargaining clout that will spill over into negotiations with private health plans.[72]

Hospital Inpatient Care

The use of hospital inpatient care continues to decline across multiple payers. Between 2006 and 2012, Medicare experienced 12 percent fewer hospitalizations per beneficiary,[73] and privately insured individuals experienced similar reductions in inpatient care. While inpatient care has declined, outpatient care has expanded. Medicare visits per beneficiary increased 28 percent from 2006 to 2012. Moreover, from 2010 to 2011 Medicare prices grew modestly, but they grew more for outpatient care than for inpatient care.[74]

Despite the fact that outpatient care has partially offset the decline in inpatient care, Medicare has not been a lucrative payer for most hospitals. Medicare payments are lower than estimated hospital costs, resulting in negative overall hospital margins hovering around -5 to -7 percent since 2007.[75] More efficient hospitals have performed better and have positive, but small, Medicare margins. In general hospitals rely on commercial payers to sustain their margins and can face significant financial difficulties when they have few commercial patients. Across all public and private payers, hospital profitability has increased because commercial price increases have outpaced those of Medicare and Medicaid.[76]

Hospitals also are affected by the broader shift in health care spending from private payers to public payers. As more baby boomers age into Medicare and as states expand their Medicaid programs, public spending is playing a larger and growing role in financing health care. Consequently, the pressure on hospitals is clear — find and follow strategies to counter loss of service volume and low public-payer margins.

Health Plan Competition

The longstanding lack of health plan competition in the non-group insurance market — the only place a significant minority of Americans can buy health coverage — has been the focus of intense policy intervention to make the market more transparent, functional, and competitive.

By prohibiting medical underwriting — or basing premiums on people's health status — standardizing health plan offerings to some degree, and providing subsidies to make coverage more affordable, the state and federal health insurance marketplaces created under the ACA are designed to stimulate health plan competition to gain the business of millions of uninsured Americans.

More than half of the 17 states and the District of Columbia that chose to establish a state-based exchange for 2014 embraced some form of active purchasing to increase the competitiveness of the local insurance market, including limiting the number of plans an insurer may offer or requiring participating insurers to offer standardized plans through the exchange, including a plan with a limited-provider network. Since the exchanges in particular and the nongroup market more generally account for a relatively small share of American's health coverage, adoption of these strategies to encourage health plan competition would need to be adopted more broadly in employer-sponsored health plans.

Regulatory and Antitrust Interventions

As market forces fail to promote price competition in health care markets, regulators are beginning to intervene, for the most part, in limited ways. Continued merger and acquisition activity, along with other potentially anticompetitive practices, may prompt increased antitrust scrutiny.

State and Federal Regulatory Efforts.

A few states have responded to current market conditions with extensive regulation. Massachusetts, for example, enacted a law pegging statewide health care expenditures to growth in the state's overall economy. The state also created an independent Health Policy Commission to set the health care cost growth benchmark and certify new payment methods and care delivery models. The commission will track and publicly report on provider and health plan performance in meeting savings targets.

On the federal regulatory front, the ACA requires all health plans — not just exchange plans — to report their medical loss ratios, or the proportion of premium dollars spent on clinical services and quality improvement. Additionally, states are required to review premium increases for plans offered in the exchanges, and plans must justify increases greater than 10 percent.

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Antitrust Enforcement.

In recent years, federal antitrust scrutiny of horizontal mergers has increased and is likely to continue. However, there are potentially other areas of antitrust enforcement that could be pursued by federal and state authorities, including prohibitions on anticompetitive contracting terms between health plans and providers.

Generally, these contracting provisions are aimed at thwarting insurer efforts to adopt narrow- or tiered-provider networks or new payment incentives that would encourage lower prices or increased efficiency. Other potentially anticompetitive contract provisions — such as most-favored-nation clauses that require providers to give a plan their best price — can create barriers to market entry by competing health plans.

Overview of Policy Options

In 2013, the Academy convened a diverse study panel of economists, antitrust experts, researchers, and hospital and insurance executives to think systematically about the shift in negotiating power from purchasers to health care providers, particularly dominant hospital systems. Recognizing that no single policy option would be applicable to all local markets — that there is no "silver bullet" to address the lack of price competition — the study panel produced a range of policy options. As a result, the study panel offers these options as a starting point for federal and particularly state policymakers interested in responding to the issue of competition in local health care markets.

Some of the policy options are intended to foster or preserve market conditions that support price competition. These options assume that laws and regulations can help foster competition by imposing rules of conduct and by addressing barriers to competition. Markets need government to set minimal regulations — "rules of the game" — to enforce contracts among parties and to create competition-

The Academy's panel generally favors policy options that support competitive market mechanisms. But when markets fail, the study panel recognizes that other types of policy interventions may be appropriate.

enhancing institutions. The Academy's panel generally favors policy options that support competitive market mechanisms. But when markets fail, the study panel recognizes that other types of policy interventions may be appropriate.

This report reflects how the panel grappled with a number of analytical challenges, primarily the typology to use for describing the policy options. Labels mean different things to different people and there is no broad consensus on how to characterize many policy options. More aggressive enforcement of antitrust policy, for example, could be seen as preserving market competition or government intervention in the market. For many policymakers, it is difficult to draw bright-line distinctions between these two policy categories; it is easier, and perhaps more useful, to consider a broad continuum of policy options, ranging from policies to foster a more competitive market to those that rely more heavily on direct regulatory intervention that limit market outcomes.

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These policy options should not be seen as either a packaged set or as competing alternatives. Panel members believed it was important to offer individual options, knowing that some may work better in combination than individually. They also may interact in ways that increase the effectiveness of each, depending on local market characteristics and the political and regulatory environment. Where feasible, policy solutions should be crafted to reflect local health care market conditions. No one policy is likely to be optimal in all markets.

The result of this work is a set of policy options that follow a continuum based on how vigorously they intervene in the market from least to most (see box on p.26):

Policy Options

- Policy Option A: Encouraging Market Entry of Competitors
- Policy Option B: Greater Price Transparency
    1. Collecting and Reporting All-Payer Claims Data
    2. Supporting Price-Conscious Consumers
- Policy Option C: Limiting Anticompetitive Health Plan-Provider Contracting Provisions
- Policy Option D: Harmonizing Network-Adequacy Requirements with the Development of Limited-Provider Networks
- Policy Option E: Active Purchasing by Public Payers
- Policy Option F: Improved Antitrust Enforcement
    1. Scrutiny of Hospitals and Insurers with Market Power and the Foreclosure of Markets to New Entrants
    2. Active Review of Vertical Mergers
    3. Conduct Remedies and Post-Merger Monitoring
- Policy Option G: Additional Public Oversight and Review
- Policy Option H: Regulating Premium Increases through Strengthened Rate Review
- Policy Option I: Limiting Out-of-Network Provider Charges
- Policy Option J: Setting Upper Limits on Permissible, Negotiated Provider Payment Rates
- Policy Option K: Expanding the Use of All-Payer and Private-Payer Rate Setting

In addition to the policy options, the study panel also developed a set of principles that identify core policy values to serve as the foundation for policy development. The principles highlight the important role of competition in lowering prices, fostering innovation, allocating resources — and even forcing poor performing providers to exit the market. The principles also recognize that where market competition falters or fails, policymakers must intervene in markets to foster competition and, in some cases, limit or set prices. As with the policy options, the principles are offered as a starting point for the creation of policies for particular market conditions.

CHAPTER TWO
Policy Principles

Crafted by a diverse group of national experts, these principles provide a starting point for a public discussion about addressing market power in health care markets. There is broad agreement among the study panel members that these principles also offer a useful framework for crafting policy. Substantively, these principles reflect a preference for market solutions and for targeted regulation in markets that lack competition — in some cases because of provider consolidation — or where new competitors are unlikely to enter the market. These principles recognize the need for policy to address broader societal goals — for example, around issues of access and quality — but the panel believes that meeting these societal goals should explicitly recognize the potential impact on prices and competition. Finally, these principles reflect the important role of competition in generating new ideas about institutions and mechanisms for innovative ways to deliver care that can increase both quality and efficiency.

- Market competition is often the best way to motivate providers to increase efficiency, improve quality, and ensure that health care prices reflect the value of services provided to consumers. Where unfettered market competition is ineffective, public policy can enhance market competition or, if that is not likely to be successful, regulate prices directly.

    - When they work well, competitive markets weed out providers that fail to efficiently deliver services that are valued by consumers. While some inefficient providers may lose business or even exit the market, consumers benefit from the overall improvements in efficiency and quality that emerge from competition.

    - Competitive markets generate prices that reflect the cost and value of services and promote innovations in health care delivery, including the development of new institutional mechanisms for the delivery and organization of care. In the long run, these innovations may provide substantial benefits to patients.

    - Health care markets are local, and policy interventions that address market failures should be tailored to local markets. In many markets, there has been significant hospital consolidation to the degree that unregulated markets are unlikely to generate competition that will lead to efficient prices or innovation.

    - There is a broad scope of regulatory interventions to foster competition, including targeting more aggressive antitrust enforcement, prohibiting providers from demanding

favorable treatment as a condition of contracting, and directly limiting prices through administrative means.

- However, all regulation risks so-called capture — or undue influence — by regulated entities. Just as markets may not work in every situation, regulation has costs and benefits that vary by context. Regulatory capture has in some situations led price regulation to be only marginally effective, if at all.

- Along with care for patients, hospitals and physicians often provide additional services with significant social value, including research, medical training, and uncompensated care. In a competitive market, prices are unlikely to support these public goods. Increased competition leads to the additional need for specific policies to support such activities.

- Greater transparency that provides consumers with accurate and timely information about price, quality, costs, and provider networks likely can help them make better choices and, in some cases, make markets more competitive. Greater transparency also may improve the functioning of markets by exposing market conditions and market behavior to public scrutiny. At the same time, policymakers must guard against providers or plans using price information for collusive purposes.

- The benefits of emerging payment reforms and delivery systems, such as ACOs and other provider configurations, may improve quality but also can contribute to excessive market consolidation. Policymakers should carefully evaluate known costs and benefits before making exceptions to competition laws to encourage new but unproved payment and delivery systems. Forcing highly integrated systems to divest if they do not deliver value is a formidable challenge.

- Significant variations in provider prices should reflect real differences in costs related to their missions or to consumer preferences in well-functioning markets, not vagaries of negotiating leverage that might produce inequitable prices of services, placing providers in very different financial circumstances unrelated to their own performance.

CHAPTER THREE
Policy Discussion

Policy Option A: Encouraging Market Entry of Competitors

The market entry of new health providers and insurers can potentially spur innovation in care delivery and price competition. Encouraging new ways of care delivery that challenge the traditional role of existing providers may benefit consumers. Barriers to provider market entry include licensure and scope-of-practice requirements, certificate-of-need requirements, and facility licensure requirements. Conversely, states may be able to structure health insurance exchanges to promote new entry by insurers.

Licensure and Scope-of-Practice Requirements.

Most states regulate clinicians, including physicians, nurse practitioners, and physician assistants, through professional licensure. These standards are typically set and enforced through autonomous professional boards made up of industry participants — often physicians — with an economic interest at stake.

Many have suggested broadening membership of such boards to include others with a range of social science and health services expertise to reduce the likelihood that the licensure process impedes competition. Research studies have found that tougher licensure leads to higher prices and reduced consumer choice.

Likewise, state scope-of-practice (SOP) laws and regulations dictate the clinical role of nurse practitioners (NPs) and physician assistants (PAs). Motivated primarily by concerns about competency, quality, and patient safety, scope-of-practice restrictions also reduce the supply of health professionals. State SOP requirements vary widely, undermining the argument that restrictive scope-of-practice requirements protect patients. For example, some states allow NPs to practice independently, while others limit their authority to diagnose, treat, and prescribe medications to patients without physician supervision. Removing barriers for nurse practitioners and physician assistants to practice more autonomously would increase the supply of primary care clinicians.

Facility and Other Licensure Requirements.

Over the last decade, both retail clinics and urgent care centers have grown rapidly and appear to offer lower-cost alternatives to physician offices and emergency departments with comparable quality for preventive care and simple acute-care needs.

State licensure requirements can influence the market entry of retail clinics and urgent care centers. For example, most states exempt retail clinics from facility licensure, relieving them of size and other requirements that would raise their costs. Instead, states often rely instead on practitioner licensure by the applicable state board for oversight. The more physician supervision required by the state, which varies by frequency, proximity, and the need for medical chart reviews, the more costly the retail clinic model becomes.

Many states also use licensure requirements to restrict use of emerging technologies like telemedicine. For example, some states bar the use of telemedicine by out-of-state providers or require separate licensing for remote providers, even for peer-to-peer professional consultation. Such a regulatory regime reduces patient access and may add to the cost of care. Advocates have suggested uniform licensing laws and state compacts that provide reciprocal access.

Certificate-of-Need Requirements.

Intended to ensure access, maintain quality, and control capital spending on health care facilities and services, state certificate-of-need (CON) requirements explicitly restrict market entry. Although no longer required by federal law, CON requirements remain on the books in more than 30 states, despite mixed findings about the effectiveness of CONs in controlling the growth of health expenditures. Some research indicates that the CON process is often used by existing providers to protect market share and diminish competition.

State Insurance Exchanges and Policies to Encourage Insurer Market Entry.

States may be able to promote competition and new entry by health insurers in the nongroup and small-group markets depending on how they structure their health insurance exchanges. States can determine how many plans will be offered, whether they must offer standardized plans, and any network restrictions. Early data from a handful of states have found evidence of new entry and greater competition in some states and fewer health insurance competitors in others as a result of how insurance exchanges are structured. Another early study has found that greater competition on the health exchanges leads to lower premiums.

Additionally, states can encourage entry of health plans by reviewing licensure and capital requirements for health plans and discouraging or prohibiting certain contracting provisions, such as most-favored-nation pricing clauses, that discourage entry by new insurers.

Advantages

Eliminating barriers to new entry of competitors is a core tenet of free markets. Existing firms can be disciplined in their pricing behavior by the threat that new competitors will enter when prices are high. While encouraging market entry is a long-term strategy to support competition, it is essential to overcoming the existing market domination by some insurers and provider systems. Licensure, facility, and exchange regulations can be revisited with a keener eye toward their implications for competition and permitting entry. Increasing health care competition based on price and quality can foster innovation and more efficient care delivery.

Disadvantages

Licensure standards are intended to promote quality and patient safety, which could decline if standards are eased. Other ways to assure quality and patient safety potentially might be more or less effective and costly. The cost of monitoring quality and safety must be weighed against the cost associated with otherwise lost competition. In the past, many in health care have pointed out that without price-sensitive buyers, greater competition and new entry by high-tech facilities could lead to a medical arms race and higher prices.

(Sources for this policy option are located on page 49)

Policy Option B: Greater Price Transparency

1. Collecting and Reporting All-Payer Claims Data

A fundamental problem in the U.S. health care system is that pricing for services is both technically complex and seldom disclosed. For example, there are thousands of different codes to describe health conditions and individual medical services and procedures. And, any two payers or providers may have very different prices for the same service. This is in contrast to more transparent goods, such as groceries or gasoline at the pump.

Establishing state-based all-payer claims databases (APCDs) could provide purchasers, payers, policymakers, and consumers with more transparent, consistent, and standardized price information for services delivered by hospitals, physicians, and other providers. Typically, APCDs include information from medical, pharmacy, and dental claims, which are combined with eligibility and provider files from all public and private payers. Rather than provider charges, APCDs include the actual prices private health plans have negotiated with providers, along with information about Medicare and Medicaid payment rates.

…the primary audiences for APCDs are purchasers, payers, and policymakers that can use price and practice-pattern information to identify lower-price, higher-quality providers. Large payers operating in a state may already have sufficient information on prices and quality of providers for most services, but APCDs can benefit potential new entrants.

More than a dozen states have APCDs, and many more are exploring the idea. Most states have initially focused on hospital prices, but APCDs also can be used to identify prices and practice patterns for other providers, including physicians. While some consumers might consult an APCD, the primary audiences for APCDs are purchasers, payers, and policymakers that can use price and practice-pattern information to identify lower-price, higher-quality providers. Large payers operating in a state may already have sufficient information on prices and quality of providers for most services, but APCDs can benefit potential new entrants.

For example, Minnesota has used its all-payer claims data to create a "Provider Peer Groupings" system that compares physician clinics and hospitals on both risk-adjusted price and quality metrics. These publicly reported data can be used by plans and employers to develop provider networks and benefit structures that reward patients — for example, through lower cost sharing — for choosing more efficient providers.

APCDs also can provide useful information about actual prices and assist policymakers in assessing the level of price competition in health care markets and what interventions might encourage competition. Consistent, accurate data about health care prices also can inform policy discussions about large variations in health care prices and spending. However, policymakers also must consider safeguards to prevent APCD data from being used for price collusion among competing providers. For example, access to the information might be limited to specific entities (e.g., purchasers only) or for specific purposes (e.g., to define episodes of care).

APCDs are typically funded through general appropriations or industry fee assessments; in some states, there is an assumption that a portion of future funding will come from data product sales. Efforts are underway to encourage states and health plans to establish standardized data collection practices. Currently, how data are released and to whom varies across states; in some, de-identified, aggregate data are published on a public website, while detailed data files are limited to certain users, such as researchers.

Advantages

By combining data across providers and payers, purchasers, payers, and policymakers have a more complete picture of price competition in health care markets and are in a better position to develop spending estimates for entire episodes of care rather than for individual services. This can assist in developing new payment models. Additionally, shining a public spotlight on health care prices can discourage egregious provider pricing.

Disadvantages

Claims data are costly to collect, analyze, and report, and methodological challenges may hinder meaningful comparisons. Without uniformity of state APCD data collection, payers would incur additional costs through having to comply with state's submission specifications. And, providing greater price information to sellers can potentially harm competition if it discourages providers from cutting prices to gain market share by making it easier for competitors to match prices. Placing more price information in circulation may result in a greater need for antitrust agencies to monitor potential collusive activities.

2. Supporting Price-Conscious Consumers

Most major health plans — and some large employers — provide enrollees with some type of online price transparency tool, whether developed in-house by health plans or through third-party vendors. Typically, these tools are customized to individual enrollee's coverage, including cost-sharing obligations, provider network, and individual claims experience. Consumers can search by condition or service type and are shown the estimated consumer out-of-pocket cost based on their benefit structure and any remaining current-year cost-sharing requirements.

In some cases, states require consumer price transparency. For example, under Massachusetts law, each health plan must operate a toll-free number to provide consumers who request information with estimated prices and cost-sharing amounts for admissions and procedures. The state does not require online access to this information.

This type of consumer price transparency is happening mostly without policy interventions. The role for public policy likely is narrow, for instance, as in the case of Massachusetts mandating a minimum level of transparency. There also may be a public role in developing best practices, as has been done with comparative quality reporting.

Advantages

Payers are in a unique position to tailor out-of-pocket price information to consumers and to make it available at key decision points. Public policies to promote best practices may accelerate diffusion and development of these tools. If consumers switch providers after comparing prices, higher-price providers that are losing market share may lower prices to gain back market share.

Disadvantages

With little compelling quality data for consumers, additional price data could lead some to seek out higher-price providers under the mistaken assumption that higher prices signal higher quality, especially if their benefit design has only weak incentives to shop for price. Despite the guidance of tools, consumers may be overwhelmed by many choices for some services and, consequently, resort to decision shortcuts that are not strongly tied to prices. Such transparency tools may not take into account consumers' individual medical circumstances or help consumers assess treatment alternatives.

(Sources for this policy option are located on page 49)

Policy Option C: Limiting Anticompetitive Health Plan-Provider Contracting Practices

State laws prohibiting anticompetitive contracting practices between health plans and providers can offer a counterbalance to market power. Generally, these practices protect providers from attempts by insurers to adopt narrow- or tiered-provider networks or new payment incentives that would encourage lower prices or increased efficiency. Other potentially anticompetitive provisions protect insurers from new health plans entering the market and may result in excessive provider payment rates.

Anti-Tiering Clauses.

When health plans develop tiered-provider networks, they lower patient cost sharing to encourage patients to use higher-quality, lower-cost providers that are placed on a preferred tier. Sometimes, as a condition of contracting with a health plan, dominant providers demand placement on the preferred tier regardless of their performance on cost and quality metrics. Some states, notably Massachusetts, prohibit providers and plans from relying on such contract provisions.

Most-Favored Nation (MFN) Clauses.

Under MFN contracting clauses, health plans require providers to give the plan their best price and to charge other insurers a higher price. On the one hand, this ensures that a dominant health plan will receive the benefit of any price concessions that a provider extends to other health plans. On the other hand, MFNs may discourage hospital discounts. Moreover, they may be used by insurers with significant market power to disrupt potential rivals, locking in their competitive advantage and preventing

new competitors from entering the insurance market because they cannot attain the same level of provider price discounts. States such as Michigan have reacted to the lack of robust competition in health care by barring MFN clauses sought by health plans.

Tying Agreements.

Many providers require a health plan to contract for all services or facilities as a condition of participating in the insurer's network. For example, a provider might contract for specialized, exclusive services, such as organ transplants or trauma care, only if the plan contracts for the full range of the provider's other services. Another form of tying is when a health plan must contract with all hospitals that are part of a single system. Tying agreements are subject to state and federal oversight, including antitrust actions, but this has largely been an under-policed area of enforcement.

Advantages

Prohibiting anti-competitive contracting practices between health plans and providers may encourage price competition and, in some cases, new market entry. While some contracting provisions can prompt antitrust scrutiny, the antitrust remedies are cumbersome relative to state legislative action to prohibit these anticompetitive contract provisions outright. Prohibitions on anti-tiering and tying agreements can be critical to health plan development of benefit designs with narrow-provider and tiered-provider networks. A number of states have been quite active in limiting anticompetitive contracting practices.

Prohibitions on anti-tiering and tying agreements can be critical to health plan development of benefit designs with narrow-provider and tiered-provider networks.

Disadvantages

In more competitive markets, outright bans on MFNs might interfere with competitive forces by restricting the ability of providers to offer insurers discounted prices. Policymakers may be hesitant to ban contract provisions, since their potential impact depends on the competitive context and can change over time.

(Sources for this policy option are located on page 51)

Policy Option D: Harmonizing Network-Adequacy Requirements with Development of Limited-Provider Networks

Many states have laws to make sure insured consumers have adequate access to covered services. And, some states have laws that prohibit health plans from excluding certain practitioners from provider networks. While designed to protect consumers and practitioners, both types of laws can hamper health plan efforts to exclude providers with practice patterns outside of the mainstream or to develop limited-provider networks.

Network-Adequacy Requirements.

Most states require health plans to meet certain standards — known as network-adequacy requirements — to ensure enrollees have timely and reasonable access to providers and needed services. For

example, state regulators may require plans to demonstrate that enrollees are within a minimum distance or a minimum travel time from hospitals, physicians, and other providers. Plans also may need to demonstrate minimum provider-enrollee ratios or compliance with minimum appointment waiting times.

State standards for network adequacy vary greatly. Some states require health plan provider networks to meet standards set by accreditation organizations, such as URAC, formerly the Utilization Review Accreditation Commission, or the National Committee for Quality Assurance. Other states have numeric network standards, or they use more subjective standards of "reasonableness," which increase flexibility but create ambiguity. Additionally, some state standards apply only to commercial HMO products, while others include PPOs, potentially contributing to consumer confusion and health plan operational challenges.

As part of the ACA, qualified health plans in the federal and state insurance exchanges must meet network-adequacy standards. Requirements by states for plans outside of exchanges and for Medicaid and Medicare Advantage plans may differ. Plans with very narrow networks draw concern that consumers will be unable to access care at the lower, in-network level of out-of-pocket costs. A key role for public policy is to ensure that health plans provide transparent and accurate information to consumers about which providers participate in each health plan network. Provider networks, however, are dynamic and keeping consumers updated can be challenging.

Any-Willing-Provider Laws (AWPs).

Under AWP laws, plans must include in their networks any provider meeting plan terms and conditions. Historically, AWP laws have served more to protect providers (by including chiropractors and other specific classes of providers in plan networks) than consumers.

Overly broad network-adequacy and AWP laws can limit plans' ability to trade greater patient volume for price concessions from providers. States will need to balance competing goals of protecting consumers and practitioners and enabling health plans to form limited-provider networks.

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Advantages

Ensuring network-adequacy standards are not overly restrictive can promote price competition by enhancing plans' ability to bargain with providers over network inclusion to obtain lower prices and, in turn, offer lower premiums to consumers. The presence of AWP interferes with insurers' ability to obtain lower prices and to steer enrollees toward higher-value providers. Plans are increasingly using broader measures of price, such as spending per episode, and measures of quality to shape networks so overly restrictive network adequacy can interfere with such initiatives. Overly restrictive standards also could preclude insurance networks built around large delivery systems.

Disadvantages

When networks are not adequate, this can interfere with patient access and saddle patients with larger than expected financial burdens. Although the problem may be transitional, health plans have been accused of failing to provide timely and accurate network information to both those considering enrolling and existing enrollees. Regulatory attention may be needed to resolve these transparency issues more quickly than if left to the health plans.

(Sources for this policy option are located on page 51)

Policy Option E: Active Purchasing by Public Payers

Public entities play a role in negotiating with or selecting health plans for a large number of people, including federal, state and municipal employees and participants in state health insurance exchanges. Sometimes public purchasers are proactive in pushing innovations that can benefit taxpayers and employees. In some cases, these innovations can impact health care delivery and payment more broadly, for example, by increasing price competition, so that other purchasers and consumers might benefit. For example, the California Public Employees Retirement System, which provides health insurance for 1.4 million California state and public agency employees, retirees, and dependents, has responded to provider pricing power by experimenting with reference pricing, which caps payment for certain services for in-network providers.

Public purchasers also can encourage health plan competition by limiting the number of plans offered to workers in hopes of stimulating price competition among insurers to gain access to a large customer base. State-based health insurance exchanges are another example of how states can promote health plan competition. Under the ACA, a state exchange can opt for a clearinghouse or open-market model that allows all health plans meeting minimum requirements to participate.

Alternatively, states can create an exchange using an active-purchaser model that relies on selective contracting and price negotiation with health plans with a goal of offering consumers higher-quality coverage and more affordable premiums. Selective contracting also may affect provider pricing because fewer plans on the exchange may give health plans more clout in negotiations with providers over prices. Likewise, states could combat insurer market power by requiring state employees to purchase coverage through exchanges, which would increase the exchanges' market share and clout when negotiating with health plans.

A key health plan tool to counter provider market power and keep costs down is the development of narrow- and tiered-provider networks. States could require health plans to offer a limited-network product to ensure lower cost coverage is available. Massachusetts, for example, requires health plans with at least 5,000 enrollees in the nongroup and small-group health insurance markets to offer either a narrow- or tiered-network plan with a base premium that is at least 14 percent lower than the premium for a similar plan with a broader provider network.

Advantages

Public employers and insurance exchanges that operate as active purchasers can use market forces to foster competition among insurers and providers on both cost and quality. If health plans are concerned about losing market share, they may try to negotiate better deals with providers that may be motivated to accept lower payment rates in return for increased patient volume.

Disadvantages

There is evidence that less competition in insurance markets increases premiums at least modestly. In such markets, the largest insurers are likely to be an insurer that the payer or state exchange needs to ensure adequate enrollee access to a broad range of health care services and geographic areas. Regardless, there is evidence that even if insurance market concentration leads to lower provider prices, a dominant plan may only demand lower prices to the extent that they get a better price than competing health plans.

(Sources for this policy option are located on page 53)

Policy Option F: Improved Antitrust Enforcement

1. Scrutiny of Hospitals and Insurers with Market Power and the Foreclosure of Markets to New Entrants

Federal antitrust scrutiny in the health sector has increased in recent years, as noted previously, and will likely remain a policy priority for federal and state antitrust enforcers. However, many local geographic markets are highly concentrated, with either a dominant hospital system or a small number of competitors with individual pricing power. Consequently, antitrust policy should also consider actions to constrain the exercise of pricing power where providers have achieved monopoly power.

Aside from anti-steering and MFN provisions explained in Policy Option C, hospitals with market power can engage in practices that stifle market entry or constrain the market share of current competitors. Such practices enable hospitals with significant market power to limit price competition.

One such practice by hospitals with market power is to bundle services where they have greater market power with services where they have relatively less market power. This practice, known as tying, is designed by the monopolist hospital to reduce competition more broadly. Through exclusive tying arrangements, monopolist providers can extend their market power and limit entry into health care markets by competitors. Such illegal tying can be challenged under the Sherman Act and Clayton Act, and tying enforcement actions could be effective in curtailing the dominance of hospitals with monopoly power.

Advantages

Scrutiny of dominant hospitals' behavior focuses regulatory attention on those geographic areas where harm to consumers is the most likely and where increasing competition is most crucial. In response to concerns raised by antitrust authorities about MFN clauses, insurers in some areas, such as

North Carolina, have dropped MFN clauses in their contracts with hospitals and other providers. It also targets dominant providers whose practices have the greatest potential to impose anticompetitive harm.

Disadvantages

Antitrust enforcement targeting anticompetitive conduct is costly because the legal standards are difficult to specify and prove empirically. There is little empirical work to support how and when certain agreements, such as exclusive agreements, may foreclose entry by potential competitors, and the legal standards are imprecise. This remains an underexplored area, both empirically and legally.

2. Active Review of Vertical Mergers

Vertical integration involves agreements between entities at different stages of the health care delivery process, including hospitals, physician practices, providers of ancillary services, and insurers. Many hospital systems, including those with market power, have acquired other providers and have articulated a conceptually compelling argument that vertical integration generates efficiencies. First, vertical integration can lower transaction costs between entities, such as improving monitoring, increasing care coordination, decreasing fragmentation, and reducing medical errors. Merging organizations may also achieve some efficiencies by implementing new information systems, instituting new compensation models, reducing medical errors, eliminating redundant services, and reducing fragmentation.

Accountable care organizations are a specific form of vertically integrated health care payment and delivery established under the ACA. Designed for the Medicare fee-for-service population, some ACOs also operate in the private insurance market. For both, the payment method usually contains incentives for the ACO to hold down spending growth.

For example, under the Medicare shared savings model, ACOs are penalized if their expenditures grow faster than an established benchmark. From the ACO's perspective, provider price increases would make lower growth in expenditures more difficult to achieve. Since ACOs do not negotiate rates with Medicare, the main concern is the added market power these organizations will have in negotiations with private health plans. There are also concerns about an ACO locking up a high share of the providers, making it difficult for rival ACOs to form. These concerns are heightened where ventures are exclusive and providers, for example, physicians, are restricted from dealing with payers or ACOs.

The trend of hospitals and physicians jointly establishing ACOs is expected to continue, and ACO formation, encouraged by the ACA, carries with it the risk that health care markets will consolidate further. As the paper by Goldsmith *et al.* that was commissioned by the study panel noted, there is virtually no evidence at this time that vertical mergers and consolidation produces any material efficiencies. Moreover, some have expressed skepticism that hospital-led ACOs will invest the same effort as other ACOs to lower costly utilization, such as emergency department visits or inpatient readmissions, if payment, for example, is based on volume. In fact, there is good reason to suspect that physician-based ACOs are likely to direct their hospital referral patterns toward lower-price

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hospitals and thus are more likely to achieve savings than hospital-based ACOs. Physician-based ACOs might therefore exert market pressures on high-cost hospitals to reduce prices." If physician-lead ACOs are able to lower costs, this should translate to lower prices, even under standard models of monopoly pricing, assuming all other conditions are held equal.

There are, however, a number of anticompetitive consequences that might follow when a dominant hospital or insurer vertically integrates with other providers. Vertical integration can capture and direct patient flow and referrals. For example, a hospital with market power might instruct the physicians it acquires to direct their patients to that hospital, even if it provides lower-quality or higher-cost care. Vertical integration can accordingly secure revenue and market share for a dominant system, which in turn can foreclose markets to entrants or other competitors. In short, ACO formation through vertical mergers might achieve efficiencies, but they also might introduce inefficiencies and strengthen the position of providers with market power.

Advantages

Vertical mergers potentially can create integrated entities comprised of hospitals and multispecialty physicians groups capable of providing a full continuum of care. Antitrust review can help sort out proposed integration that is designed to achieve efficiencies from integration that could lead to greater exercise of market power. Communications by the antitrust enforcement agencies are important to educate providers on how to integrate legitimately within the boundaries of antitrust law. Advisory opinions, follow-up letters, statements, and reports permit the agencies to apply the most up-to-date evidence on efficiencies related to financial integration, clinical integration, the role of exclusivity and market shares, and likely competitive effects.

Disadvantages

While most vertical arrangements can be reviewed prior to merger, more lenient criteria sometimes apply to ACOs. Greater effort is needed to monitor integrated entities after the fact, and if market power concerns are raised, it is more difficult and costly for the integrated entities to address them. Much of the evidence on quality and efficiency gains is elusive, particularly for newer integration arrangements, making their potential difficult to assess beforehand.

Moreover, existing empirical studies do not provide sufficient guidance to sort out which clinical and administrative components are necessary to achieve efficiencies — what degree of care monitoring, decision support through health information technology, dissemination of clinical protocols, etc. Despite missing evidence on the best approach to achieving efficiencies, the agencies must make judgments about transactions and whether to challenge them, either before the fact or later when efficiencies do not emerge and higher prices result.

3. Conduct Remedies and Post-Merger Monitoring

One option for supervising hospitals with market power or entities that seek to merge is to impose conduct remedies. Such restrictions might include, for example, creating firewalls that prevent the dissemination of information within the newly created entity; requirements to maintain existing health plan contracts and, for future contracts, to negotiate in good faith with health plans or become subject to binding arbitration; prohibitions on most-favored-nation provisions and anti-tiering and anti-steering provisions in contracts with health plans; prohibitions on hospital-based billing of physicians; maintenance of an open medical staff; and limits on the expansion of services and further acquisitions. The conditions imposed are case-specific and designed to limit the ability of the affected providers to use their market power in various ways that reflect local conditions. Such arrangements can include some form of periodic reporting by the private party and are typically time limited.

The conditions imposed are case-specific and designed to limit the ability of the affected providers to use their market power in various ways that reflect local conditions.

Conduct remedies are often implemented through consent decrees that follow an antitrust enforcement action. For example, conduct remedies might be part of a negotiated settlement to a challenged merger, where entities are permitted to merge but must adhere to certain restrictions on their future pricing or market behavior. Conduct remedies may also follow a suit against a monopolist, such as the Department of Justice's suit against Blue Cross Blue Shield of Michigan, where the insurer stopped certain contracting practices and other anticompetitive conduct.

In the 1990s, several state legislatures used a regulatory mechanism called a Certificate of Public Advantage (COPA) that is similar to conduct remedies in a consent decree. A COPA allows hospitals or other providers to merge or enter into collaborative agreements on the condition of significant state oversight of the new entity, including limits on contracting, employment, and prices. Similar to consent orders signed to settle an antitrust investigation, COPAs also can be a way for a state to encourage consolidation through its health planning agencies, guided by a statutory reporting process. COPAs can shield parties not just from state enforcement but also federal antitrust laws under the doctrine of state action immunity when there is a "clearly articulated and affirmatively expressed state policy to displace competition" and when such agreements are actively supervised by the state.

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With Asheville, N.C., for example, the theory was that high costs kept health care services out of rural areas while antitrust laws prevented a merger of hospital competitors that would allow providers to mitigate costs and increase access to services in rural areas. State health planners encouraged a merger because it was believed that the state oversight that followed would impose price discipline on services in lieu of market competition.

New York recently passed a COPA law that will extend the state's antitrust immunity to Nassau Health Care Corp. to collaborate with other health care providers to achieve improvements in clinical outcomes, to share services with the goal of reduced procurement costs and back-office functions, and, finally, to jointly negotiate reimbursement rates with commercial payers. States, such as Pennsylvania and Massachusetts, have entered into consent decrees that were not COPAs but involved significant oversight of the merging entity's contracting and pricing practices.

Advantages

Mergers that might otherwise be blocked entirely can go forward with consent decrees, allowing providers more freedom to pursue creative integration models while mitigating any likely anticompetitive harm. In some cases, conduct remedies allow providers to preserve the full range of hospital services in geographic proximity to the communities traditionally served by those facilities. Conduct remedies can be entered into with limited judicial oversight since the role of the courts can be limited to specific requirements, such as ensuring that negotiations were adversarial and obligations imposed on the parties were consistent with the public interest broadly, allowing either side to strike a deal quickly when the cost of litigation is too high or too uncertain.

COPAs also may provide an advantage to safety-net facilities that otherwise would have little to offer in terms of potential partnership. State antitrust immunity may ensure that these entities grow and that they realize some, even if not all, of the benefits of competition through savings, improving utilization of hospital resources, and avoiding duplication of hospital resources.

It is difficult to anticipate and prohibit in a consent degree all the ways a provider might exercise market power and raise prices.

Disadvantages

It is difficult to anticipate and prohibit in a consent degree all the ways a provider might exercise market power and raise prices. For example, the entity may avoid price or margin limits in one market by instead imposing price increases in a related but unregulated, market. As a result, the protections for payers — both consumers and insurers — may be limited. Though the state is required to actively supervise the resulting entity, state oversight often relies on self-reporting by the new entity. Neither courts nor other agencies are well-equipped to assess the competitive behavior of health care providers or to evaluate the competitive consequences of mergers. At the same time, it is easy for such agreements, whether consent decrees or COPAs, to become politicized in a way that forces the executive branch to fight a constant rear guard battle for the duration of the agreements.

…conduct remedies are not a substitute for aggressive efforts to prevent mergers; private parties are significantly more likely to agree to a COPA or other form of consent decree if the state or federal government has a broad theory of what constitutes a transaction that unfairly restrains competition.

Regulators seeking to craft a COPA or any other conduct remedy can only guess at what the health care market would look like "but for" the proposed merger. Finally, conduct remedies are not a substitute for aggressive efforts to prevent mergers; private parties are significantly more likely to agree to a

COPA or other form of consent decree if the state or federal government has a broad theory of what constitutes a transaction that unfairly restrains competition.

(Sources for this policy option are located on page 53)

Policy Option G: Additional Public Oversight and Review

Policymakers can lose sight of the cumulative effect of marketplace changes and how market changes relate to one another. An independent commission or board charged with monitoring merger transactions, competition, and overall health care spending could be used to raise public awareness about price and quality changes across health care segments. Such an oversight process can establish the basis for additional policy remedies if voluntary compliance with spending targets is not achieved.

Public monitoring may be viewed as a middle ground between policies aimed at preserving market competition and policies that rely on direct government intervention. By reinforcing awareness of provider and insurer consolidation and rising health expenditures, public monitoring could assist health care purchasers, payers, and policymakers by providing guidance for the development of proposed market-based or regulatory interventions.

One example of public monitoring is the Massachusetts Health Policy Commission (HPC) a quasi-independent entity within the executive branch charged with establishing the annual health care cost growth benchmark and monitoring progress through annual cost trend hearings. Intended as a cost-containment measure, the HPC combines exhortation with regulatory threat. As part of its work, the HPC is required to identify dominant providers that charge comparatively high prices and that have relatively high costs. The Commission also has the power to compel health care entities that exceed the cost growth benchmark to file and implement performance improvement plans and may fine entities that fail to implement them.

With regard to market consolidation, providers must submit proposed transactions to the Commission for review of health care market and expenditure impact. Although the Commission cannot block a proposed merger or acquisition, it has the capacity to analyze such transactions and can, based on its findings, recommend further action to the state attorney general. Finally, the HPC has certain regulatory authority over ACOs and also distributes grant funding for targeted initiatives aimed at delivery system reform.

Massachusetts provides just one example of a commission structure. Clearly, there are many possible ways to structure a public monitoring board and assign its role and authorities. Such monitoring would be informed by, but separate from, existing agency activities, such as antitrust scrutiny or oversight of premiums by state departments of insurance. With the increasing availability of public and private claims data across a broad range of providers and payers, monitoring has become a more viable state strategy.

The powers and authority of a commission can be tailored to fit the political culture and the priorities of the particular states considering such an option.

Advantages

An independent commission should be less vulnerable to political pressures than other state agencies with formal authority to intervene in the market; this appears to be the case even where such a commission has significant analytical capacity and can influence plan-provider negotiations. The powers and authority of a commission can be tailored to fit the political culture and the priorities of the particular states considering such an option.

Disadvantages

While an independent commission may serve a different function, its activities may overlap with operations of other state agencies, potentially creating diffusion of responsibility and possibly conflicting policy positions on specific matters that arise. Moreover, the commission's influence is only as great as the authority it has been assigned. Without credible intervention tools, its impact may be limited. Yet, its presence might serve to preempt consideration of other, possibly more definitive, approaches.

(Sources for this policy option are located on page 55)

Policy Option H: Regulating Premium Increases Through Strengthened Rate Review

In markets with little insurance competition, review of insurers' rate increases may give health plans greater negotiating leverage and increase pressure on downstream provider payment rates. Under the ACA, insurers must publicly disclose and justify rate increases of 10 percent or more for non-grandfathered plans in the non-group and small-group markets. States that have an effective rate review process in place, as defined by federal regulations, have the authority to review rate increases over 10 percent; for states that lack the authority and/or infrastructure to do so, the U.S. Department of Health and Human Services (HHS) will conduct rate reviews. But HHS reviews are nonbinding, and only states have the authority to reduce rates.

…not all state rate-review processes are created equal. States that have statutory authority to approve or disapprove rates before they are implemented (prior approval authority) are better positioned to negotiate reductions in rates than states that use retrospective authority (file and use regulation).

States could provide their insurance departments with greater authority to review and limit requested premium increases. However, not all state rate-review processes are created equal. States that have statutory authority to approve or disapprove rates before they are implemented (prior approval authority) are better positioned to negotiate reductions in rates than states that use retrospective authority (file and use regulation). File and use regulation often requires only a certification that states meet certain standards and often relies on consumer complaints to identify a problem. Currently, some states may be able to issue a determination that a proposed rate increase is unreasonable but cannot block it since the insurer does not actually need permission to raise rates. In states without the authority to deny excessive rate increases, health plans can raise rates as much as they did before the ACA was enacted.

In addition, states typically have a standard that guides the review and approval of rates. Most states use subjective standards, barring rate increases that are "excessive, inadequate, or unfairly discriminatory." Only a minority of states requires plans to keep rate increases under a prescribed level. Furthermore, state laws may have limited reach. Some states may exempt some plans from rate review. For example, Pennsylvania exempts for-profit plans, Maine's rates are deemed approved if they meet medical loss ratio standards, and South Carolina allows the formation of out-of-state "trusts" that allow many plans to bypass rate review altogether.

Strengthened rate review could potentially take several forms. States could provide their insurance departments with expanded authority to review and limit premium increases in tandem with standardized review of requested provider price increases. Rhode Island, for example, has expanded the insurance department's rate-review authority to include limits on annual price increases for inpatient and outpatient services. States also could regulate the growth of premiums through expenditure growth targets or soft caps. The impact of this effort on prices is evolving.

Advantages

Regulating premiums may give insurers leverage to resist provider price demands that they would otherwise accept and pass on to purchasers and enrollees. It could also benefit consumers by constraining plan margins and lead to greater public discourse over premiums and greater transparency over rate setting methods and insurer justifications for proposed increases.

Disadvantages

Insurers may respond to premium rate regulation by exiting the market. Since insurer margins tend to be low, without regulation of downstream provider payment rates, the potential for significant savings from premium regulation is limited. Although there is anecdotal evidence, for example, from Massachusetts, that regulatory pressure on premiums can lead to lower provider rates, it is unclear whether this approach can be a successful long-term strategy.

Leverage by some providers might actually exacerbate pricing differentials across providers. As price increases are permitted for the more powerful provider systems, the rest of the providers would be left to absorb the overall pricing pressure from limits on premium increases. This could increase pricing disparities between have and have-not providers. Finally, state insurance departments have an obligation to monitor plan solvency as well as focus on premium reduction. Once they are actively engaged, state insurance departments can become subject to political pressures that distort the appropriate "actuarially sound" standard.

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(Sources for this policy option are located on page 55)

Policy Option I: Limiting Out-of-Network Provider Charges

A survey comparing charges billed by out-of-network providers to Medicare fees found that plan members were routinely billed 10 to 20 times Medicare rates for out-of-network care.

An alternative to directly regulating prices is restricting out-of-network provider charges. Physicians, hospitals, and other providers that do not contract with health plans typically bill patients for the full charges of treatment. Depending on their coverage, patients can be responsible for paying the full amount charged if their plan does not cover any out-of-network services, or if they have a plan that covers out-of-network services, they will have to pay any difference between their health plans' allowed amounts for out-of-network care and the providers' full charges. Known as balance billing, the practice leaves consumers at risk of paying significant out-of-pocket costs. A survey comparing charges billed by out-of-network providers to Medicare fees found that plan members were routinely billed 10 to 20 times Medicare rates for out-of-network care.

Limits on balance billing prevent the use of provider market power. Restrictions may be as narrow as prohibiting additional charges for specific services, such as emergency care or other situations where consumers have no ability to choose providers, such as an assistant surgeon or an anesthesiologist.

Alternatively, policymakers might, as the Medicare Advantage program does, generally limit out-of-network rates to a benchmark rate, such as a percentage of the Medicare rate. Such limits would not only protect consumers but would also bolster health plans' ability to negotiate lower payment rates with hospitals and physicians.

Advantages

Limiting out-of-network provider charges would protect consumers from significant out-of-pocket costs, especially when there is no advance notice that a provider is out of network or where circumstances do not allow consumers to pursue in-network alternatives. It also helps consumers accurately assess health plan costs. While the ACA establishes minimal actuarial value for plans sold on exchanges, the value of the plan does not include out-of-network care. Limits on charges would also give insurers more bargaining leverage when negotiating in concentrated provider markets since out-of-network care would be less lucrative. This could be seen as a relatively moderate regulatory approach compared to setting or limiting overall payment rates.

Disadvantages

Such limits create a disincentive for plan members to stay in network, when other reforms to the health system are intended to create more price-sensitive consumers. Such limits also remove the economic rewards for providing higher-quality care.

(Sources for this policy option are located on page 56)

Policy Option J: Setting Upper Limits on Permissible, Negotiated Provider Payment Rates

Across the country, physicians and hospitals negotiate payment rates that are, on average, significantly higher than Medicare rates. Moreover, there is significant inter-market and intra-market variation in those rates. One approach to limiting this variation is to address the highest price providers. For example, policymakers could impose a ceiling on the payment rates negotiated by a health plan and a provider, using Medicare as a benchmark. An upper limit on negotiated prices could be set, for example, at 200 percent or 250 percent of Medicare. The ceiling would apply to all payers, whether individuals who self-pay or insurers. An upper limit on what hospitals and physicians can charge gives insurers important leverage during negotiations, especially when bargaining with dominant providers.

Though an upper limit on provider rates is a form of rate setting, it is intended to focus on the price outliers, not all providers. In applying an upper-payment limit, states could choose a ceiling that takes into account the particular attributes of their local health care markets. If the ceiling were set too high, there would be little impact on health care prices and outliers would remain unaffected. If it is set too low and does not cover providers' reasonable costs, it would jeopardize providers' financial stability and potentially lead to lower quality of care. To implement upper-payment limits, states would need reliable and accurate payment and cost data.

Advantages

Setting an upper-payment limit targets providers that can exercise the greatest market power. It may prod providers to hold down operating costs and even decrease barriers to entry for new health plans, such as ones started by regional physician groups or local cooperatives. Though an interventionist approach, placing an upper limit on provider rates does not require as complex an administrative apparatus as all-payer rate setting or other price-setting approaches. To the extent that upper limits are decided by commissioners or other public officials, there is some measure of accountability.

Disadvantages

This policy option may not be compatible with or may at the least be difficult to reconcile with delivery systems that are based on bundled or capitated payments, which are seen as a way to stimulate integrated and value-based health care systems. This diversity of payment models could make upper limits hard to administer. Like any kind of regulatory price-setting approach, there is the risk that interfering with market winners and losers may prevent providers from having the resources or incentives to adopt new technology, produce societal goods, or provide higher-quality medical procedures. Providers also may not have sufficient capital for new technology or revenue to support teaching and research missions.

(Sources for this policy option are located on page 56)

Policy Option K: Expanding Use of All-Payer and Private-Payer Rate Setting

Rate setting is the policy instrument most industrialized countries use to address cost control and equitable treatment of providers — usually through a form of all-payer rate setting that covers both hospital and physician services. The most common model for rate setting involves a public agency, either in the executive branch or a quasi-independent agency, setting payment rates for providers, including payment rates for patients without insurance. Rate setting may include Medicaid, if permitted under state legislation, and Medicare, if a state successfully negotiates a federal waiver.

During the 1970s and 1980s, seven states enacted some form of hospital rate setting to counter the inflationary incentives inherent in the then predominant cost-based method of hospital reimbursement. All but two states — Maryland and West Virginia — dropped rate setting as the private insurance market moved away from indemnity coverage to managed care plans with provider networks. But some states are reconsidering the approach.

In addition to constraining price growth, rate setting was established to address price discrimination, improve hospital financial stability, ensure adequate and equitable funding for uncompensated care, and improve access to and quality of care for different communities.

In addition to constraining price growth, rate setting was established to address price discrimination, improve hospital financial stability, ensure adequate and equitable funding for uncompensated care, and improve access to and quality of care for different communities. Since hospitals are encouraged to serve all patients in need of medical care regardless of their ability to pay, rate setting ensures that all hospitals participate in funding medical care for indigents as well as other programs aimed at providing a social benefit (medical education, disaster training, addressing population health needs) in a manner that is spread across all payers.

There are different rate setting regimes. One version — the policy originally adopted by Maryland and in effect for over three decades — was to have all hospitals bill approved payment rates for service specific and departmental units. Aggregate payments to hospitals were capped by an average per case rate based on a version of diagnosis-related groups that categorizes patients based on clinically similar conditions, severity of illness and mortality risk — all of which are intended to be a proxy for resource use. Similar caps applied to outpatient facilities. The payment formula also penalized excess volume growth. A different payment regime relying on global budgets was applied to rural hospitals.

It is worth noting that Maryland's new five-year Medicare demonstration that began in 2014 uses an updated version of rate setting to undertake comprehensive coordinated care across different settings; its new focus on population health is based at least initially on global budgets that limit total hospital spending growth per capita to state GDP growth. Under the new approach, Maryland can allow risk-based payment, including the development of ACOs.

Another approach — the policy adopted by West Virginia — applies only to non-governmental payers and imposes annual revenue limits based on the average charge per discharge and inflation; higher rate increases are based on a hospital's ranking against its peers on costs and charges. There are no restrictions on payment methods, but all contract language is reviewed and there is a floor on payments based on costs; approval is required for new services and excess revenue must be returned before the next year's update is approved. The same authority that sets parameters for rates also grants certificates of need required for new facilities.

Several studies have examined the impact of rate setting on cost growth and on hospital quality. These studies suggest that rate setting contained costs during a time when selective contracting was not the norm or not permitted but that in the absence of competition may lead to higher prices. American Hospital Association data indicate that while the ratio of private payer rates to hospital costs has increased nationally, in Maryland it has been fairly steady since the creation of the rate setting system. Maryland's cost per admission dropped relative to other states — from significantly above the national average to just below the national average (although per capita spending on hospital care in a year was high because of higher hospitalization rates). Previous studies found mixed results with respect to the impact of rate setting on patient outcomes and the impact of resource constraints on patient health.

Advantages

In a market where there is no or little competition among hospitals, rate setting may reduce prices and control costs, allowing a public debate over community needs for services and what configuration of hospitals can best meet those needs. Rate setting may reduce hospital competition based on payer mix and provide additional resources to so-called have-not hospitals that serve low-income and uninsured individuals. In communities where there are disparities of wealth, ensuring a more equitable distribution of resources among hospitals, clinics, and other providers can improve access to health care and health outcomes, particularly for individuals who may not have the purchasing power to ensure adequate care. Rate setting also can increase transparency in the health care system by providing extensive and timely data.

Disadvantages

The cost of operating a rate setting system and collecting provider information can be substantial and the effectiveness of such a system without the inclusion of Medicare and Medicaid is likely to be limited at best, in part because a system with just private payers does little to increase the market leverage of public safety-net hospitals. Moreover, rate setting in one sector, such as hospitals, may create incentives for providers to shift care to sites where rate setting is not in effect, transforming care in ways that do not reflect improved efficiency or quality. There also is risk that interfering with market winners and losers may prevent providers from having the resources or incentive to adopt new technology, produce societal goods, or provide higher-quality medical procedures. However, it may be difficult for states to set up a rate setting system that includes Medicare and Medicaid. Waivers are needed that shift significant power to federal authorities and inclusion would mean higher Medicaid costs for most states.

(Sources for this policy option are located on page 56)

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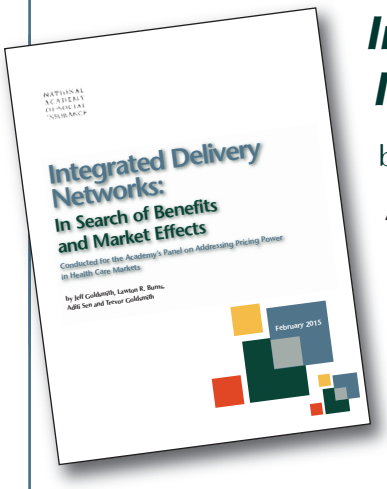


Integrated Delivery Networks: In Search of Benefits and Market Effects

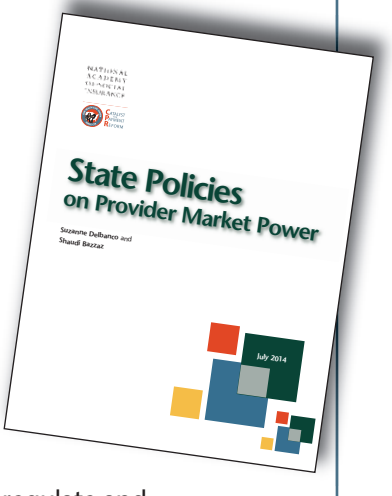
by Jeff Goldsmith, Lawton R. Burns, Aditi Sen and Trevor Goldsmith, February 2015

Any examination of the role that hospitals play in health care cost growth is complicated by the fact that in many large markets, hospitals may be part of integrated delivery networks (IDNs), either vertically integrated health services networks that include physicians, post-acute services and/or health plans or fully integrated provider systems inside a health plan. Looking at the benefits to society, the authors found that there is evidence that IDNs have raised physician costs, hospital prices and per capita medical care spending; looking at the benefits to the providers, the evidence also showed that greater investments in IDN development are associated with lower operating margins and return on capital. As part of this report, the authors conducted a new analysis of 15 of the largest IDNs in the country. While data on hospital performance at the IDN level are scant, the authors found no relationship between the degree of hospital market concentration and IDN operating profits, between the size of the IDN's bed complement or its net collected revenues and operating profits, no difference in clinical quality or safety scores between the IDN's flagship hospital and its major in-market competitor, higher costs of care in the IDN's flagship hospital versus its in-market competitor, and higher costs of care when more of the flagship hospital's revenues were at risk.

The authors conclude that the public interest would be served if IDNs provided more detailed routine operating disclosures, particularly the amount of hospital operating profit as a percentage of the IDN's total earnings and the IDN's physician and hospital compensation policies. How IDNs allocate overhead and ancillary services income between the three main lines of business should also be disclosed. It should also be possible to determine from an IDN disclosure if capitated risk is transmitted from the IDN's health plan or risk-accepting organization to its hospitals and physicians. Analysis of societal benefits would also be materially aided by a comprehensive, national all-payer claims database.

State Policies on Provider Market Power

by Suzanne Delbanco and Shaudi Bazzaz, July 2014



Health care economists broadly agree that the market power of certain health care providers is a major driver of price increases, and is associated with significant payment variation across and within markets. This report catalogues the laws and regulations that state governments are using to enhance the competitiveness of health care markets and reduce the ability of providers to use market power in such a way that creates negative consequences for those who use and pay for care. The authors researched regulatory approaches, specifically recent state efforts pertaining to: antitrust; price and quality transparency; competition in health plan contracting; price regulation; the development of Accountable Care Organizations (ACOs); expanding the authority of state Departments of Insurance; and facilitating the entry of new providers into the marketplace.

Specifically, this paper catalogues existing state statutes and regulations that address the contracting practices of health plans and providers likely to reduce competition and lead to higher prices. In doing so, this paper provides insight into the current scope of state authority to regulate and monitor health care prices. In addition, because states may pursue policies that would not be captured in a review of laws and regulations, this paper also explores efforts beyond the legislative realm by states taking an active role to address these issues.

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April 2015 | Issue Brief

Health Insurance Coverage in 2013: Gains in Public Coverage Continue to Offset Loss of Private Insurance

Laura Skopec, John Holahan, and Megan McGrath

Executive Summary

Since the Great Recession peaked in 2010, the economic picture has steadily improved, and in 2013, GDP increased relative to 2012 and the unemployment rate fell but remained fairly high at 7.4 percent. In addition, the uninsured rate decreased slightly (0.1 percentage point) in 2013, continuing the trend from 2011 and 2012. Despite these improvements, rates of coverage through employer sponsored insurance have declined since 2010, though more slowly in recent years than at the height of the recession. Gains in coverage since 2010 have been largely due to increases in coverage through public programs such as Medicaid and the Children's Health Insurance Program (CHIP).

Population changes also affected insurance coverage patterns between 2008 and 2013. The only income group with net population growth between 2008 and 2013 was families at or below 138 percent of poverty, which grew by 17.6 million. In contrast, the population with family incomes above 400 percent of poverty shrank by 8.3 million. There were also fewer workers in 2013 (138.0 million) than in 2008 (140.4 million), with a low point of 133.1 million workers in 2010. In addition, national population growth between 2008 and 2013 was concentrated in the South and West, which gained 4.3 million and 1.9 million people, respectively. These regions tend to have lower rates of employer coverage and lower Medicaid eligibility thresholds for adults.

It is important to understand the effect of these population shifts and economic forces on coverage to assess the impact of the ACA. Many of the health insurance coverage expansions in the ACA went into effect on January 1, 2014, making 2013 the final baseline year against which to measure coverage changes under the ACA. Though 2013 is not a perfect baseline (several smaller coverage expansions under the ACA went into effect in 2010, including allowing dependents to stay on their parents' plan until age 26, and a handful of states fully or partially expanded eligibility for their Medicaid programs in 2010 or 2011), understanding trends in coverage during the recession and recovery will help disentangle the effects of the ACA on health insurance coverage from demographic and economic factors.

In this brief, we examine coverage patterns for the nonelderly population from 2008 through 2013 using data from the American Community Survey. While prior research on this topic has frequently relied on the Census Bureau's March Supplement to the Current Population Survey (CPS), long planned improvements to the insurance questions for that survey resulted in a break in trend between the 2013 CPS and the 2014 CPS, which collected data on coverage in 2012 and 2013, respectively. Therefore, in order to examine trends from 2008 to 2013, we focused our analysis on the American Community Survey.

Overview

The economy has steadily improved since the Great Recession peaked in 2010, but recovery in employment and household income has lagged behind GDP growth. While real GDP recovered to its 2007 high by 2011, the unemployment rate declined but remained high through 2013 (7.4 percent), and median household income continued to decline through 2012. The recession accelerated the long-standing decline in employer-sponsored health insurance (ESI),[1] and through 2013 most of the recovery in the uninsured rate was due to increased enrollment in public insurance, primarily Medicaid and the Children's Health Insurance Program (CHIP). For adults, coverage through Medicare and military healthcare programs also increased slightly between 2010 and 2013, though not as substantially as Medicaid and CHIP coverage. With the exception of young adults ages 19 to 25, who are able to remain on their parents' health plan until age 26 under the Affordable Care Act (ACA), ESI coverage rates for adults and children continued to decrease between 2010 and 2013. These declines in ESI coverage are partly attributable to changes in population characteristics among the nonelderly, including an increase in the number of low-income families, population growth in low-ESI regions, and workforce growth in low-ESI industries.

Data and Methods

This brief uses data from the American Community Survey (ACS), an annual survey conducted by the Census Bureau and designed to be representative at the national and state level. The public microdata sample for the ACS contains 1.9 million observations annually, making it by far the largest of the federal surveys. The ACS contains data on income, health insurance, demographics, work status, and industry sufficient to allow analyses of the differences in insurance coverage patterns across various populations. In addition, the very large sample size allows for state-level trend analyses (not included here).

Prior issue briefs in this series used the Current Population Survey Annual Social and Economic Supplement (CPS) to describe trends in health insurance coverage.[2] However, long planned improvements to the insurance questions for that survey resulted in a break in trend between the 2013 CPS and the 2014 CPS, which collected data on coverage in 2012 and 2013, respectively.[3] This brief therefore focuses on trends from 2008 to 2013 using the ACS. While the ACS has a significantly larger sample size than the CPS, it also has a few disadvantages. First, the income information in the CPS is much more detailed than that collected in the ACS, and income data from the CPS is therefore the source of official estimates of poverty in the United States.[4] Second, the ACS does not collect data on employer size, so this brief does not present trends in ESI coverage by firm size.

This analysis uses the ACS iPUMS files created by the Minnesota Population Center, which have consistent variable definitions over time and include constructed variables on family relationships and income that are used to create Health Insurance Units (HIU)[5] and calculate HIU income as a percent of the FPL.[6] In addition, the Urban Institute has developed a series of logical coverage edits to the ACS designed to correct for known inaccuracies in survey-based estimates of health insurance coverage.[7] In particular, the ACS over-represents private non-group coverage relative to other surveys and under-represents Medicaid and CHIP coverage among children relative to administrative data.[8] These logical coverage edits reassign coverage types for respondents when other information collected in the ACS, such as receipt of Supplemental Nutrition Assistant Program (SNAP) or other public assistance, implies that a respondent's coverage has likely been misclassified.[9]

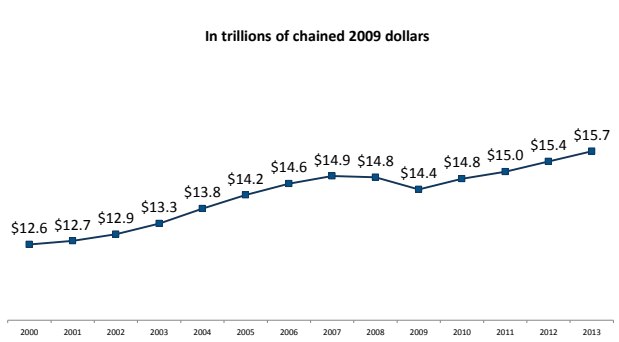
Finally, all individuals reporting multiple health insurance types have been assigned to a single primary insurance type using a hierarchy, which further corrects for over-reporting of private non-group coverage. The hierarchy used for all analyses in this brief is as follows: employer-sponsored insurance, Medicaid or CHIP, military health care or Medicare, private non-group insurance, or uninsured.

Continued Economic Recovery

Most economic indicators suggest continued recovery since the peak of the recession in 2009 and 2010. Real GDP fell from $14.9 trillion in 2007 to $14.4 trillion in 2009 but recovered starting in 2010 to hit $15.7 trillion in 2013 (Figure 1). The unemployment rate increased from 4.6 percent in 2007 to peak at 9.6 percent in 2010, falling back to 7.4 percent in 2013 (Figure 2). The most recent data (February 2015) suggest that the unemployment rate has now recovered to 2008 levels (5.6 percent).[10]

Figure 1

Real GDP, 2000-2013



SOURCE: Bureau of Economic Analysis. "Current-dollar and 'real' GDP." February 27, 2015. Available at: http://www.bea.gov/national/index.htm#gdp.

Real median household income and real per capita income also fell between 2008 and 2010 and have shown less recovery than other economic indicators. Median household income continued to fall between 2010 and 2012 and increased only $180 between 2012 and 2013, not a statistically significant change. Similarly, real per capita income remains more than $1,500 below its 2006 peak (Figure 3).

Figure 2

National unemployment rate, 2000-2013

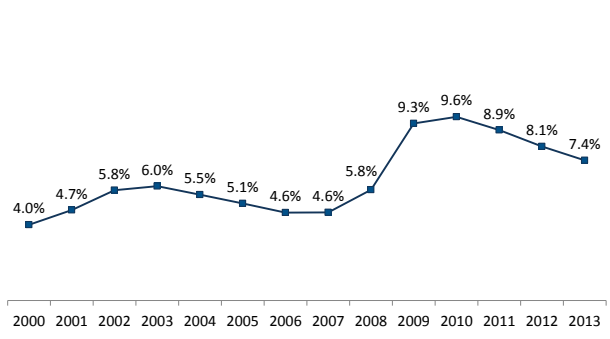


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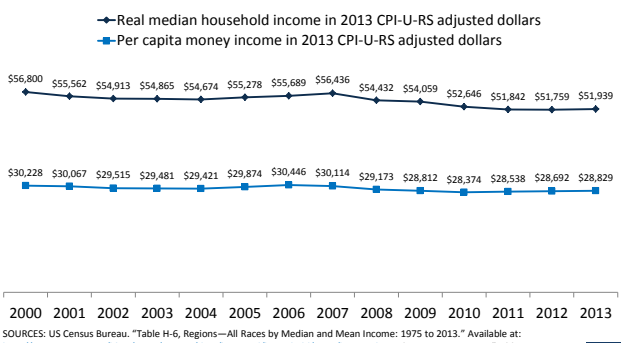
Figure 3

Real median household income and per capita income, 2000-2013



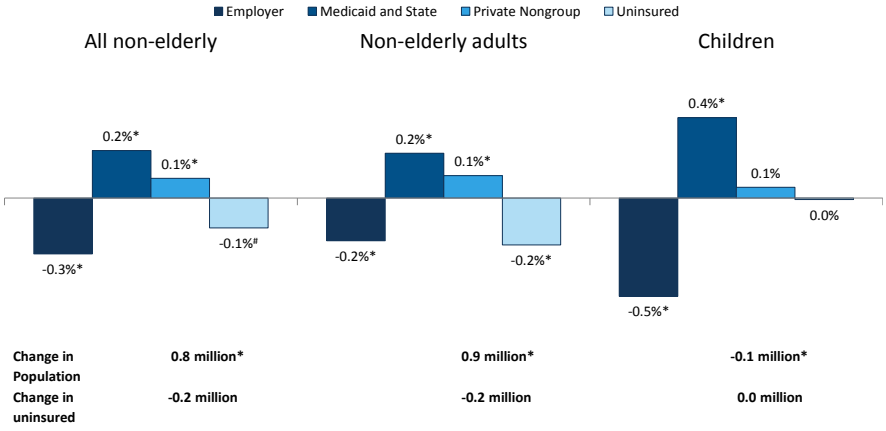
SOURCES: US Census Bureau. "Table H-6, Regions—All Races by Median and Mean Income: 1975 to 2013." Available at: http://www.census.gov/hhes/www/income/data/historical/household/2013/h06AR.xls; and US Census Bureau. "Table P-1. CPS Population and PER Capita Money Income, All Races: 1967 to 2013." Available at: http://www.census.gov/hhes/www/income/data/historical/people/2013/p01AR.xls.

Changes in Health Insurance Coverage from 2012 to 2013

As the economy continued to improve between 2012 and 2013, the uninsured rate fell by 0.1 percentage point and the number of uninsured Americans fell by 200,000 (Figure 4). The decrease in the uninsured rate was entirely among nonelderly adults and was primarily due to increases in public coverage. From 2012 to 2013, the ESI coverage rate declined 0.3 percentage points, leading to 300,000 fewer people with ESI, while Medicaid and Children's Health Insurance Program (CHIP) coverage increased by 0.2 percentage points, or 700,000 people. The reduction in ESI and increase in Medicaid and CHIP coverage rates were more prominent among children than nonelderly adults. In addition, nearly all of the reduction in the number of uninsured was among non-Hispanic whites below 138 percent of the FPL (data not shown). Finally, private non-group coverage increased by 0.1 percentage points among nonelderly adults, all of which was due to an increase of non-group coverage among young adults (young adult data not shown). The additional 200,000 young adults with non-group coverage may reflect young adults staying on their parents' non-group plan until age 26 or, potentially, misreporting of October through December 2013 enrollment in the Marketplaces for 2014.[11] Because the changes in insurance coverage from 2012 to 2013 were small overall, the remainder of this brief will focus on trends in insurance coverage from 2008 to 2013.

Figure 4

Percent point changes in health insurance coverage among the nonelderly (ages 0-64) by age group, 2012-2013



	All non-elderly	Non-elderly adults	Children
Change in Population	**0.8 million***	**0.9 million***	**-0.1 million***
Change in uninsured	**-0.2 million**	**-0.2 million**	**0.0 million**

NOTES: * Change is statistically significant at the 5% level # Change is statistically significant at the 10% level.
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2012 and 2013 American Community Survey

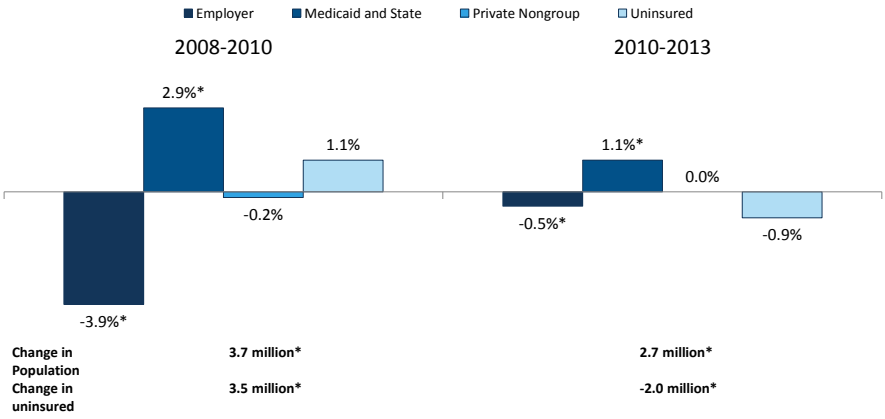
Changes in Coverage among the Nonelderly Population, 2008–2013

Figure 5 shows the changes in health insurance coverage that occurred during the recession and recovery for the nonelderly population (under age 65). The Great Recession began in December 2007 and ended in June 2009, making 2010 the first full year since 2007 in which GDP did not decline.[12] Therefore, 2010 is used as the break point between the recession and recovery throughout this brief. From 2008 to 2010, the ESI coverage rate fell from 61.0 percent to 57.1 percent. At the end of this period, 8.2 million fewer nonelderly adults and children had ESI coverage. In addition, 500,000 fewer people had private non-group coverage at the end of this period. Some of these coverage losses were offset by gains in public coverage. The Medicaid coverage rate increased from 15.3 percent to 18.2 percent during this period, resulting in 8.1 million additional people with Medicaid coverage. In addition, military (CHAMPUS) and Medicare coverage increased by 0.3 percent (data not shown).[13] In total, the uninsured rate grew from 16.8 percent to 17.9 percent, meaning 3.5 million more people were uninsured in 2010 than in 2008.

Between 2010 and 2013, as the economy began to improve, the uninsured rate began to fall. In 2013, the uninsured rate had fallen to 16.9 percent, still slightly above the level of 2008. Most of the gains in insurance coverage during the economic recovery came from public coverage sources. Between 2010 and 2013, there was a 1.1 percentage point increase in Medicaid and CHIP coverage,[14] resulting in 3.5 million additional people covered by the Medicaid program. While this increase in Medicaid coverage may reflect, in part, the early Medicaid expansions undertaken in 2010 and 2011 by four states (California, Connecticut, the District of Columbia, and Minnesota), those early expansions alone did not affect a large enough population to account for the entire increase in Medicaid coverage.[15] From 2010 to 2013, ESI coverage declined another 0.5 percentage points, from 57.1 percent to 56.6 percent.

Figure 5

Percentage point changes in health insurance coverage among the nonelderly, 2008-2013



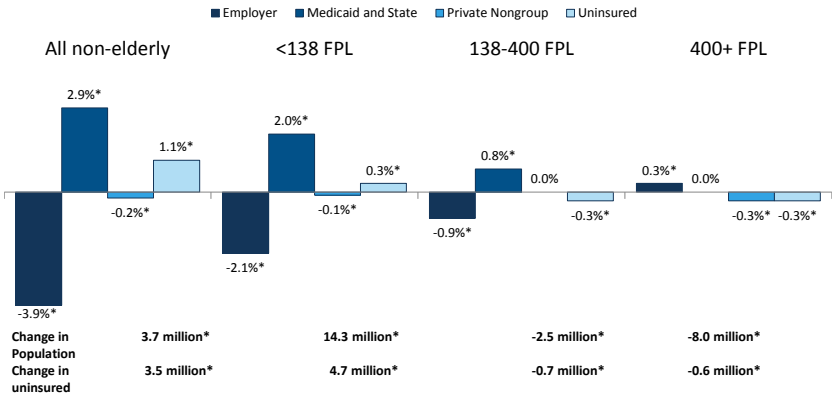
NOTES: * Change is statistically significant at the 5% level # Change is statistically significant at the 10% level.
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008-2013 American Community Survey

Changes in Coverage by Income

Between 2008 and 2010, the entirety of the net increase in the number of uninsured was due to loss in coverage among those with family incomes below 138 percent of the FPL (Figure 6). Increases in Medicaid coverage made up for much of the loss of ESI in this income group, and the uninsured rate among this group increased by only 0.3 percentage points. However, the size of the population with income below 138 percent of the FPL swelled by 14.3 million, leading to 4.7 million more low-income Americans uninsured. In contrast, both the income group between 138 to 400 percent FPL and the income group above 400 percent FPL shrank between 2008 and 2010, and there were 1.3 million fewer uninsured Americans in these income groups in 2010 than in 2008.

Figure 6

Percentage point changes in health insurance coverage among the nonelderly by income, 2008-2010



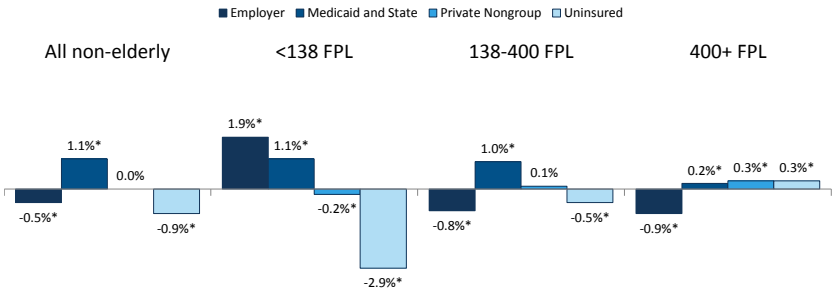
	All non-elderly	<138 FPL	138-400 FPL	400+ FPL
Change in Population	3.7 million*	14.3 million*	-2.5 million*	-8.0 million*
Change in uninsured	3.5 million*	4.7 million*	-0.7 million*	-0.6 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008 and 2010 American Community Survey

As shown in Figure 7, the uninsured rate for those with family incomes below 138 percent of the FPL declined as the economy improved between 2010 and 2013, leading to 1.6 million fewer uninsured Americans in this income group. Only those with incomes below 138 percent of the FPL showed a net gain in ESI coverage between 2010 and 2013, though the ESI coverage rate for that group remained low at 20.8 percent (compared to 18.9 percent in 2010). ESI coverage declined from 64.6 percent to 63.8 percent for those with incomes between 138 and 400 percent of the FPL, and from 88.1 percent to 87.2 percent for those with incomes above 400 percent of the FPL between 2010 and 2013. The loss of ESI was offset by gains in Medicaid among the middle income group, and the uninsured rate fell 0.5 percentage points for that group. The highest income group showed a 0.3 percent increase in the uninsured rate, meaning an additional 200,000 people with incomes above 400 percent of the FPL were uninsured. Overall, there were 2 million fewer uninsured Americans in 2013 than in 2010 due to increases in Medicaid coverage among those with incomes below 400 percent of the FPL and increases in ESI among those with incomes below 138 percent of the FPL, who had the largest ESI losses during the Great Recession.

Figure 7

Percentage point changes in health insurance coverage among the nonelderly by income, 2010-2013



	All non-elderly	<138 FPL	138-400 FPL	400+ FPL
Change in Population	2.7 million*	3.3 million*	-0.3 million*	-0.3 million*
Change in uninsured	-2.0 million*	-1.6 million*	-0.6 million*	0.2 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2010 and 2013 American Community Survey

Changes in Coverage by Age

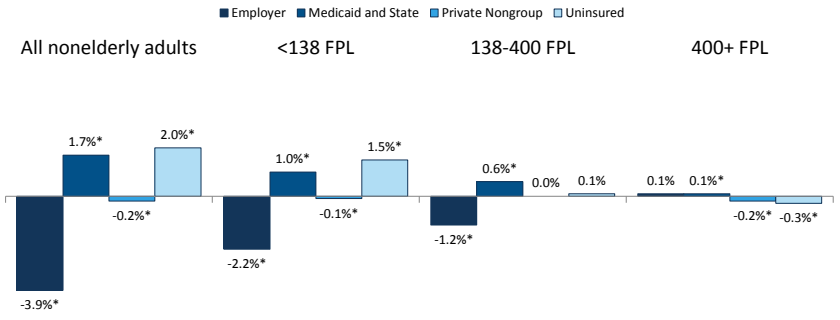
The health insurance coverage patterns for children, young adults, and adults differ from 2008 to 2013. The uninsured rate for nonelderly adults was more than double that for children throughout this period, in part because Medicaid and CHIP have higher income eligibility limits for children. In addition, the ACA provision allowing young adults to stay on their parents' plan until the age of 26 led to significant gains in ESI coverage among this population beginning in 2010 that were not shared by older adults.[16] Given these different policy contexts, we examined coverage changes from 2008 to 2013 separately for each of these age groups.

All Nonelderly Adults

From 2008 to 2010, there was a 3.9 percentage point decrease in the ESI coverage rate for nonelderly adults and a 1.7 percentage point increase in Medicaid and other state coverage (Figure 8). In total, the uninsured rate for nonelderly adults increased by 2.0 percentage points, and 4.4 million more nonelderly adults were uninsured. All of the increase in the number of uninsured was among adults in families with income at or below 138 percent of the FPL (4.9 million). The number of nonelderly adults in families with incomes above 400 percent of the FPL shrank significantly, by 5.7 million, and this group saw a small decrease in the uninsured rate of 0.3 percentage points between 2008 and 2010.

Figure 8

Percentage point changes in health insurance coverage among nonelderly adults by income, 2008-2010

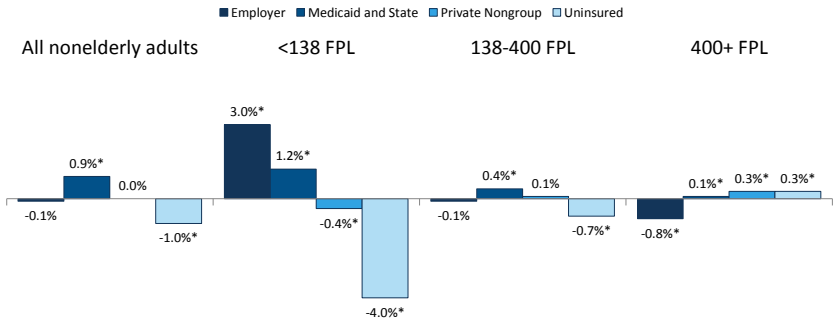


	All nonelderly adults	<138 FPL	138-400 FPL	400+ FPL
Change in Population	3.5 million*	9.9 million*	-0.6 million*	-5.7 million*
Change in uninsured	4.4 million*	4.9 million*	-0.1 million*	-0.4 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008 and 2010 American Community Survey

Figure 9

Percentage point changes in health insurance coverage among nonelderly adults by income, 2010-2013



	All nonelderly adults	<138 FPL	138-400 FPL	400+ FPL
Change in Population	3.4 million*	3.5 million*	0.2 million*	-0.3 million*
Change in uninsured	-1.1 million*	-0.9 million*	-0.4 million*	0.2 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2010 and 2013 American Community Survey

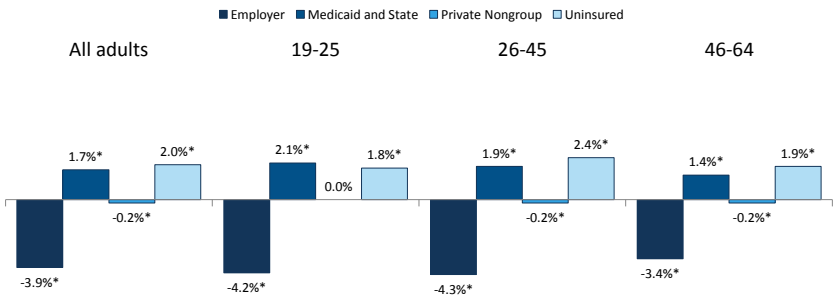
Between 2010 and 2013, the overall ESI coverage rate for nonelderly adults was nearly stable, and the uninsured rate declined by 1 percentage point in part due to increases in public coverage. However, there was significant variation by income group. Nonelderly adults below 138 percent of the FPL saw a 3.0 percentage point gain in ESI coverage and a 1.2 percentage point gain in Medicaid and CHIP coverage, leading to a 4.0 percentage point reduction in the uninsured rate for that income group. In contrast, ESI coverage for those with incomes above 400 percent of the FPL continued to decline, leading to a 0.3 percentage point increase in the uninsured rate for that group.

Young Adults

Beginning in September 2010, the ACA required most health plans to allow children to stay on their parents' plan as a dependent until age 26. Between 2008 and 2010, this age group lost ESI coverage at a rate similar to the rest of the adult population (Figure 10). However, the trend for young adults diverged significantly from other nonelderly adults from 2010 to 2013 (Figure 11). While other age groups continued to lose ESI coverage, albeit more slowly than between 2008 and 2010, young adults had large gains in ESI coverage. Between 2010 and 2013, 2.6 million young adults gained ESI coverage, a 6.7 percentage point increase in the ESI coverage rate (Figure 11). Young adults did not gain Medicaid and CHIP coverage as quickly as other age groups in this time period.

Figure 10

Percentage point changes in health insurance coverage among nonelderly adults by age, 2008-2010

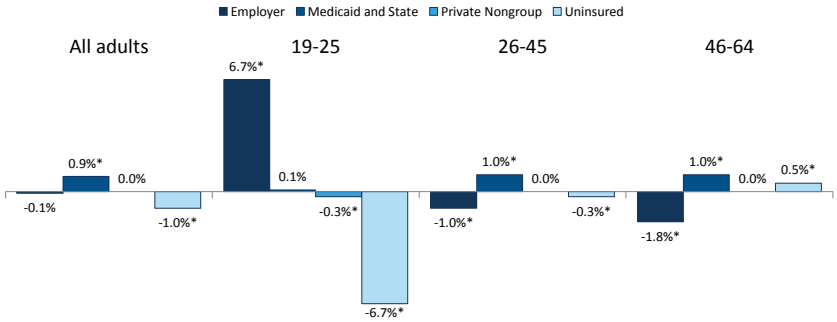


	All adults	19-25	26-45	46-64
Change in Population	3.5 million*	0.7 million*	-0.8 million*	3.6 million*
Change in uninsured	4.4 million*	0.7 million*	1.7 million*	1.9 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008 and 2010 American Community Survey

Figure 11

Percentage point changes in health insurance coverage among nonelderly adults by age, 2010-2013



	All adults	19-25	26-45	46-64
Change in Population	3.4 million*	1.1 million*	0.7 million*	1.6 million*
Change in uninsured	-1.1 million*	-1.7 million*	-0.1 million*	0.6 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2010 and 2013 American Community Survey

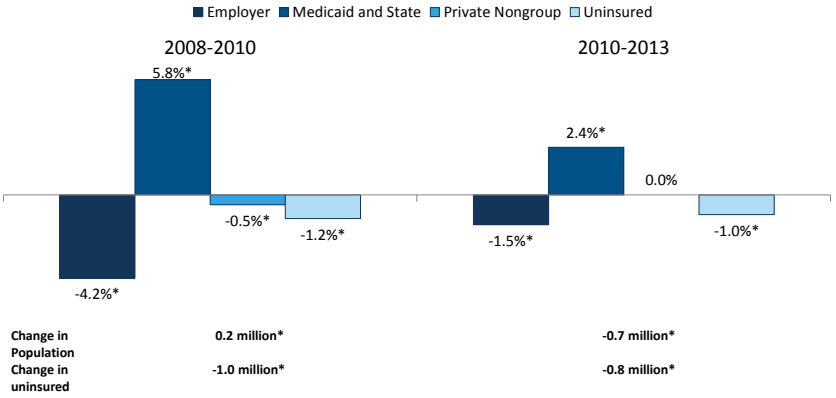
These gains for young adults created a near-stabilization of ESI coverage rates between 2010 and 2013 for all nonelderly adults. For other adult groups, however, ESI coverage losses continued, resulting in 700,000 adults ages 26 to 64 losing ESI coverage between 2010 and 2013. Similarly, nearly all of the decrease in the uninsured rate and number uninsured seen among nonelderly adults between 2010 and 2013 was among young adults. While the ACA policy had the intended effect of decreasing the uninsured rate among young adults, it masked a continued trend of loss in ESI coverage among other age groups.

CHILDREN

The pattern of coverage for children under age 19 is different from that of adults, primarily due to greater access to Medicaid and CHIP coverage. During the recession, children were more likely to lose access to ESI than adults. Between 2008 and 2010, the ESI coverage rate for children fell 4.2 percentage points, from 54.7 percent to 50.5 percent (Figure 12). Most of this loss of ESI was among low-income children and was more than made up for by increases in Medicaid and CHIP coverage. The Medicaid and CHIP coverage rate for children increased from 31.7 percent to 37.5 percent in this time period, meaning 4.6 million additional children were covered in those programs, 4.5 million of whom had family incomes below 138 percent of the FPL. Overall, the uninsured rate for children actually declined during the recession, from 9.2 percent to 8.0 percent, and 1 million fewer children were uninsured in 2010 than in 2008.

Figure 12

Percentage point changes in health insurance coverage among children, 2008-2013



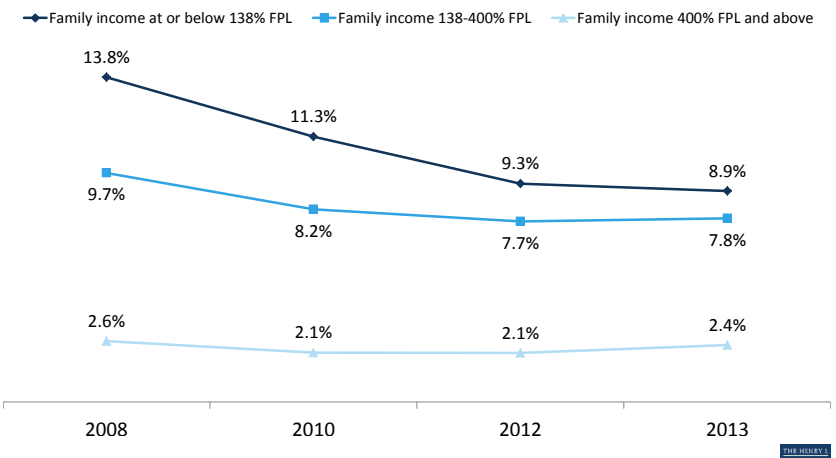
NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008-2013 American Community Survey

The economic recovery from 2010 to 2013 showed a similar pattern for children (Figure 12). The ESI coverage rate among children continued to fall, from 50.5 percent in 2010 to 49.1 percent in 2013. This continued reduction in ESI coverage was spread across all income groups. However, this loss of ESI coverage was more than made up for by continued gains in Medicaid and CHIP coverage, which increased from 37.5 percent in 2010 to 39.8 percent in 2013. Overall, 800,000 fewer children were uninsured in 2013 than in 2010, 700,000 of whom had with family incomes below 138 percent of the FPL. The uninsured rate for children with family incomes above 400 percent of the FPL increased 0.3 percentage points between 2010 and 2013, largely due to losses of ESI coverage in that income group (data not shown).

The increases in Medicaid and CHIP coverage rates for children seen during the Great Recession and recovery have reduced the disparity in the uninsured rate among children by income (Figure 13). In 2008, children in families with income of less than 138 percent of the FPL had an uninsured rate of 13.8 percent, versus 2.6 percent for those in families with incomes above 400 percent of the FPL. By 2013, the uninsured rate for low-income children was down to 8.9 percent, compared to 2.4 percent for higher-income children.

Figure 13

Trend in the uninsured rate among children, 2008-2013



SOURCE: Urban Institute Analysis of the 2008-2013 American Community Survey

Changes in Coverage by Other Demographic Characteristics

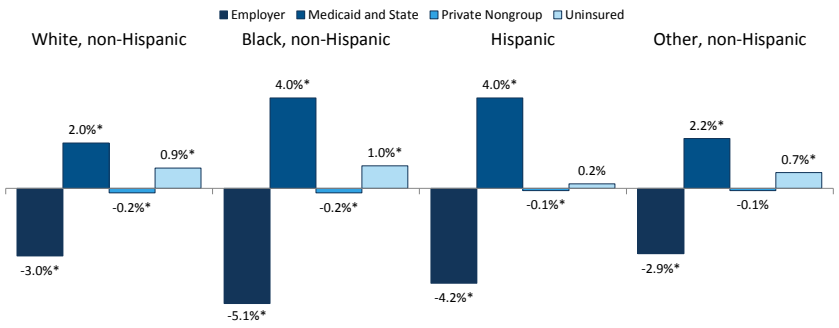
There are two important demographic trends in the United States that affect health insurance coverage among the nonelderly. First, racial and ethnic minority populations have grown. Between 2008 and 2013, the non-Hispanic White population shrank by 5.4 million people, while the Hispanic population grew by 6.4 million people. The non-Hispanic Black population also grew by 1.5 million people during this time period, and other racial and ethnic groups also grew by 3.8 million people.[17] Hispanics and non-Hispanic Blacks have lower rates of ESI and higher uninsured rates than non-Hispanic Whites, so increases in the size of these populations tend to increase the uninsured rate and the number of uninsured. Second, the US population has shifted geographically. The Northeast and Midwest saw almost no population growth between 2008 and 2013, while the South and West grew by 4.3 million people and 1.9 million people, respectively. On average, the South and West have lower ESI coverage rates and higher uninsured rates than the Northeast and Midwest. In addition, states that have not expanded Medicaid under the ACA are concentrated in these regions, which will exacerbate the regional disparities in uninsured rates in 2014.

Race and Ethnicity

Between 2008 and 2010, non-Hispanic Blacks and Hispanics had more substantial reductions in ESI coverage than non-Hispanic Whites (Figure 14). While some of this disparity was made up by increases in public coverage, overall 2.3 of the 3.5 million people who lost coverage between 2008 and 2010 were people of color. The increases in the uninsured rate were concentrated among low-income people of all racial and ethnic groups. Non-Hispanic Whites over 400 percent of the FPL fared best during the recession, experiencing an increase in the ESI coverage rate and 400,000 fewer uninsured (data not shown).

Figure 14

Percentage point changes in health insurance coverage by race and ethnicity, 2008-2010



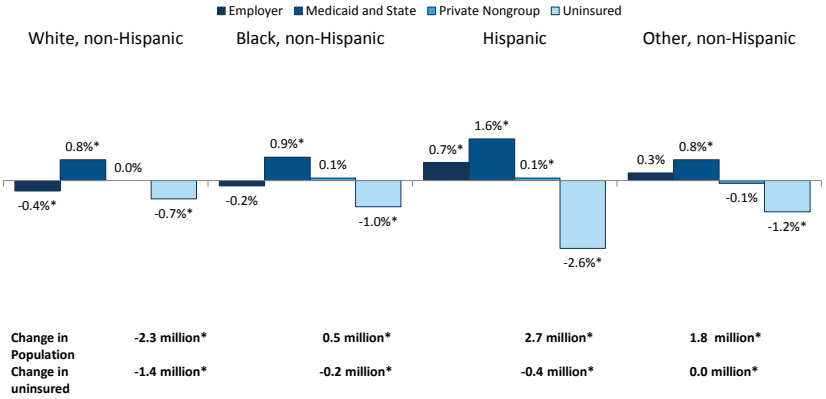
NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008 and 2010 American Community Survey

As the economy recovered between 2010 and 2013, the uninsured rate fell for all racial and ethnic groups, largely due to increases in public coverage (Figure 15). Hispanics saw the largest percentage point decrease in the uninsured rate, from 32.2 percent in 2010 to 29.7 percent in 2013. This is due to increases in both public coverage and ESI coverage among the Hispanic population.

Between 2008 and 2013, the gap in the uninsured rate between non-Hispanic whites and Hispanics narrowed, from 19.6 percentage points in 2008 to 17.1 percentage points in 2013 (Figure 16). Most of this narrowing was due to increases in the Medicaid coverage rate for Hispanics, from 24.2 percent in 2008 to 29.8 percent in 2013, a gain of 4.4 million Hispanic Medicaid enrollees (Figures 14 and 15). Despite these gains, the uninsured rate for Hispanics remained more than double that for non-Hispanic Whites in 2013. The gap in the uninsured rate between non-Hispanic Whites and non-Hispanic Blacks remained virtually unchanged, narrowing by only 0.2 percentage points.

Figure 15

Percentage point changes in health insurance coverage by race and ethnicity, 2010-2013

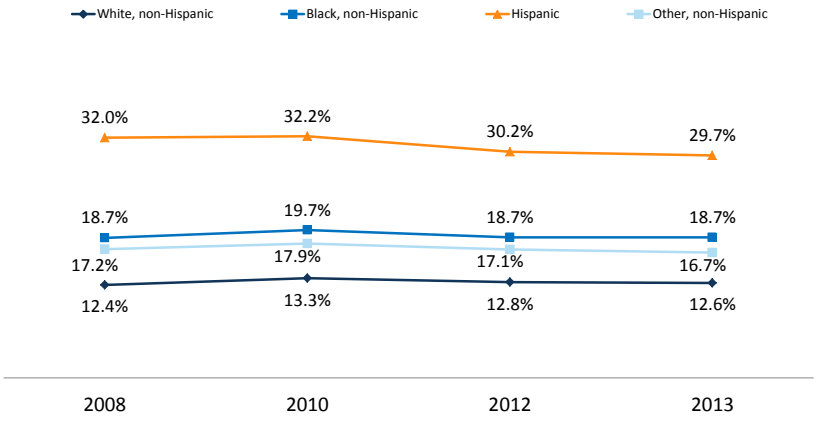


	White, non-Hispanic	Black, non-Hispanic	Hispanic	Other, non-Hispanic
Change in Population	-2.3 million*	0.5 million*	2.7 million*	1.8 million*
Change in uninsured	-1.4 million*	-0.2 million*	-0.4 million*	0.0 million*

NOTES: * Change is statistically significant at the 5% level #Change is statistically significant at the 10% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2010 and 2013 American Community Survey

Figure 16

Trends in the uninsured rate by race and ethnicity, 2008-2013



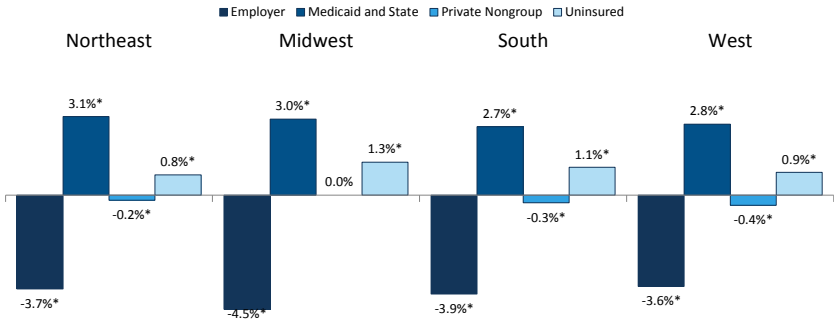
SOURCE: Urban Institute Analysis of the 2008-2013 American Community Survey

Geographic Region

The effects of the recession and recovery on health insurance coverage were not consistent across the country, as shown in Figures 17 and 18. Between 2008 and 2010, the Midwest saw the largest losses of ESI coverage, from 66.3 percent to 61.9 percent, and the largest increase in the uninsured rate, from 12.9 percent to 14.2 percent (Figure 17). The Northeast fared the best in the early years of the recession, with only 400,000 additional uninsured. This was due, in part, to slightly larger percentage point gains in Medicaid coverage in the Northeast, which traditionally has higher income thresholds for adults and children than the South or West.

Figure 17

Percentage point changes in health insurance coverage by region, 2008-2010



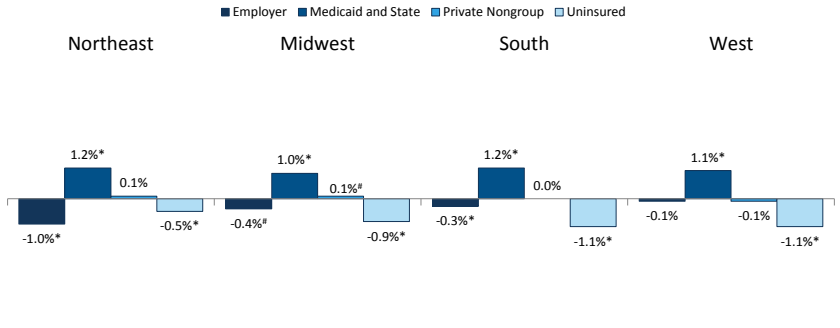
	Northeast	Midwest	South	West
Change in Population	0.2 million*	0.1 million*	2.5 million*	0.9 million*
Change in uninsured	0.4 million*	0.8 million*	1.6 million*	0.7 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008 and 2010 American Community Survey

During the recovery, the Northeast saw the largest continued reduction in ESI coverage, resulting in approximately 500,000 fewer Northeast residents with ESI in 2013 than in 2010 (Figure 18). The South and West saw the largest percentage point decreases in the uninsured rate (1.1 percent), largely due to gains in public coverage. In addition, population shifts between regions continued between 2010 and 2013, with the Midwest experiencing a net population loss, the Northeast experiencing no net change in population, and the South and West each increasing in population by a million or more people.

Figure 18

Percentage point changes in health insurance coverage by region, 2010-2013



	Northeast	Midwest	South	West
Change in Population	0.0 million*	-0.2 million*	1.9 million*	1.0 million*
Change in uninsured	-0.2 million*	-0.6 million*	-0.7 million*	-0.5 million*

NOTES: * Change is statistically significant at the 5% level
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2010 and 2013 American Community Survey

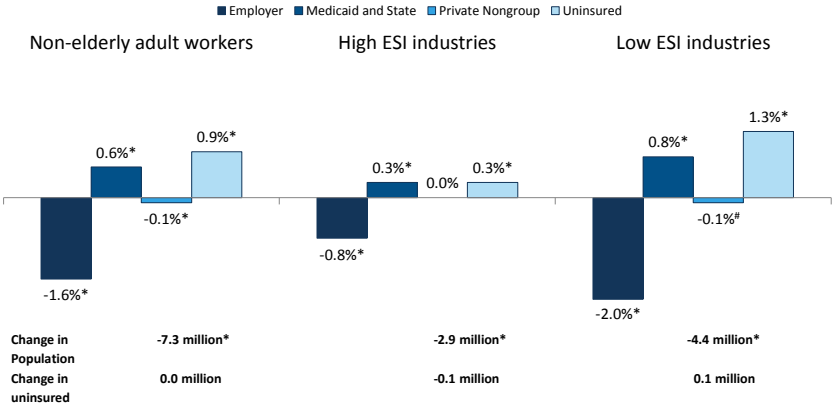
The effect of the recovery between 2010 and 2013 on insurance coverage also differed substantially by state (see Appendix A, Table 7 for uninsured rates by state). Overall, the uninsured rate declined in 39 states and increased in 12 states between 2010 and 2013. Oregon had largest percentage point decrease in the uninsured rate (2.3 percentage points), while Alaska had the highest percentage point increase (1.2 percentage points). In all but 4 states, the Medicaid and CHIP coverage rate increased between 2010 and 2013. Montana had the largest percentage point increase in Medicaid coverage (3.7 percentage points), and Alaska had the largest decline (1.8 percentage points). Finally, ESI coverage rates increased in 17 states and declined in 34 states. Wyoming had the largest increase in ESI at 3.2 percentage points, and Connecticut had the largest decline at 3.3 percentage points.

Changes in Coverage among Workers

Between 2008 and 2010, the total number of workers aged 18 to 64 declined from 140.4 million to 133.1 million. . Overall, between 2008 and 2010, workers experienced a decline in ESI coverage from 72.4 percent to 70.8 percent, which translates to a loss of ESI coverage for 7.5 million workers (Figure 19). This ESI loss was partially mitigated by increases in Medicaid coverage for low-income workers, but overall the uninsured rate for workers rose 0.9 percentage points. More workers in "low ESI" industries lost ESI than those in "high ESI" industries (4.6 million and 2.8 million, respectively).[18] From 2008 to 2010, the low ESI industries saw a larger decline in the number of workers than high ESI industries (4.4 million and 2.9 million, respectively). Because of the decline in the number of workers, the total number of uninsured workers was flat between 2008 and 2010 despite an increase in the uninsured rate.

Figure 19

Percentage point changes in health insurance coverage among workers, by industry, 2008-2010



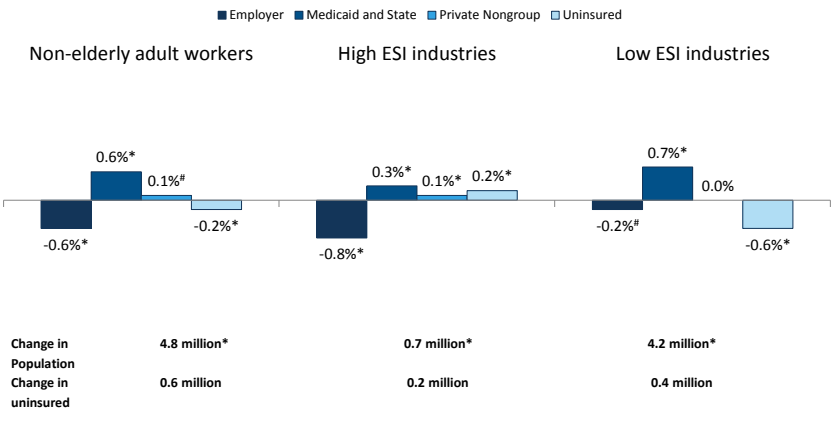
	Non-elderly adult workers	High ESI industries	Low ESI industries
Change in Population	-7.3 million*	-2.9 million*	-4.4 million*
Change in uninsured	0.0 million	-0.1 million	0.1 million

NOTES: * Change is statistically significant at the 5% level # Change is statistically significant at the 10% level.
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2008 and 2010 American Community Survey

Between 2010 and 2013, the number of workers recovered from 133.1 million to 138.0 million. This increase was concentrated in low ESI industries, which grew by 4.2 million workers between 2010 and 2013. The rate of ESI coverage among all workers also continued to decline between 2010 and 2013, dropping from 70.8 percent to 70.2 percent in that time period (Figure 20). The decline in the ESI coverage rate was more substantial for high ESI industries, where the ESI coverage rate fell by 0.8 percentage points. Workers in high ESI industries saw an increase in the uninsured rate between 2010 and 2013, and 200,000 more were uninsured. Workers in low ESI industries, conversely, had a 0.6 percentage point reduction in the uninsured rate between 2010 and 2013 due to increases in Medicaid coverage. However, because of the population growth in low ESI industries, there were 400,000 more workers in low ESI industries without health insurance in 2013 than in 2010.

Figure 20

Percentage point changes in health insurance coverage among workers, by industry, 2010-2013



	Non-elderly adult workers	High ESI industries	Low ESI industries
Change in Population	4.8 million*	0.7 million*	4.2 million*
Change in uninsured	0.6 million	0.2 million	0.4 million

NOTES: * Change is statistically significant at the 5% level # Change is statistically significant at the 10% level.
Coverage through CHAMPUS and Medicare are not shown because coverage rates for those coverage types among the nonelderly change little year-to-year.
SOURCE: Urban Institute Analysis of the 2010 and 2013 American Community Survey

Conclusion

The coverage provisions of the ACA that went into effect on January 1, 2014 were primarily designed to increase health insurance coverage among low-to middle-income adults. These provisions include both the establishment of Health Insurance Marketplaces to provide subsidized private non-group health insurance and, in 28 states and the District of Columbia, an expansion of Medicaid eligibility to adults up to 138 percent of the FPL. The 2013 American Community Survey does not capture these expansions, though it does capture early expansions of Medicaid by four states and the expansion of dependent coverage to young adults. Despite capturing some of the early coverage expansions under the ACA, the 2013 ACS serves as a final, albeit imperfect, baseline against which to measure the coverage shifts resulting from the major coverage expansions in the ACA. In addition, the 2013 ACS provides the opportunity to clarify trends in coverage during the economic recovery that preceded the major ACA coverage expansions.

The Great Recession led to a significant increase in the uninsured rate and accelerated the decline in ESI coverage, particularly among those with incomes below 138 percent of the FPL. Since 2010, the recovery has steadily improved uninsured rates, but ESI coverage has continued to decline, albeit at a slower rate, for children and adults aged 26 and older. Adults aged 19 to 25 experienced significant growth in ESI from 2010 to 2013 due to the ACA policy allowing young adults to continue receiving insurance through their parents' plan until age 26. In addition, most of the growth in employment between 2010 and 2013 was in low ESI industries, and the average ESI coverage rate in those industries was 20 percentage points below that for high ESI industries in 2013 (63.2 percent and 83.2 percent, respectively).

The increases in the uninsured rate during the Great Recession occurred mostly among low-income families, and the reductions in the uninsured rate during the recovery have primarily been through growth in Medicaid and CHIP. Coverage for children, in particular, was stabilized by growth in Medicaid and CHIP enrollment that offset losses in ESI coverage. While adult enrollment in Medicaid grew by 2.6 percentage points between 2008 and 2013, the effect was less pronounced than the 8.1 percentage point growth for children, likely due to lower eligibility levels for adults than for children.

As the ACA is fully implemented, ESI will remain the largest source of insurance coverage for Americans. However, much of the growth in coverage under the ACA is expected to come from Medicaid enrollment and increases in private non-group health insurance coverage purchased through the Health Insurance Marketplaces. It is therefore important to continue to track trends in ESI coverage alongside coverage gains in Medicaid and private non-group health insurance under the ACA to fully understand the effects of the ACA on health insurance coverage.

This issue brief was prepared by Laura Skopec, John Holahan, and Megan McGrath of the Urban Institute

Appendix A: Data Tables

TABLE 1: CHANGE IN HEALTH INSURANCE COVERAGE AMONG THE NONELDERLY BY INCOME, 2008–2013

	Coverage distribution within income category		Change, 2008–2010		Coverage distribution within income category	Change 2010–2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
All incomes (millions of people)	261.4	265.1		3.7[a]	267.8		2.7[a]
Employer	61.0%	57.1%	-3.9%*	-8.2[a]	56.6%	-0.5%*	0.3
Medicaid and State	15.3%	18.2%	2.9%*	8.1[a]	19.3%	1.1%*	3.5[a]
CHAMPUS/Medicare	2.4%	2.6%	0.3%*	0.8[a]	2.8%	0.2%*	0.6[a]
Private Non-group	4.5%	4.2%	-0.2%*	-0.5[a]	4.3%	0.0%	0.2[b]
Uninsured	16.8%	17.9%	1.1%*	3.5[a]	16.9%	-0.9%*	-2.0[a]
Less than 138% FPL	**71.6**	**85.9**		**14.3[a]**	**89.2**		**3.3[a]**
Employer	21.0%	18.9%	-2.1%*	1.2[a]	20.8%	1.9%*	2.3[a]
Medicaid and State	41.6%	43.6%	2.0%*	7.7[a]	44.7%	1.1%*	2.4[a]
CHAMPUS/Medicare	3.0%	2.9%	-0.1%	0.4[a]	3.1%	0.2%*	0.2[a]
Private Non-group	3.3%	3.2%	-0.1%*	0.4[a]	3.0%	-0.2%*	-0.1[a]
Uninsured	31.0%	31.4%	0.3%*	4.7[a]	28.4%	-2.9%*	-1.6[a]
138 to 400% FPL	99.6	97.1		-2.5[a]	96.7		-0.3
Employer	65.5%	64.6%	-0.9%*	-2.5[a]	63.8%	-0.8%*	-1.0[a]
Medicaid and State	9.3%	10.1%	0.8%*	0.6[a]	11.1%	1.0%*	0.9[a]
CHAMPUS/Medicare	2.6%	3.0%	0.4%*	0.3[a]	3.3%	0.3%*	0.3[a]
Private Non-group	4.7%	4.6%	0.0%	-0.2[a]	4.7%	0.1%	0.1
Uninsured	17.9%	17.6%	-0.3%*	-0.7[a]	17.1%	-0.5%*	-0.6[a]
400% FPL and above	90.2	82.2		-8[a]	81.9		-0.3
Employer	87.9%	88.1%	0.3%*	-6.8[a]	87.2%	-0.9%*	-1.0[a]
Medicaid and State	1.2%	1.2%	0.0%	-0.1[a]	1.4%	0.2%*	0.2[a]
CHAMPUS/Medicare	1.6%	1.9%	0.3%*	0.1[a]	2.0%	0.1%*	0.1[a]
Private Non-group	5.2%	4.9%	-0.3%*	-0.7[a]	5.1%	0.3%*	0.2[a]
Uninsured	4.2%	4.0%	-0.3%*	-0.6[a]	4.3%	0.3%*	0.2[a]

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

* Indicates change in percent of people is statistically significant (at the 95% confidence level).
# Indicates change in percent of people is statistically significant (at the 90% confidence level)
a Indicates change in numbers of people is statistically significant (at the 95% confidence level).
b Indicates change in numbers of people is statistically significant (at the 90% confidence level).

TABLE 2: CHANGE IN HEALTH INSURANCE COVERAGE AMONG NONELDERLY ADULTS BY INCOME, 2008–2013

	Coverage distribution within income category		Change, 2008–2010		Coverage distribution within income category	Change 2010–2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
All incomes (millions of people)	183.0	186.5		3.5[a]	189.9		3.4[a]
Employer	63.7%	59.9%	-3.9%*	-5.0[a]	59.7%	-0.1%	1.8[a]
Medicaid and State	8.3%	10.1%	1.7%*	3.5[a]	10.9%	0.9%*	2.0[a]
CHAMPUS/Medicare	2.7%	3.0%	0.3%*	0.7[a]	3.3%	0.3%*	0.6[a]
Private Non-group	5.2%	5.0%	-0.2%*	-0.1[b]	5.0%	0.0%	0.1[a]
Uninsured	20.0%	22.0%	2.0%*	4.4[a]	21.0%	-1.0%*	-1.1[a]
Less than 138% FPL	45.0	54.9		9.9[a]	58.3		3.5[a]
Employer	23.6%	21.5%	-2.2%*	1.1[a]	24.5%	3.0%*	2.5[a]
Medicaid and State	26.4%	27.4%	1.0%*	3.2[a]	28.6%	1.2%*	1.6[a]
CHAMPUS/Medicare	4.1%	3.9%	-0.2%*	0.3[a]	4.1%	0.2%*	0.3[a]
Private Non-group	4.5%	4.4%	-0.1%*	0.4[a]	4.1%	-0.4%*	-0.1[a]
Uninsured	41.3%	42.8%	1.5%*	4.9[a]	38.7%	-4.0%*	-0.9[a]
138 to 400% FPL	68.6	68.0		-0.6[a]	68.2		0.2
Employer	65.8%	64.7%	-1.2%*	-1.2[a]	64.6%	-0.1%	0.1
Medicaid and State	4.2%	4.7%	0.6%*	0.4[a]	5.1%	0.4%*	0.3[a]
CHAMPUS/Medicare	2.8%	3.3%	0.5%*	0.3[a]	3.7%	0.3%*	0.2[a]
Private Non-group	5.6%	5.6%	0.0%	0.0	5.6%	0.1%	0.1
Uninsured	21.6%	21.7%	0.1%	-0.1	21.0%	-0.7%*	-0.4[a]
400% FPL and above	69.3	63.6		-5.7[a]	63.4		-0.3
Employer	87.7%	87.8%	0.1%	-4.9[a]	87.0%	-0.8%*	-0.8[a]
Medicaid and State	0.7%	0.8%	0.1%*	0.0	0.9%	0.1%*	0.1[a]
CHAMPUS/Medicare	1.6%	1.9%	0.3%*	0.1[a]	2.0%	0.1%*	0.1[a]
Private Non-group	5.2%	5.0%	-0.2%*	-0.5[a]	5.3%	0.3%*	0.2[a]
Uninsured	4.8%	4.5%	-0.3%*	-0.4[a]	4.8%	0.3%*	0.2[a]

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

* Indicates change in percent of people is statistically significant (at the 95% confidence level).
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a Indicates change in numbers of people is statistically significant (at the 95% confidence level).
b Indicates change in numbers of people is statistically significant (at the 90% confidence level).

TABLE 3: CHANGE IN HEALTH INSURANCE COVERAGE AMONG NONELDERLY ADULTS BY AGE, 2008–2013

	Coverage distribution within income category		Change, 2008–2010		Coverage distribution within income category	Change 2010–2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
All nonelderly adults	183.0	186.5		3.5[a]	189.9		3.4[a]
Employer	63.7%	59.9%	-3.9%*	-5.0[a]	59.7%	-0.1%	1.8[a]
Medicaid and State	8.3%	10.1%	1.7%*	3.5[a]	10.9%	0.9%*	2.0[a]
CHAMPUS/Medicare	2.7%	3.0%	0.3%*	0.7[a]	3.3%	0.3%*	0.6[a]
Private Non-group	5.2%	5.0%	-0.2%*	-0.1[b]	5.0%	0.0%	0.1[a]
Uninsured	20.0%	22.0%	2.0%*	4.4[a]	21.0%	-1.0%*	-1.1[a]
Ages 19–25	28.9	29.6		0.7[a]	30.7		1.1[a]
Employer	50.5%	46.2%	-4.2%*	-0.9[a]	53.0%	6.7%*	2.6[a]
Medicaid and State	9.8%	12.0%	2.1%*	0.7[a]	12.1%	0.1%	0.2[a]
CHAMPUS/Medicare	1.6%	1.9%	0.3%*	0.1[a]	2.0%	0.1%*	0.1[a]
Private Non-group	7.7%	7.7%	0.0%	0.1[b]	7.5%	-0.3%*	0.0
Uninsured	30.4%	32.2%	1.8%*	0.7[a]	25.5%	-6.7%*	-1.7[a]
Ages 26–45	81.4	80.6		-0.8[a]	81.3		0.7[a]
Employer	64.1%	59.8%	-4.3%*	-4.0[a]	58.7%	-1.0%*	-0.4[a]
Medicaid and State	8.5%	10.4%	1.9%*	1.5[a]	11.4%	1.0%*	0.9[a]
CHAMPUS/Medicare	1.5%	1.7%	0.2%*	0.2[a]	2.0%	0.3%*	0.2[a]
Private Non-group	3.8%	3.6%	-0.2%*	-0.2[a]	3.6%	0.0%	0.0
Uninsured	22.1%	24.5%	2.4%*	1.7[a]	24.2%	-0.3%*	-0.1
Ages 46–64	72.7	76.3		3.6[a]	78.0		1.6[a]
Employer	68.6%	65.2%	-3.4%*	-0.1	63.4%	-1.8%*	-0.3[a]
Medicaid and State	7.6%	9.0%	1.4%*	1.3[a]	10.0%	1.0%*	0.9[a]
CHAMPUS/Medicare	4.4%	4.8%	0.4%*	0.4[a]	5.1%	0.3%*	0.3[a]
Private Non-group	5.7%	5.5%	-0.2%*	0.0	5.5%	0.0%	0.1[a]
Uninsured	13.6%	15.5%	1.9%*	1.9[a]	16.0%	0.5%*	0.6[a]

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

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b Indicates change in numbers of people is statistically significant (at the 90% confidence level).

TABLE 4: CHANGE IN HEALTH INSURANCE COVERAGE AMONG CHILDREN BY INCOME, 2008–2013

	Coverage distribution within income category		Change, 2008–2010		Coverage distribution within income category	Change 2010–2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
All incomes (millions of people)	78.4	78.6		0.2[a]	77.9		-0.7[a]
Employer	54.7%	50.5%	-4.2%*	-3.2[a]	49.1%	-1.5%*	-1.5[a]
Medicaid and State	31.7%	37.5%	5.8%*	4.6[a]	39.8%	2.4%*	1.6[a]
CHAMPUS/Medicare	1.6%	1.7%	0.1%#	0.1[b]	1.8%	0.1%*	0.0[b]
Private Non-group	2.8%	2.3%	-0.5%*	0.0[a]	2.4%	0.0%	0.0
Uninsured	9.2%	8.0%	-1.2%*	-1.0[a]	7.0%	-1.0%*	-0.8[a]
Less than 138% FPL	26.6	31.0		4.4[a]	30.8		-0.2
Employer	16.6%	14.3%	-2.2%*	0.0	13.7%	-0.6%*	-0.2[a]
Medicaid and State	67.3%	72.3%	5.0%*	4.5[a]	75.4%	3.1%*	0.8[a]
CHAMPUS/Medicare	1.1%	1.1%	0.1%#	0.1[a]	1.1%	-0.1%	0.0
Private Non-group	1.3%	1.0%	-0.3%*	0.0[a]	0.9%	-0.1%*	0.0[a]
Uninsured	13.8%	11.3%	-2.5%*	-0.2[a]	8.9%	-2.3%*	-0.7[a]
138 to 400% FPL	30.9	29.1		-1.9[a]	28.5		-0.5[a]
Employer	64.7%	64.5%	-0.2%	-1.3[a]	61.9%	-2.6%*	-1.1[a]
Medicaid and State	20.6%	22.7%	2.0%*	0.2[a]	25.3%	2.7%*	0.6[a]
CHAMPUS/Medicare	2.2%	2.3%	0.0%	0.0	2.5%	0.3%*	0.1[a]
Private Non-group	2.7%	2.4%	-0.3%*	0.0[a]	2.4%	0.1%	0.0
Uninsured	9.7%	8.2%	-1.5%*	-0.6[a]	7.8%	-0.4%*	-0.2[a]
400% FPL and above	20.9	18.6		-2.3[a]	18.6		0.0
Employer	88.4%	89.2%	0.7%*	-1.9[a]	88.0%	-1.2%*	-0.2[b]
Medicaid and State	2.6%	2.5%	0.0%	-0.1[a]	3.2%	0.6%*	0.1[a]
CHAMPUS/Medicare	1.5%	1.8%	0.3%*	0.0	1.8%	0.0%	0.0
Private Non-group	4.9%	4.4%	-0.5%*	0.0[a]	4.7%	0.2%*	0.0[a]
Uninsured	2.6%	2.1%	-0.5%*	-0.1[a]	2.4%	0.3%*	0.1[a]

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

* Indicates change in percent of people is statistically significant (at the 95% confidence level).
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TABLE 5: CHANGE IN HEALTH INSURANCE COVERAGE AMONG THE NONELDERLY BY RACE AND ETHNICITY, 2008–2013

	Coverage distribution within income category		Change, 2008–2010		Coverage distribution within income category	Change 2010–2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
White, non-Hispanic	165.9	162.9		-3.0[a]	160.5		-2.3[a]
Employer	69.0%	66.0%	-3.0%*	-7.0[a]	65.5%	-0.4%*	-2.3[a]
Medicaid and State	10.6%	12.6%	2.0%*	3.0[a]	13.4%	0.8%*	1.0[a]
CHAMPUS/Medicare	2.5%	2.8%	0.3%*	0.4[a]	3.1%	0.3%*	0.4[a]
Private Non-group	5.5%	5.3%	-0.2%*	-0.5[a]	5.3%	0.0%	-0.1
Uninsured	12.4%	13.3%	0.9%*	1.1[a]	12.6%	-0.7%*	-1.4[a]
Black, non-Hispanic	32.4	33.4		1.0[a]	33.9		0.5[a]
Employer	49.0%	43.9%	-5.1%*	-1.2[a]	43.7%	-0.2%	0.2[b]
Medicaid and State	27.4%	31.4%	4.0%*	1.6[a]	32.3%	0.9%*	0.5[a]
CHAMPUS/Medicare	2.9%	3.3%	0.4%*	0.2[a]	3.5%	0.2%*	0.1[a]
Private Non-group	1.9%	1.7%	-0.2%*	-0.1[a]	1.7%	0.1%	0.0[a]
Uninsured	18.7%	19.7%	1.0%*	0.5[a]	18.7%	-1.0%*	-0.2[a]
Hispanic	43.6	47.3		3.7[a]	50.0		2.7[a]
Employer	40.4%	36.2%	-4.2%*	-0.5[a]	36.9%	0.7%*	1.3[a]
Medicaid and State	24.2%	28.2%	4.0%*	2.8[a]	29.8%	1.6%*	1.6[a]
CHAMPUS/Medicare	1.5%	1.6%	0.1%*	0.1[a]	1.7%	0.1%*	0.1[a]
Private Non-group	2.0%	1.8%	-0.1%*	0.0	2.0%	0.1%*	0.1[a]
Uninsured	32.0%	32.2%	0.2%	1.3[a]	29.7%	-2.6%*	-0.4[a]
Other, non-Hispanic	19.5	21.6		2.1[a]	23.4		1.8[a]
Employer	59.2%	56.2%	-2.9%*	0.6[a]	56.5%	0.3%	1.1[a]
Medicaid and State	16.0%	18.2%	2.2%*	0.8[a]	19.0%	0.8%*	0.5[a]
CHAMPUS/Medicare	2.2%	2.3%	0.1%	0.1[a]	2.4%	0.1%#	0.1[a]
Private Non-group	5.5%	5.4%	-0.1%	0.1[a]	5.3%	-0.1%	0.1[a]
Uninsured	17.2%	17.9%	0.7%*	0.5[a]	16.7%	-1.2%*	0.0

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

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TABLE 6: CHANGE IN HEALTH INSURANCE COVERAGE AMONG THE NONELDERLY BY REGION, 2008–2013

	Coverage distribution within income category		Change, 2008–2010		Coverage distribution within income category	Change 2010–2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
Northeast	46.9	47.1		0.2[a]	47.1		0.0[a]
Employer	66.9%	63.2%	-3.7%*	-1.6[a]	62.2%	-1.0%*	-0.5[a]
Medicaid and State	16.2%	19.3%	3.1%*	1.5[a]	20.5%	1.2%*	0.6[a]
CHAMPUS/Medicare	1.4%	1.5%	0.1%#	0.0[a]	1.7%	0.2%*	0.1[a]
Private Non-group	3.9%	3.7%	-0.2%*	0.0[a]	3.8%	0.1%	0.0
Uninsured	11.6%	12.3%	0.8%*	0.4[a]	11.9%	-0.5%*	-0.2[a]
Midwest	57.2	57.3		0.1[a]	57.2		-0.2[a]
Employer	66.3%	61.9%	-4.5%*	-2.5[a]	61.5%	-0.4%#	-0.3[a]
Medicaid and State	14.7%	17.7%	3.0%*	1.7[a]	18.7%	1.0%*	0.5[a]
CHAMPUS/Medicare	1.7%	1.9%	0.2%*	0.1[a]	2.1%	0.2%*	0.1[a]
Private Non-group	4.3%	4.3%	0.0%	0.0	4.4%	0.1%#	0.1
Uninsured	12.9%	14.2%	1.3%*	0.8[a]	13.3%	-0.9%*	-0.6[a]
South	95.6	98.1		2.5[a]	100.0		1.9[a]
Employer	57.1%	53.3%	-3.9%*	-2.4[a]	52.9%	-0.3%*	0.7[a]
Medicaid and State	15.2%	17.9%	2.7%*	3.0[a]	19.1%	1.2%*	1.5[a]
CHAMPUS/Medicare	3.3%	3.6%	0.3%*	0.4[a]	3.9%	0.2%*	0.3[a]
Private Non-group	4.2%	4.0%	-0.3%*	-0.1[a]	3.9%	0.0%	0.1
Uninsured	20.2%	21.3%	1.1%*	1.6[a]	20.2%	-1.1%*	-0.7[a]
West	61.7	62.6		0.9[a]	63.6		1.0[a]
Employer	57.7%	54.1%	-3.6%*	-1.7[a]	54.0%	-0.1%	0.5[a]
Medicaid and State	15.5%	18.4%	2.8%*	1.9[a]	19.5%	1.1%*	0.9[a]
CHAMPUS/Medicare	2.3%	2.5%	0.3%*	0.2[a]	2.7%	0.2%*	0.1[a]
Private Non-group	5.5%	5.1%	-0.4%*	-0.2[a]	5.0%	-0.1%	0.0
Uninsured	19.1%	20.0%	0.9%*	0.7[a]	18.9%	-1.1%*	-0.5[a]

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

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TABLE 7: CHANGE IN UNINSURANCE AMONG THE NONELDERLY BY STATE, 2010–2013

	Number and Share of State Population Uninsured				Change, 2010–2013	
	2010		2013		Percentage point change	Change in millions of people
	Number Uninsured	Uninsured Rate	Number Uninsured	Uninsured Rate		
United States	47.3	17.9%	45.4	16.9%	-0.9%*	-2.0[a]
Alabama	0.7	17.3%	0.7	16.4%	-0.8%#	0.0[a]
Alaska	0.1	19.3%	0.1	20.5%	1.2%	0.0
Arizona	1.1	19.7%	1.1	20.6%	0.9%*	0.1[a]
Arkansas	0.5	20.2%	0.5	19.0%	-1.2%#	0.0[b]
California	6.8	21.0%	6.5	19.7%	-1.3%*	-0.3[a]
Colorado	0.8	18.0%	0.7	16.1%	-1.9%*	-0.1[a]
Connecticut	0.3	10.5%	0.3	11.0%	0.5%	0.0
Delaware	0.1	11.8%	0.1	11.8%	0.0%	0.0
DC	0.0	9.1%	0.0	7.7%	-1.3%#	0.0
Florida	3.9	25.7%	3.9	24.6%	-1.1%*	-0.1[b]
Georgia	1.9	22.0%	1.8	21.2%	-0.8%*	0.0
Hawaii	0.1	8.9%	0.1	8.6%	-0.3%	0.0
Idaho	0.3	20.7%	0.3	18.9%	-1.8%*	0.0[b]
Illinois	1.8	15.8%	1.6	14.5%	-1.3%*	-0.2[a]
Indiana	0.9	16.9%	0.9	16.1%	-0.8%*	0.0[a]
Iowa	0.3	11.0%	0.3	10.5%	-0.4%	0.0
Kansas	0.4	15.8%	0.4	14.6%	-1.3%*	0.0[a]
Kentucky	0.7	17.7%	0.6	17.0%	-0.7%#	0.0
Louisiana	0.8	20.3%	0.8	19.4%	-1.0%*	0.0[b]
Maine	0.1	12.8%	0.1	13.6%	0.8%	0.0
Maryland	0.7	13.0%	0.6	11.8%	-1.2%*	-0.1[a]
Massachusetts	0.3	5.4%	0.3	4.8%	-0.6%*	0.0[a]
Michigan	1.2	14.6%	1.1	13.2%	-1.4%*	-0.1[a]
Minnesota	0.5	10.3%	0.5	9.7%	-0.5%	0.0
Mississippi	0.5	20.8%	0.5	19.7%	-1.1%#	0.0[a]
Missouri	0.8	15.4%	0.8	15.4%	0.1%	0.0
Montana	0.2	20.3%	0.2	20.0%	-0.3%	0.0
Nebraska	0.2	13.8%	0.2	12.4%	-1.4%*	0.0[a]
Nevada	0.6	25.5%	0.6	23.5%	-2.0%*	0.0[a]
New Hampshire	0.1	12.6%	0.1	12.6%	0.0%	0.0
New Jersey	1.1	15.2%	1.2	15.5%	0.3%	0.0
New Mexico	0.4	23.1%	0.4	22.5%	-0.6%	0.0
New York	2.3	13.8%	2.1	12.7%	-1.1%*	-0.2[a]
North Carolina	1.6	19.4%	1.5	18.4%	-1.0%*	-0.1[a]
North Dakota	0.1	11.9%	0.1	12.3%	0.3%	0.0
Ohio	1.4	14.1%	1.3	12.9%	-1.3%*	-0.1[a]
Oklahoma	0.7	21.9%	0.7	20.3%	-1.5%*	0.0[a]
Oregon	0.7	20.1%	0.6	17.8%	-2.3%*	-0.1[a]
Pennsylvania	1.3	12.2%	1.2	11.7%	-0.5%*	-0.1[a]
Rhode Island	0.1	14.1%	0.1	14.1%	0.0%	0.0
South Carolina	0.8	20.4%	0.7	18.6%	-1.8%*	-0.1[a]
South Dakota	0.1	14.0%	0.1	14.7%	0.6%	0.0
Tennessee	0.9	16.7%	0.9	16.4%	-0.3%	0.0
Texas	5.8	26.3%	5.7	24.5%	-1.7%*	-0.2[a]
Utah	0.4	17.1%	0.4	14.9%	-2.2%*	0.0[a]

TABLE 7: CHANGE IN UNINSURANCE AMONG THE NONELDERLY BY STATE, 2010–2013

	Number and Share of State Population Uninsured				Change, 2010–2013	
	2010		2013		Percentage point change	Change in millions of people
	Number Uninsured	Uninsured Rate	Number Uninsured	Uninsured Rate		
Vermont	0.0	9.4%	0.0	8.3%	-1.1%	0.0
Virginia	1.0	14.6%	1.0	14.3%	-0.3%	0.0
Washington	0.9	16.3%	1.0	16.5%	0.2%	0.0
West Virginia	0.3	17.3%	0.2	16.3%	-0.9%	0.0[b]
Wisconsin	0.5	11.2%	0.5	10.8%	-0.4%	0.0
Wyoming	0.1	16.7%	0.1	15.2%	-1.6%	0.0

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

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TABLE 8: CHANGE IN HEALTH INSURANCE COVERAGE AMONG WORKERS BY INDUSTRY, 2008-2013

	Coverage distribution within income category		Change, 2008-2010		Coverage distribution within income category	Change 2010-2013	
	2008	2010	Percentage point change	Change in millions of people	2013	Percentage point change	Change in millions of people
All workers	140.4	133.1		-7.3[a]	138.0		4.8[a]
Employer	72.4%	70.8%	-1.6%[*]	-7.5[a]	70.2%	-0.6%[*]	2.6[a]
Medicaid and State	4.3%	4.9%	0.6%[*]	0.5[a]	5.5%	0.6%[*]	1.1[a]
CHAMPUS/Medicare	1.3%	1.5%	0.1%[*]	0.1[a]	1.6%	0.2%[*]	0.3[a]
Private Non-group	4.8%	4.7%	-0.1%[*]	-0.4[a]	4.8%	0.1%[#]	0.3[a]
Uninsured	17.2%	18.1%	0.9%[*]	0.0	17.9%	-0.2%[*]	0.6[a]
High ESI industries	50.2	47.3		-2.9[a]	48.0		0.7[a]
Employer	84.9%	84.1%	-0.8%[*]	-2.8[a]	83.2%	-0.8%[*]	0.2
Medicaid and State	2.2%	2.5%	0.3%[*]	0.1[a]	2.8%	0.3%[*]	0.2[a]
CHAMPUS/Medicare	1.2%	1.5%	0.3%[*]	0.1[a]	1.7%	0.2%[*]	0.1[a]
Private Non-group	3.1%	3.1%	0.0%	-0.1[a]	3.2%	0.1%[*]	0.1[a]
Uninsured	8.6%	8.9%	0.3%[*]	-0.1[a]	9.1%	0.2%[*]	0.2[a]
Low ESI industries	90.2	85.8		-4.4[a]	90.0		4.2[a]
Employer	65.5%	63.5%	-2.0%[*]	-4.6[a]	63.2%	-0.2%[#]	2.4[a]
Medicaid and State	5.4%	6.2%	0.8%[*]	0.5[a]	6.9%	0.7%[*]	0.9[a]
CHAMPUS/Medicare	1.5%	1.5%	0.0%	0.0[b]	1.6%	0.1%[*]	0.2[a]
Private Non-group	5.7%	5.6%	-0.1%[#]	-0.3[a]	5.6%	0.0%	0.2[a]
Uninsured	22.0%	23.2%	1.3%[*]	0.1	22.6%	-0.6%[*]	0.4[a]

Source: Analysis of the Urban Institute's Health Policy Center's American Community Survey (ACS) Medicaid/CHIP Simulation Model based on data from the Integrated Public Use Microdata Series (IPUMS) from 2010 and 2013.

Note: Excludes persons aged 65 and older and those in the Armed Forces. Estimates reflect an adjustment for the misreporting of coverage on the ACS.

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[1] Blavin, F., Holahan, J., Kenney, G., and Chen, V. 2013. A Decade of Coverage Losses: Implications for the Affordable Care Act. The Urban Institute. Available at: http://www.urban.org/UploadedPDF/412514-Implications-for-the-Affordable-Care-Act.pdf.

[2] Holahan, J. and McGrath, M. 2014. As the Economy Improves, the Number of Uninsured is Falling but not because of a Rebound in Employer Sponsored Insurance. Kaiser Family Foundation. Available at: http://kff.org/uninsured/issue-brief/as-the-economy-improves-the-number-of-uninsured-is-falling-but-not-because-of-a-rebound-in-employer-sponsored-insurance/ ; Holahan, J. and McGrath, M. 2013. Reversing the Trend? Understanding the Recent Increase in Health Insurance Coverage among the Nonelderly Population. Kaiser Family Foundation. Available at: http://kff.org/uninsured/issue-brief/reversing-the-trend-understanding-the-recent-increase-in-health-insurance-coverage-among-the-nonelderly-population/; and Holahan, J. and Chen, V. 2011. Changes in Health Insurance Coverage in the Great Recession, 2007-2010. Kaiser Family Foundation. Available at: http://kff.org/medicaid/issue-brief/changes-in-health-insurance-coverage-in-the/.

[3] O'Hara, B. and Medalia, C. 2014. CPS and ACS Health Insurance Estimates: Consistent Trends from 2009-2012. SEHSD Working Paper 2014-29. Available at: https://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/CPS_ACS_Trends.pdf

[4] United States Census Bureau. Fact Sheet – Differences Between CPS ASEC and ACS. Available at: https://www.census.gov/hhes/www/poverty/about/datasources/factsheet.html.

[5] The HIU is a unit of analysis for determining family income that more accurately reflects eligibility for public assistance than does analysis at the household level. The HIU includes members of a family who can be covered under one health insurance policy, such as the policyholder, spouse, children under age 19, and full-time students under age 23. The household, by contrast, may include other relatives or unrelated individuals.

[6] Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010. Further information on the creation of the ACS iPUMS files is available at: www.ipums.org.

[7] For further details, see Lynch, V. Kenney, G.M., Haley, J., and Resnick, D. 2011. Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits. Report to the U.S. Census Bureau. Available at: http://www.census.gov/hhes/www/hlthins/publications/Improving%20the%20 Validity%20of%20the%20Medicaid-CHIP%20Estimates%20on%20the%20ACS.pdf

[8] Ibid and Haley, J.M., Lynch, V., and Kenney, G.M. 2014. The Urban Institute Health Policy Center's Medicaid/CHIP Eligibility Simulation Model. The Urban Institute. Available at: http://www.urban.org/publications/413069.

[9] Ibid

[10] Bureau of Labor Statistics. "Labor Force Statistics from the Current Population Survey." March 19, 2015. Available at: http://data.bls.gov/timeseries/LNS14000000.

[11] The public use file of the American Community Survey does not include a postmark or interview date, so it is not possible to determine whether the 200,000 additional young adults with private non-group coverage enrolled before or after October 2013.

[12]While 2007 may provide a better pre-recession measure, the ACS did not begin asking about health insurance until the 2008 survey year. Official recession dates from National Bureau of Economic Research.

[13] Given the relative stability of and limited eligibility for military and Medicare coverage among the nonelderly population, this coverage is not shown throughout this brief.

[14] This coverage type includes Medicaid, CHIP, and other state coverage programs for those with low incomes or a disability.

[15] Sommers, B.D, Kenney, G.M., and Epstein, A.M. 2014. "New Evidence on the Affordable Care Act: Coverage Impacts of Early Medicaid Expanions." Health Affairs 33(1): 78-87.

[16] Sommers, B.D., Buchmueller, T., Decker, S.L., Carey, C., and Kronick, R. 2013. The Affordable Care Act Has Led to Significant Gains in Health Insurance and Access to Care for Young Adults. Health Affairs 32(1): 165-174.

[17] The other group includes Asians, Pacific Islanders, American Indians, Alaska Natives, and anyone reporting two or more races.

[18] High ESI industries are those with ESI coverage rates of more than 80 percent in 2012 and consist primarily of finance, manufacturing, information and communications firms. Low ESI industries had ESI coverage rates of less than 80 percent in 2012 and consist primarily of agriculture, construction, and wholesale and retail trade.

Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform

Toplines

Abstract

States have long been the testing ground for new models of health care and coverage. Section1332 of the Affordable Care Act, which takes effect in less than two years, throws open the door to innovation by authorizing states to rethink the law's coverage designs. Under State Innovation Waivers, states can modify the rules regarding covered benefits, subsidies, insurance marketplaces, and individual and employer mandates. States may propose broad alternatives or targeted fixes, but all waivers must demonstrate that coverage will remain as accessible, comprehensive, and affordable as before the waiver and that the changes will not add to the federal deficit. This issue brief describes how states may use State Innovation Waivers to reallocate subsidies, expand or streamline their marketplaces, replace or modify the mandates, and otherwise pursue their own brand of reform tailored to local market conditions and political preferences.

OVERVIEW

The Affordable Care Act (ACA) establishes a new national paradigm for health coverage while leaving room for considerable experimentation by states. Indeed, building on a long history of state innovation with coverage, payment, and delivery models, the ACA is fueling far-reaching campaigns by governors to reform state health care systems across payers and providers. The door to innovation will be thrown open even further in 2017, when section 1332 of the ACA invites states to find alternative ways to meet the coverage goals of the law while staying within its fiscal constraints.

Developed with bipartisan support that continues to this day, section 1332, known as State Innovation Waivers, authorizes states to request five-year renewable waivers from the U.S. Departments of Health and Human Services (HHS) and the Treasury of the ACA's key coverage provisions, including those related to benefits and subsidies, the exchanges (also known as marketplaces), and the individual and employer mandates.[1] Depending on their policy and political priorities, states may propose waivers to pursue broad alternative approaches to expand coverage or targeted fixes intended to smooth the rough edges of the ACA. Some ACA provisions, such as guaranteed issue, may not be waived and all applications must demonstrate that coverage remains as accessible, comprehensive, and affordable as before the waiver and that the proposed changes will not contribute to the federal deficit.

In this brief, we examine the requirements of section 1332 and explore how states might utilize the waivers. We do so with limited guidance from HHS, whose only regulations to date relate almost entirely to the application process.[2] Thus, our exploration is based on the statutory language, considerable experience with exchanges and Medicaid waivers, and interviews with policy experts and state officials (Appendix A).

THE BASICS

What May Be Waived?

States may propose alternatives to four pillars of the ACA:

- **Benefits and Subsidies.** States may modify the rules governing covered benefits, as well as the subsidies that are available through the marketplaces. States seeking to reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies to implement their alternative approaches.
- **Marketplaces and Qualified Health Plans.** States may replace their marketplaces or supplant the plan certification process with alternative ways to provide health plan choice, determine eligibility for subsidies, and enroll consumers in coverage.
- **The Individual Mandate.** States may modify or eliminate the requirement that individuals maintain minimum essential coverage.
- **The Employer Mandate.** States may modify or eliminate the requirement that large employers offer affordable coverage to their full-time employees.

Fair Play Rules May Not Be Waived

States may not waive the ACA's nondiscrimination provisions, which prohibit carriers from denying coverage or increasing premiums based on medical history. States are also precluded from waiving related "fair play" rules that guarantee equal access at fair prices for all enrollees.

Waiver Guardrails

State Innovation Waivers must satisfy four criteria:

- **Comprehensive Coverage.** States must provide coverage that is "at least as comprehensive" as coverage absent the waiver.
- **Affordable Coverage.** States must provide "coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as coverage absent the waiver.
- **Scope of Coverage.** States must provide coverage to "at least a comparable number of residents" as would have been covered without the waiver.
- **Federal Deficit.** The waiver must not increase the federal deficit.

Coordination with Other Waivers

HHS is required to coordinate and consolidate the 1332 waiver process with waiver processes for Medicaid, Medicare, the Children's Health Insurance Program, and other federal laws relating to the provision of health care services. Such consolidation of waivers allows for better alignment of coverage programs and may create some flexibility in how waiver packages are assessed.

Taken together, these provisions confirm the ACA's central policy goal—ensuring that every American has access to affordable and meaningful coverage—while giving states considerable flexibility to decide how best to achieve this within their borders. Ultimately, the extent of that flexibility will be defined by statute, regulation, and most notably, through the lens of the administration reviewing the 1332 waiver requests.

Consolidating 1332 and 1115 Waivers: Arkansas

Arkansas' section 1115 expansion waiver, also known as the private option, authorizes the state to use Medicaid funds to purchase qualified health plan (QHP) coverage on the marketplace. While the Government Accountability Office challenged the program's budget neutrality, the expansion has been enormously successful. Nearly 200,000 newly eligible adults enrolled in coverage through QHPs in the Arkansas marketplace, which substantially increased its size and helped drive down premium costs. As premiums go down, federal costs related to tax credits likewise decrease. Such savings do not count toward budget neutrality, however, because they are not savings to the Medicaid program. Under a consolidated 1115 and 1332 waiver, one could envision HHS permitting states to demonstrate budget neutrality across waivers. Arkansas Governor Asa Hutchinson recently alluded to a 1332 waiver as playing a role in the future of the private option.

POSSIBLE WAIVER STRATEGIES

State Innovation Waivers create a fresh opportunity for states to pursue their own brand of reform tailored to local market conditions and political preferences. As one commentator noted, "Without even changing the law, 1332 could change the ACA almost beyond recognition."[3] The possibilities are far ranging, but all are subject to the coverage and fiscal guardrails discussed above. There is considerable interest in the waivers across the political spectrum, although few state officials have identified a particular path forward. The most

compelling ideas may emerge after state officials and key stakeholders come together and—through the public and transparent process required under section 1332—forge consensus. Interviews with policy experts and state officials suggest the following areas of interest.

Rethinking Subsidies for Marketplace Plans

The ACA seeks to make coverage affordable for those above Medicaid income-eligibility levels through a combination of subsidies that includes premium tax credits and cost-sharing reductions. State officials at both ends of the political spectrum question whether the law's subsidy rules strike the right balance. Some are concerned that cost-sharing levels are too high and will impede access to care. Others would welcome health plans with greater cost-sharing and lower premiums to attract younger and healthier populations. Both approaches seek to minimize "subsidy cliffs" (dramatic drops in subsidy amount as income rises) and establish more graduated subsidies.

For example, a state may pursue a consolidated 1332 and Medicaid waiver to smooth the subsidy cliff faced by individuals moving from Medicaid to the marketplace. It could align premiums for higher-income Medicaid enrollees with those of lower-income marketplace enrollees and, in doing so, could redeploy the aggregate value of tax credits and cost-sharing reductions to increase subsidies for those with more modest incomes and develop more graduated subsidies.

Alternately, some states may pursue the addition of high-deductible, lower-premium plans with greater cost-sharing than is currently allowed in the marketplaces and use the savings to offer health savings accounts to ease cost burdens on low-income individuals—similar to what Indiana has implemented for its Medicaid enrollees. While this may increase the number of individuals covered and decrease premiums if the overall risk pool is improved, the waiver application would need to meet the requirement that coverage be at least as affordable as coverage absent the waiver. The same concerns would apply to states interested in allowing value-based purchasing models that increase cost-sharing for lower-value services or lower-quality plans. Such waiver approaches would have to address how the benefits to some consumers would be balanced against the increased

Precedent for Redeploying Federal Subsidies: The Basic Health Program

Under the Basic Health Program (section 1331 of the ACA), states may receive 95 percent of the aggregate value of subsidies that otherwise would have gone to individuals with incomes up to 200 percent of the federal poverty level who are eligible to purchase marketplace coverage and use those funds to offer more affordable coverage. The method for calculating the aggregate federal funding available under this approach suggests how HHS might calculate the funding available to states under State Innovation Waivers. Under Basic Health Program (BHP) regulations, HHS develops rate cells, breaking down the potentially eligible population by age range, geographic area, coverage category, household size, and income level. The payment rate is calculated by taking the sum of 95 percent of the tax credits and cost-sharing reductions—adjusted for risk and other factors—multiplied by the projected number of enrollees within each rate cell. The aggregate amount the state receives is equal to the sum of

costs to others. States also must be mindful that current spending on subsidies will influence the amount available through a 1332 waiver.

the payment amounts for each rate cell, reconciled retrospectively based on actual enrollment, coverage category, household size, and income level.

Notably, come 2017, section 1332 will allow states to accomplish the goals of the BHP with 100 percent of the aggregate subsidy amount, rather than 95 percent as authorized for the BHP.

Reforming the Marketplaces

The marketplaces play a central role in the ACA, though some states have done little to support them (ceding control to the federal government) while others are broadening their role. Section 1332 allows for either approach, although states currently using the federal marketplace may be limited in their ability to modify its provisions unless and until the federal marketplace can accommodate more state-specific policies. These states may eliminate the federal marketplace entirely, however, as long as their waiver applications address the law's coverage and fiscal goals.

Eliminating the marketplaces may be an especially attractive option in smaller states where only limited numbers use them. States may choose to replace them with a system that offers vouchers for eligible individuals to purchase coverage from any lawful seller of ACA-compliant coverage. Alternately, states may leverage the rapid growth of Web brokers and private exchanges to outsource marketplace functions to one or more competing Web-based sellers. The federal marketplace already allows a version of this approach, but states may want to move beyond what is currently allowed by the statute.

Other states may want to enhance their marketplaces' scale and leverage by using a 1332 waiver to offer coverage options for additional populations or even to serve as the sole provider of coverage. (Vermont state officials contemplated but ultimately did not pursue this approach, citing fiscal constraints.) States may take incremental steps in this direction by, for instance, adding state employees or other large purchasing pools to their marketplaces.

Contemplating the Options Posed by 1332

In Hawaii, a longstanding and popular employer mandate, the Prepaid Health Care Act, has led to a high coverage rate (92%) among state residents. Efforts to reconcile Prepaid Health Care Act and ACA provisions have created challenges for Hawaii and motivated the legislature to establish a task force focused on 1332 waiver possibilities. The task force has not yet made any substantive recommendations but has engaged stakeholders in a review of options—a process that could be a model for other states wanting to ensure that all options are considered in a public and transparent way.

Waivers focused on reforming the marketplaces are likely to have little impact on the coverage guardrails, though states should be mindful of how changes affect access to coverage across different populations.

Replacing or Modifying the Individual and Employer Mandates

With some exceptions, the ACA penalizes individuals who do not have minimum essential coverage or employers that do not offer such coverage. Arguably the least popular provisions in the law, the individual and employer mandates may be prominently featured in states' 1332 waiver applications. Possible alternatives to the individual mandate include implementing penalties for late enrollment (similar to Medicare), reducing opportunities for enrollment (e.g., multiyear waiting periods if open enrollment is missed), or establishing automatic enrollment. On their own, waivers of the individual mandate would not impact the comprehensiveness of coverage, though they could reduce the number of individuals covered, decrease affordability, and increase federal costs (if premiums rise as a result). Much would depend on how effective the mandate alternative is at maintaining scope of coverage and a balanced risk pool.

As an alternative to the employer mandate, states may implement a "play or pay" requirement in which employers must pay a flat percentage of payroll in benefits or taxes. With the relatively low enrollment in the Small Business Health Options Program (SHOP), many states may welcome the flexibility to experiment with new approaches to serving the small business community. While waivers of the employer mandate might have little impact on coverage, they might have a significant fiscal impact: such a waiver would reduce the penalty revenue to the federal government and therefore raise the federal deficit, absent some other waiver component to offset it.

Targeted Fixes

In the earlier sections, we reflect on some of the more expansive ideas that have emerged around 1332 waivers. In this final section, we look at more targeted approaches. By targeted, we do not mean small or unimportant, but rather approaches that focus on a narrow slice of the law, such as undoing the ACA requirement that small-group rating rules apply to businesses with 51 to 100 employees. Other targeted reforms that were suggested in our interviews include:

- **Filling Coverage Gaps.** States might address coverage gaps, such as the "family glitch," which makes dependents ineligible for tax credits if they are offered employer coverage, regardless of whether that coverage is affordable.
- **Advancing State Reform Priorities.** States might provide incentives for health care

Smoothing the Law's Rough Edges

The Minnesota Department of Human Services has identified several opportunities for better aligning coverage rules across subsidy programs, including:

- *Income counting.* Income is counted differently under Medicaid, the state's Basic Health Program, and the marketplaces.
- *Eligibility verification.* Verification rules are not entirely consistent across Medicaid and the marketplaces.
- *Implementation of a consistent enrollment effective date.* The ACA and the Social Security Act use different enrollment start dates for Medicaid, QHPs, and the BHP.
- *Definition of American Indian.* The definition of American Indians differs for purposes of Medicaid and marketplace coverage.

quality improvement by reallocating
subsidies to favor plans with higher quality ratings, as is currently done in Medicare Advantage.

- **Grace Periods.** States might replace the ACA's three-month grace periods for nonpayment with the one-month grace periods that are common in states for plans outside the marketplace.

- **Aligning Rules.** States might alter the rules on issues such as the definition and verification of income to align exchange, Medicaid, and other program rules.

- **Simplifying Regulations.** States might want to preserve federal reforms, such as cost-sharing reductions, but replace complex federal recordkeeping rules.

CONCLUSION

State Innovation Waivers involve a delicate balancing act: providing states with considerable latitude to experiment with alternative coverage mechanisms while also requiring that they continue to meet the coverage and affordability goals of the Affordable Care Act. Combined with Medicaid waivers, they may provide states with the opportunity to move beyond the politics of the ACA and pursue their own reforms. Indeed, if state policymakers agree on the value of having accessible, affordable, and meaningful health care coverage for all, then 1332 waivers offer a way to achieve these goals while reinforcing states' leadership role in regulating their insurance markets and serving as the laboratories of health reform.

Appendix A. List of Interviewees

Stuart Butler, Ph.D., Senior Fellow, Economic Studies, Brookings Institution

Devon Green, Special Counsel for Health Care Reform, Vermont Agency of Administration

Gordon Ito, Insurance Commissioner, Hawaii Department of Commerce and Consumer Affairs, and Vice Chair, Hawaii State Innovation Waiver Task Force

Scott Leitz, Chief Executive Officer, MNsure (Minnesota Health Insurance Marketplace)

Robin Lunge, Director of Health Care Reform, Vermont Agency of Administration

John McDonough, Dr.P.H., Professor, Department of Health Policy and Management, and Director, Center for Executive and Continuing Professional Education, Harvard University School of Public Health

Len Nichols, Ph.D., Director, Center for Health Policy Research and Ethics, and Professor of Health Policy, College of Health and Human Services, George Mason University

Marie Zimmerman, Medicaid Director, Minnesota Department of Human Services

Notes

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

[2] U.S. Department of the Treasury and U.S. Department of Health and Human Services. Final Rule. "Application, Review, and Reporting Process for Waivers for State Innovation." *Federal Register* 77, no. 38 (Feb. 27, 2012):11700, http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf (http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf).

[3] S. M. Butler, "Why the GOP Needs an Alternative to the Obamacare Repeal Strategy," *Health360* (blog), Brookings Institution, Jan. 28, 2015, http://www.brookings.edu/blogs/health360/posts/2015/01/28-gop-obamacare-repeal-strategy-alternative-butler (http://www.brookings.edu/blogs/health360/posts/2015/01/28-gop-obamacare-repeal-strategy-alternative-butler).

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April 2015 | Issue Brief

Medicaid Expansion, Health Coverage, and Spending: An Update for the 21 States that have not Expanded Eligibility

Matthew Buettgens, John Holahan, and Hannah Recht

Summary

Ever since the Supreme Court ruled in June 2012 that states could effectively choose whether or not to accept the Affordable Care Act's expansion of Medicaid eligibility, that choice has been one of the most prominent and often one of the most contentious issues for states. In this report, we provide new projections of the impact of Medicaid expansion on health coverage, Medicaid enrollment, and costs in states that have not expanded Medicaid. We find that if the 21 states that have not expanded Medicaid as of April 2015 were to do so:

- The number of nonelderly people enrolled in Medicaid would increase by nearly 7 million, or 40 percent.
- 4.3 million fewer people would be uninsured.
- There would be $472 billion more federal Medicaid spending from 2015 to 2024.
- States would spend $38 billion more on Medicaid from 2015 to 2024.
- Savings on reduced uncompensated care would offset between 13 and 25 percent of that additional state spending.
- States would be able to realize other types of budgetary savings if they expanded Medicaid that are not included in this report.

Introduction

A central goal of the Affordable Care Act (ACA) is to significantly reduce the number of uninsured by providing affordable coverage options through Medicaid and new Health Insurance Marketplaces. As enacted, the ACA would expand Medicaid for nearly all low-income Americans with incomes up to 138 percent of poverty ($16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For those that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible from 2014 to 2016.[1] The federal share gradually phases down to 90 percent in 2020 and remains at that level thereafter. The state's standard FMAP applies to services for those that were previously eligible for Medicaid. There is no deadline for states to adopt the expansion; however, the federal match rates are tied to specific years.

As of April 2015, 21 states have not expanded Medicaid. These decisions will have enormous consequences for health coverage for the low-income population. In states that do not implement the Medicaid expansion, millions of low-income adults that could have gained Medicaid will remain ineligible for the program. A small

number of these people may be eligible for tax credits to purchase private coverage, but the majority will be left without an affordable coverage option.

As of the time of writing, the Medicaid expansion issue continues to be debated in a number of state legislatures. The most recent state to adopt the Medicaid expansion was Montana. The expansion in Montana requires federal waiver approval to be implemented. To inform state decisions about expanding Medicaid, we estimate the coverage and cost impact if these states opted to implement the Medicaid expansion.

In this report, we provide state-level estimates of Medicaid enrollment and the number of uninsured in 2016, both with and without Medicaid expansion, for the 21 states that have not expanded eligibility. We also provide estimates of Medicaid and uncompensated care spending for the period 2015 to 2024. Our spending estimates include acute care for the nonelderly, care for the elderly, and long-term care. Because Medicaid and CHIP are funded by the federal and state governments in partnership, we estimated both the federal and state shares of spending. We used the Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS) to estimate the effects of the ACA.[2] This paper updates estimates from 2012 and 2013.[3] We have made a number of important updates since the older reports:

- State expansion decisions are as of April 2015. The previous update from July 2013 included 27 states that had not adopted the expansion. Since that time, Indiana, Michigan, Montana, New Hampshire, Ohio and Pennsylvania have adopted the expansion.
- The current 10-year budget window is 2015-2024. Federal matching rates under the ACA vary by year, so years included affect how total spending is divided into federal and state shares.
- We account for changes in state eligibility rules other than ACA Medicaid expansion since 2011. For example, in 2014, Wisconsin extended eligibility of childless adults to 100 percent FPL and lowered the eligibility threshold for parents from 200 percent to 100 percent FPL.
- We use final ACA regulations on Medicaid eligibility determination and the income thresholds based on modified adjusted gross income that are now used to determine eligibility for most Medicaid beneficiaries.
- We updated pre-ACA Medicaid enrollment and spending for the non-elderly, along with spending on the elderly and long-term care from the latest available MSIS (2012 or 2011, depending on the state).
- The model is based on three years (2009-2011) of the American Community Survey (ACS) pooled together. This survey has a much greater sample size than the Current Population Survey used in our earlier model, improving state-level estimates of the characteristics and costs of enrollees.
- The survey data were aged to 2015-2024 using the latest Census projections. Projections available at the time the work was done on the earlier paper were still based on the 2000 Census, not the 2010 Census. Since Census does not produce state-level population projections, we used our own projections for the largest states, based on Census population estimates through 2013.
- Cost growth projections incorporate estimates of actual growth from 2011-2013, which was lower than historical trends.

This report focuses exclusively on Medicaid funding. Children covered through Title XXI Medicaid programs funded through the Children's Health Insurance Program (CHIP) are not included in our estimates.

The ACA requires states to maintain eligibility standards for children until 2019. After that, states can cut back eligibility for both Medicaid and CHIP to 138 percent of the FPL. In this report, we assume that states maintain eligibility levels for children past 2019.

About HIPSM

The Health Insurance Policy Simulation Model (HIPSM) is a sophisticated microsimulation model that is used to estimate the impacts of health reforms and to inform state and national policy design choices. HIPSM has been used to assist state and federal governments with ACA implementation and analysis of policy options under the ACA. The core data in the model are from the Census Bureau's American Community Survey, an annual survey of 3 million U.S. residents. Census Bureau population projections are used to produce estimates through 2024. Health care use and spending are estimated for each individual for different insurance types based on data from the Medical Expenditure Panel Survey-Household Component. The cost of covering an individual in Medicaid varies according to health status, age, previous coverage, state of residence, and other characteristics. We incorporated state-specific trends in Medicaid costs using data from the Medicaid Statistical Information System, adjusting for the differences in health care costs between adults eligible with and without Medicaid expansion.

We model eligibility status for Medicaid, 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. Not everyone who is eligible for Medicaid enrolls in the program. HIPSM estimates take-up of Medicaid based on an individual's characteristics, such as income, age, health status, and current coverage, rather than applying a uniform participation rate across the population. The model is calibrated so that overall take-up rates are comparable to findings in the empirical economics literature.[4]

Results

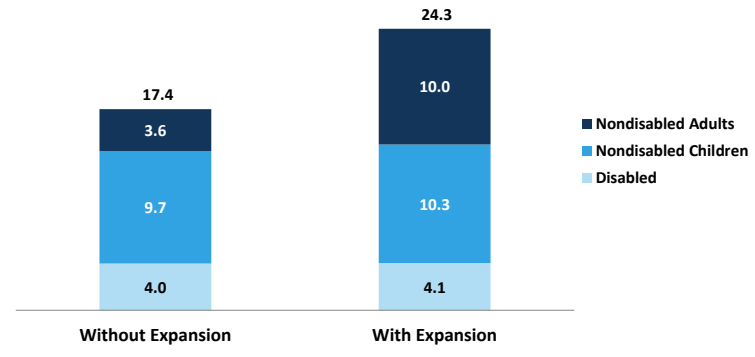
Increases in Medicaid Enrollment

With no change in state expansion decisions, we estimate that in 2016, 17.4 million nonelderly people will be enrolled in Medicaid in the 21 states that have not expanded Medicaid eligibility (Figure 1). Were these states to expand Medicaid, enrollment would increase by 40 percent to 24.3 million. Those gaining eligibility under expansion would all be nondisabled nonelderly adults, so the increase in enrollment would be concentrated in that group (from 3.6 million to 10.0 million). However, more than 525,000 more children would also be covered. Although children do not gain eligibility under expansion, the expansion of coverage to parents is expected to make them more likely to enroll their children.

Figure 1

Estimated Medicaid Enrollment if Non-Expansion States Expanded Medicaid, 2016

Enrollment in millions:



Note: Components may not sum to totals due to rounding.
Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

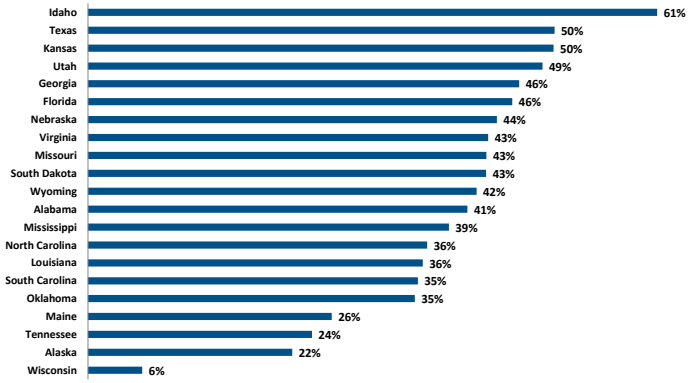
There are considerable differences between states in the extent to which enrollment would grow under expansion (Figure 2 and Table 1). Important state-specific factors that affect enrollment growth under expansion include the underlying income distribution, Medicaid eligibility rules before the ACA, the share of the population who are immigrants, and the availability of employer-sponsored insurance to low-income working families. Three states would see increases in Medicaid enrollment of 50 percent or more: Idaho, Texas, and Kansas. Fourteen states would see enrollment grow between 30 and 50 percent. The smallest rates of growth would occur in states such as Wisconsin that have already extended Medicaid eligibility for adults (both parents and childless adults) beyond what was required by law. In Wisconsin, for example, adults are already eligible up to 100 percent of the FPL through a state plan amendment and under a Section 1115 waiver.

Decreases in the Number of Uninsured People

Although our focus is on the difference in the number of uninsured with or without Medicaid expansion, this difference should be understood in the context of the total number of uninsured people in these states. We estimate that if the ACA had never been implemented, 22.2 million people would be uninsured in 2016 in the 21 states that have not expanded Medicaid (Figure 3). The ACA, even without Medicaid expansion, is expected to reduce the number of uninsured to 14.1 million, a decrease of 37 percent. Were all of these states to expand Medicaid, the number of uninsured would decline further to 9.8 million, a decrease of 56 percent from the number without the ACA.

Figure 2

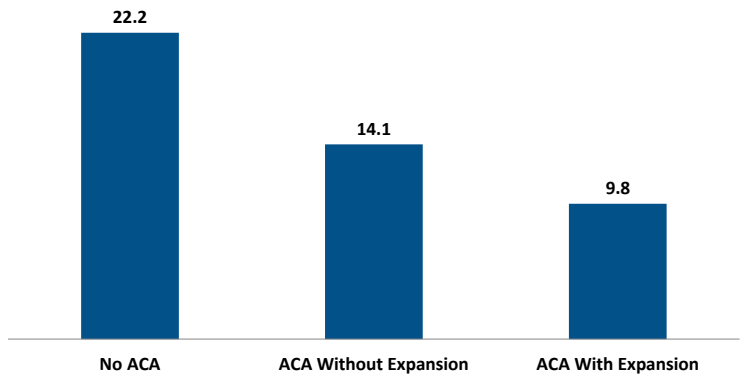
Estimated Change in Medicaid Enrollment if Non-Expansion States Expanded Medicaid, 2016



Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

Figure 3

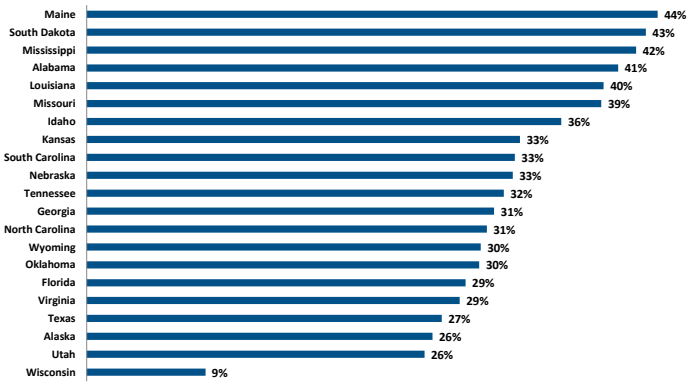
Estimated Number of Uninsured if Non-Expansion States Expanded Medicaid, 2016



Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

Figure 4

Estimated Percent Decrease in Uninsured Population due to Expansion, 2016



Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

Six states would see their uninsured populations reduced by about 40 percent or more if they implemented the Medicaid expansion (Figure 4 and Table 2): Maine, South Dakota, Mississippi, Alabama, Louisiana, and Missouri. The only state that would see a reduction in the uninsured of less than 25 percent would be Wisconsin. As mentioned above, Wisconsin already covers adults up to 100 percent of the FPL under Medicaid under a Section 1115 waiver.

Medicaid Spending

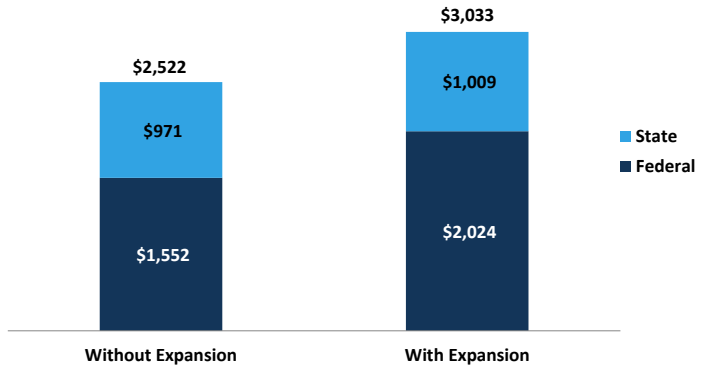
We estimate that from 2015 to 2024, the Medicaid programs in the 21 non-expansion states would spend $2,552 billion with no change in their expansion status, with $1,552 billion funded by the federal government and $971 billion funded by the states (Figure 5). This spending figure includes acute care for the nonelderly as well as care for the elderly and long-term care. Were these states to expand Medicaid, federal Medicaid spending from 2015 to 2024 would rise by 30% while state spending would rise by 4%.

Not surprisingly, the states that would see the largest increases in enrollment with expansion would also see some of the largest increases in the federal and state Medicaid spending (Figure 6 and 7 and Table 3). Idaho and Georgia would see increases of 50 and 48 percent in federal spending and 10 and 8 percent in state spending, respectively. Wisconsin would see a much smaller increase in federal spending for Medicaid and actually spend less in state funding if it were to expand Medicaid. That is because Wisconsin already covers some people who would be considered newly eligible if the state were to expand Medicaid. The federal government would pay a much higher share of the costs of those people than they currently do. Wisconsin would see its state spending on Medicaid decline by nearly 5 percent if the state were to expand eligibility.

Figure 5

Estimated Medicaid Expenditures if Non-Expansion States Expanded Medicaid, 2015-2024

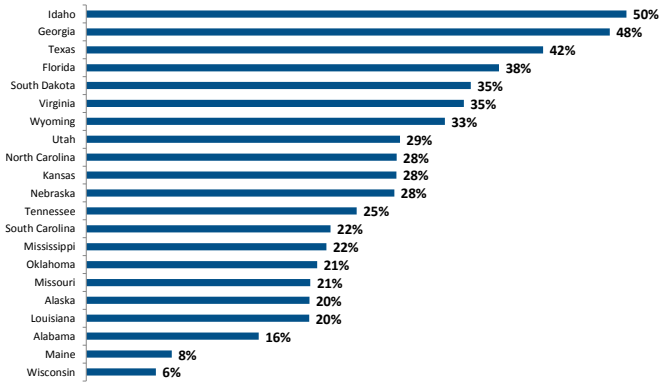
Cost in billions:



Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

Figure 6

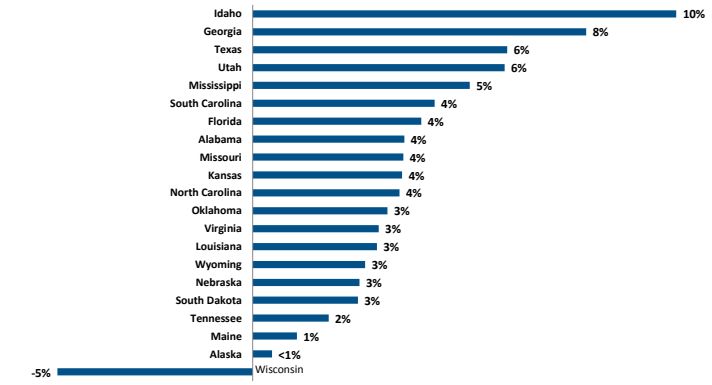
Estimated Difference in Federal Expenditure with Expansion, By State, 2015-2024



Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

Figure 7

Estimated Change in State Medicaid Spending if Non-Expansion States Expanded Medicaid, 2016



Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

It is important to keep in mind that Medicaid expansion affects state budgets in other ways than the amount spent on the care of those enrolled. States can realize savings in other areas that offset these increases. We discuss some of these savings in more detail below.

Reductions in Uncompensated Care

As discussed above, if all states were to expand Medicaid, there would be 4.3 million fewer uninsured people in 2016. Fewer uninsured people would lead to lower spending on uncompensated health care. A recent study found that, in 2013, those uninsured for a full year paid for an average of 30 percent of their care themselves, while the remaining 70 percent of health care expenditures were uncompensated.[5] Based on this research, we estimate that between 2015 and 2024, uninsured people in states not expanding Medicaid would consume $266 billion in uncompensated care under current Medicaid policy decisions. Were these states to expand Medicaid, the amount of uncompensated care over this period would fall to $185 billion.

The authors of the study cited above also estimated that, overall, 24 percent of uncompensated care was funded by state and local governments. State and local savings on uncompensated care could be difficult to realize. State and local funding of uncompensated care is often very complex, and it will likely be difficult politically to reduce payments to providers. We estimated potential state and local government savings assuming that they could realize savings of between 25 percent and 50 percent of the reduction in the state and local share of uncompensated care provided. Under these assumptions, we estimate that states would see between $5 and $10 billion in uncompensated care savings over the next 10 years. (Table 4)

Discussion

If the 21 states that have not expanded Medicaid were to do so, 4.3 million more people would have health coverage in 2016. Many of the states that have decided against Medicaid expansion are those who would gain the most. This applies when examining the impact of expansion on the uninsured, increases in federal Medicaid funding, or reductions in uncompensated care. Wisconsin would spend less on Medicaid if it expanded eligibility, even without taking into account any other sources of state savings. Most other expansion states would see state Medicaid spending increase by 2 to 6 percent. We estimate that Idaho and Georgia would see larger percent increases. These increases do not accurately reflect the overall impact of Medicaid expansion on the state budget. Reduced costs for uncompensated care are one of several sources of savings that would help to mitigate that increase in state costs. Assuming that states only realize 25 to 50 percent of the reduction in their share of uncompensated care, those savings would offset 13 to 25 percent of the total increase in state Medicaid spending due to expansion. In addition, states could realize other types of budgetary savings and increases in revenue if they expanded Medicaid that are not included in this report.

While this report provides estimates of the coverage and fiscal effects of Medicaid expansion, there are data and analysis that support the estimates. The latest data from CMS show that as of January 2015, 70.0 million people were enrolled in Medicaid or CHIP. Between summer 2013 and January 2015, there was a net increase of nearly 11.2 million people enrolled in Medicaid and CHIP among the 49 states reporting data for both periods. Most of this growth was in large states in the West that implemented the Medicaid expansion. States that expanded Medicaid experienced significantly greater net Medicaid and CHIP enrollment growth between summer 2013 and January 2015 than states that have not expanded. Nationally, total Medicaid and CHIP

enrollment grew by 19% between summer 2013 and January 2015. States that implemented the Medicaid expansion experienced over three times greater enrollment growth compared to states where the Medicaid expansion is not in effect (26% vs. 8%).[6] States that have not implemented the Medicaid expansion are also experiencing increases in enrollment due to simplified and streamlined enrollment systems as well as outreach and enrollment efforts for enrollment in Marketplace coverage that have resulting in higher Medicaid participation among those already eligible.

Similarly, several surveys that have shown notable increases in health coverage in 2014 under the ACA, particularly among states that have expanded Medicaid.[7] The decision not to adopt the Medicaid expansion has already begun to create inequities in coverage between states.

In making decisions about expansion, states are also considering fiscal implications. This paper does not attempt to assess the overall impact of Medicaid expansion on state budgets. Our analysis is limited to effects that can be estimated on a 50-state basis. Medicaid expansion has many other, highly significant state fiscal consequences that cannot be quantified without state-specific information. If those factors were taken into account, the state budget effects of expansion would be much more favorable than what we show above.

Numerous studies where a combination of public and private research has examined fiscal effects in all relevant categories—that is, state costs from increased Medicaid enrollment, state savings from increased federal match for current beneficiaries, state savings on non-Medicaid health care costs, and state revenue effects of expansion—have shown that, on balance, Medicaid expansion would help, not hurt state budgets over a multi-year period extending well beyond 2016. Recent state budget projections from expansion states confirm this analysis. Washington State has projected net savings of $79.0 million in state fiscal year 2014 and $258.7 million in 2015 due to expansion.[8] Analysis by Deloitte estimated that Kentucky would spend $919.1 million less between state fiscal years 2014 and 2021 due to Medicaid expansion.[9] These reports point to savings both within and outside state Medicaid programs (in areas such as mental health spending and corrections) as well as increases in revenue resulting in net fiscal savings to states as a result of implementing the expansion. The Kentucky report also points to increases in jobs as a result of the Medicaid expansion.

There is also evidence that the ACA is already having an impact on health care provided to the uninsured. A number of reports are finding that hospitals in Medicaid expansion states showed overall declines in self-pay and charity care, while hospitals in non-expansion states showed no change beyond normal variation.[10] Hospitals, however, are also likely to see some reductions in federal reimbursement from Medicare and Medicaid DSH as well as reductions in future increases to Medicare fee-for-service hospital payments that were included in the ACA. Medicaid DSH reductions were originally scheduled to go into effect beginning in FY 2014 but have been delayed to 2018. Hospitals in states that do not implement the Medicaid expansion will face these reductions without also seeing increases in Medicaid revenue from additional coverage.

States account for a number of factors in making decisions about adopting the Medicaid expansion; however, based on this analysis we conclude that the economic case for Medicaid expansion for state officials is extremely strong.

This brief was prepared by Matthew Buettgens, John Holahan, and Hannah Recht of the Urban Institute.

Table 1. Medicaid Enrollment in 2016 (Thousands)										
	Medicaid Enrollment without Expansion				Medicaid Enrollment with Expansion				Difference	
	Disabled	Non-disabled Adults	Non-disabled Children	Total	Disabled	Non-disabled Adults	Non-disabled Children	Total	Total Change	Percent Change
Total	**4,040**	**3,627**	**9,727**	**17,395**	**4,086**	**9,997**	**10,253**	**24,336**	**6,941**	**40%**
Alabama	230	143	346	718	232	408	371	1,011	293	41%
Alaska	18	32	65	115	18	57	65	141	25	22%
Florida	625	526	1,459	2,610	632	1,639	1,527	3,798	1,188	46%
Georgia	322	221	824	1,367	327	798	874	2,000	633	46%
Idaho	41	23	105	168	42	114	115	271	103	61%
Kansas	73	41	155	270	74	162	169	405	135	50%
Louisiana	213	185	459	857	215	474	475	1,164	308	36%
Maine	74	75	79	228	74	134	80	287	60	26%
Mississippi	172	91	296	559	174	285	315	775	216	39%
Missouri	198	148	416	762	201	441	446	1,088	326	43%
Nebraska	38	32	112	181	38	105	118	261	80	44%
North Carolina	337	325	759	1,420	341	811	786	1,937	517	36%
Oklahoma	120	124	356	601	122	317	373	812	211	35%
South Carolina	169	183	383	735	171	424	400	995	260	35%
South Dakota	20	18	61	99	20	57	65	142	42	43%
Tennessee	302	309	603	1,213	303	584	618	1,505	292	24%
Texas	684	444	2,301	3,429	694	1,994	2,457	5,146	1,717	50%
Utah	43	67	153	263	44	179	168	391	128	49%
Virginia	185	144	429	758	187	438	457	1,083	325	43%
Wisconsin	166	485	327	977	166	540	329	1,034	57	6%
Wyoming	11	11	41	63	11	35	43	89	26	42%
Source: Urban Institute Analysis based on HIPSM-ACS, 2015.										

Table 2: Number of Uninsured in 2016 (Thousands)				
	Number of Uninsured Without Expansion	Number of Uninsured With Expansion	Difference	Percent Difference
Total	**14,057**	**9,789**	**-4,267**	**-30%**
Alabama	436	259	-177	-41%
Alaska	66	48	-17	-26%
Florida	2,587	1,837	-750	-29%
Georgia	1,249	860	-389	-31%
Idaho	161	103	-59	-36%
Kansas	233	156	-77	-33%
Louisiana	488	295	-193	-40%
Maine	92	52	-40	-44%
Mississippi	332	192	-139	-42%
Missouri	485	294	-191	-39%
Nebraska	128	87	-42	-33%
North Carolina	1,021	709	-313	-31%
Oklahoma	422	295	-127	-30%
South Carolina	490	330	-160	-33%
South Dakota	58	33	-25	-43%
Tennessee	562	383	-179	-32%
Texas	4,076	2,969	-1,107	-27%
Utah	263	195	-68	-26%
Virginia	628	448	-179	-29%
Wisconsin	233	212	-21	-9%
Wyoming	46	32	-14	-30%
Source: Urban Institute Analysis based on HIPSM-ACS, 2015.				

Table 3: Medicaid Expenditures, 2015–2024 ($ Billions)								
	Federal Expenditures				State Expenditures			
	ACA Without Expansion	ACA With Expansion	Difference	Percent Difference	ACA Without Expansion	ACA With Expansion	Difference	Percent Difference
Total	**1,551.5**	**2,023.6**	**472.1**	**30%**	**970.8**	**1,009.0**	**38.2**	**4%**
Alabama	56.2	65.0	8.9	16%	26.3	27.3	1.0	4%
Alaska	14.1	17.0	2.9	20%	14.1	14.2	0.1	0%
Florida	206.9	285.2	78.3	38%	145.0	151.1	6.0	4%
Georgia	99.5	147.3	47.8	48%	51.4	55.6	4.2	8%
Idaho	20.8	31.1	10.3	50%	8.2	9.1	0.9	10%
Kansas	29.4	37.8	8.4	28%	22.3	23.1	0.8	4%
Louisiana	74.7	90.0	15.3	20%	47.8	49.3	1.5	3%
Maine	27.0	29.1	2.1	8%	16.8	17.0	0.2	1%
Mississippi	58.0	70.7	12.8	22%	21.4	22.5	1.1	5%
Missouri	87.2	105.1	17.9	21%	53.4	55.3	2.0	4%
Nebraska	19.6	25.1	5.5	28%	16.2	16.6	0.4	3%
North Carolina	146.6	188.3	41.7	28%	76.2	79.0	2.8	4%
Oklahoma	53.0	64.3	11.2	21%	29.8	30.8	1.0	3%
South Carolina	67.6	82.8	15.2	22%	28.2	29.5	1.3	4%
South Dakota	9.2	12.5	3.2	35%	8.0	8.2	0.2	3%
Tennessee	101.0	126.0	25.0	25%	53.7	54.7	1.0	2%
Texas	305.7	433.8	128.1	42%	215.2	228.7	13.5	6%
Utah	26.0	33.5	7.5	29%	11.0	11.7	0.7	6%
Virginia	67.0	90.2	23.2	35%	67.0	69.1	2.1	3%
Wisconsin	75.8	80.7	4.8	6%	52.6	50.0	-2.5	-5%
Wyoming	6.2	8.2	2.0	33%	6.2	6.3	0.2	3%

Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

Table 4: State Spending on Uncompensated Care, 2015–2024 ($ Millions)				
	ACA without Expansion	ACA with Expansion	Potential State Savings due to Expansion	
			Low (25%)	High (50%)
Total	**63,870**	**44,425**	**4,861**	**9,723**
Alabama	2,113	1,184	232	464
Alaska	424	251	43	87
Florida	12,545	8,598	987	1,974
Georgia	5,247	3,510	434	868
Idaho	749	551	50	99
Kansas	1,248	850	99	199
Louisiana	2,004	1,257	187	373
Maine	594	365	57	115
Mississippi	1,569	1,064	126	253
Missouri	3,393	2,010	346	691
Nebraska	628	476	38	76
North Carolina	5,406	3,641	441	883
Oklahoma	2,371	1,582	197	394
South Carolina	1,743	1,254	122	244
South Dakota	244	202	10	21
Tennessee	2,672	1,843	207	415
Texas	14,859	11,055	951	1,902
Utah	1,375	1,026	87	174
Virginia	3,089	2,289	200	400
Wisconsin	1,312	1,208	26	52
Wyoming	284	208	19	38

Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

ENDNOTES

[1] Beginning in 2014, the higher FMAP for newly-eligible Medicaid beneficiaries is available for non-elderly, non-disabled adults with incomes up to 138% FPL who would not be eligible for Medicaid under the rules that a state had in place on December 1, 2009.

A few states had already expanded coverage to parents and childless adults up to 100% FPL or to higher income levels across the state at the time the ACA was passed. Costs related to these populations qualify for the "expansion" or "transition" FMAP instead. In recognition of these states already provided coverage at these higher Medicaid eligibility levels, these states can receive a phased-in increase in their federal matching rate for adults without dependent children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults. In addition, expansion states that do not have any newly-eligible Medicaid beneficiaries because they already covered people up to 138% FPL or higher (e.g. Massachusetts) also receive a temporary (January 1, 2014 through December 31, 2015) 2.2 percentage point increase in their federal matching rate for all populations.

For more information on how claiming works for the Medicaid expansion, please see the following brief:

Robin Rudowitz, Understanding How States Access the ACA Enhanced Medicaid Match Rates. (Washington, DC: Kaiser Family Foundation,) September 2014. http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/.

[2] More information about methodology can be found at "Further Methodological Information for 'Tax Preparers Could Help Most Uninsured Get Covered,'" accessed May 7, 2014, http://www.urban.org/health_policy/health_care_reform/taxfilingmethodology.cfm and Urban Institute. "The Urban Institute's Health Microsimulation Capabilities," Washington, DC: Urban Institute, 2010, http://www.urban.org/publications/412154.html.

[3] John Holahan, Matthew Buettgens, and Stan Dorn, *The Cost of Not Expanding Medicaid*, (Washington, DC; The Kaiser Commission on Medicaid and the Uninsured; July 2013) http://kff.org/medicaid/report/the-cost-of-not-expanding-medicaid/; John Holahan, Matthew Buettgens, Caitlin Carroll, Stan Dorn, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, Kaiser Commission on Medicaid and the Uninsured, November 2012, http://kff.org/health-reform/report/the-cost-and-coverage-implications-of-the/

[4] Matthew Buettgens (2011) HIPSM Methodology. The Urban Institute, Washington, DC. http://www.urban.org/research/publication/health-insurance-policy-simulation-model-hipsm-methodology-documentation

[5] Teresa A. Coughlin, John Holahan, Kyle Caswell, and Megan McGrath (2014) Uncompensated Care for the Uninsured in 2013: A Detailed Examination. The Urban Institute. Washington, DC. http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

[6] Samantha Artiga, Robin Rudowitz, Alexandra Gates and Laura Snyder, *Recent Trends in Medicaid and CHIP Enrollment as of January 2015: Early Findings from the CMS Performance Indicator Project* (Washington, DC; The Kaiser Commission on Medicaid and the Uninsured; March 2015). http://kff.org/medicaid/issue-brief/recent-trends-in-medicaid-and-chip-enrollment-as-of-january-2015-early-findings-from-the-cms-performance-indicator-project/

[7] Sharon K. Long, Michael Karpman, Genevieve M. Kenney, Douglas Wissoker, Nathaniel Anderson and Stephen Zuckerman (2015) "QuickTake: Taking Stock: Health Insurance Coverage under the ACA as of December 2014." The Urban Institute, Washington, DC;

HHS/ASPE (2015) Health Insurance Coverage and the Affordable Care Act. http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

[8] Stan Dorn, Norton Francis, Robin Rudowitz, and Laura Snyder (2015) "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Kaiser Commission on Medicaid and the Uninsured. http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states

[9] Dorn, et al. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/

[10] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Insurance Expansion, Hospital Uncompensated Care and the Affordable Care Act," March 23, 2015, http://aspe.hhs.gov/health/reports/2015/MedicaidExpansion/ib_UncompensatedCare.pdf; Teresa A. Coughlin, Sharon K. Long, Rebecca Peters, Robin Rudowitz and Rachel Garfield. *Evolving Picture of Nine Safety-Net Hospitals: Implications of the ACA and Other Strategies*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), April 2015, http://kff.org/health-reform/issue-brief/evolving-picture-of-nine-safety-net-hospitals-implications-of-the-aca-and-other-strategies/. Peter Cunningham, Rachel Garfield, Robin Rudowitz. *How Are Hospitals Faring Under the Affordable Care Act? Early Experiences from Ascension Health*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), April 2015, http://kff.org/health-reform/issue-brief/how-are-hospitals-faring-under-the-affordable-care-act-early-experiences-from-ascension-health; Colorado Hospital Association. "Impact of Medicaid Expansion on Hospital Volumes." ACA Center for Health Information and Data Analytics. June 2014. http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014.aspx.

Ready, Set, Enroll

April 2015 Update

Evolving Enrollment Support Models at California Community Health Centers

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Introduction

Since coverage expansion was implemented under the Affordable Care Act in January 2014, California has experienced significant growth in Medi-Cal (California Medicaid program) and new enrollment into Covered California (state health benefit exchange). Community Health Centers (CHCs) have played an essential role across California by engaging existing patients, leading community outreach and education efforts, and playing a central role in providing in-person enrollment, renewal and post-enrollment support to many of California's most vulnerable residents.

In addition to briefly reviewing statewide enrollment trends, this enrollment brief highlights CHC second year enrollment experiences, evolving enrollment and client engagement strategies, and important changes in the service and staffing models that CHCs are using to provide enrollment support services. This enrollment brief also reviews in detail the President's 2014 executive action on immigration, its potential impact on Medi-Cal eligibility and emerging CHC strategies to support coverage enrollment by undocumented clients. Key findings include the following:

- Most CHCs reported meaningful decreases in the number of Covered California and Medi-Cal applications they supported during the 2014-15 Open Enrollment period compared to 2013-14;
- Statewide, more than 6 out of every 10 completed enrollments during the second Open Enrollment period were for Medi-Cal, highlighting a continued trend in high Medi-Cal enrollment and capping a 41% annual growth in statewide Medi-Cal enrollment;
- Though coverage renewal and churn experiences have varied widely, CHCs highlighted common concerns, such as poor/incomplete member communication about the Medi-Cal renewal process, and lack of continuity of care and coverage gaps for enrollees moving between programs, among others;
- More complex client service needs, seasonal changes in enrollment volume, the need for highly trained staff, and uncertain future funding to support enrollment staffing, among other issues, are prompting CHCs to re-evaluate enrollment support service models and staffing levels;
- If allowed to move forward, the President's executive action could make up to 1.2 million California residents, or half of the undocumented population, newly eligible for DACA or DAPA deferred actions status. Provided they meet other Medi-Cal requirements, many of these residents could also be eligible to enroll in state-funded full scope Medi-Cal, suggesting a potentially significant coverage expansion opportunity.

In addition to synthesizing publicly available data and research, interviews were conducted with five Community Health Centers (CHCs) in California and one regional consortia, including: Alameda Health Consortium (Alameda County); AltaMed Health Services (Los Angeles County); Clinica Sierra Vista (Kern and Fresno Counties); Community Health Alliance of Pasadena (Los Angeles County); Marin Community Clinics (Marin County), and; San Ysidro Health Center (San Diego County).

Funded by Blue Shield of California Foundation, this enrollment brief is the last of four quarterly updates describing statewide Medi-Cal and Covered California enrollment trends, community health center (CHC) enrollment experiences and best practices, and key enrollment policy and implementation issues affecting enrollment entities in California. All of the "Ready, Set, Enroll" reports can be found at **pachealth.org**.

Covered California and Medi-Cal Enrollment Trends

Covered California

An estimated 495,073 Californians have enrolled and selected a Covered California Qualified Health Plan during the 2014-15 Open Enrollment Period (thru February 2015), representing 35% of the prior Open Enrollment period volume. Although data is not yet available on how many enrollees have also paid their first premium, during the first Open Enrollment period 80% of enrollees paid their premium. Other notable trends during the second Open Enrollment period include the following:

- *Proportional Increase in Latino and Young Adult Enrollment* – Latinos accounted for 37% of enrollments compared to 31% percent in the first year. In contrast, Asians made up 23% of first year enrollments and only 18% of second year enrollments. Young adults aged 18-34 represented 34% of second year enrollments compared to 29% in the first year.[1]

- *Minor Changes in the Enrollment Channel* – Reliance on Certified Insurance Agents and Service Center Representatives both increased in the second year, whereas self-enrollment decreased from 41% of enrollments in the first year to 30% in the second year. [2]

- *High Rate of Renewal* – An estimated 92% of continuing enrollees successfully renewed coverage.[3]

- *Service Channel* – Reliance on Certified Insurance Agents and Service Center Representatives both increased in the second year, whereas self-enrollment decreased from 41% in 2013-14 to 30% of enrollments in 2014-15.[4]

Medi-Cal

Eligible Californians can enroll into Medi-Cal at any time and are not limited to enrollment during the Covered California Open Enrollment period. Between December 2013 and January 2015 Medi-Cal enrollment increased by 3,568,638 individuals, or 41%. As of January 2015, an estimated 12,170,138 Californians were enrolled into Medi-Cal.[5]

- *High Medi-Cal Enrollment During Open Enrollment Periods* – Medi-Cal enrollment has far outpaced Covered California enrollment in the first two years. In total, more than 2.71 million Californians completed Medi-Cal applications during the 2013-14 and 2014-15 Covered California Open Enrollment periods compared to 1.89 million individuals that enrolled and selected a Covered California Qualified Health Plan.

- *Uncertain Renewal Rates* – The Department of Health Care Services (DHCS) estimates that up to 1 million Medi-Cal enrollees per month will be up for renewal. Historically, about 80% of Medi-Cal enrollees have renewed coverage on time, but up-to-date data on Medi-Cal terminations and renewal is not yet available.[6] Several factors may impact renewals in 2015, including the introduction of a longer and more complicated renewal form, sunset of a temporary one-year renewal postponement for Low Income Health Program (LIHP) and other enrollee categories, and high caseload demands at county eligibility offices, among other factors.

[1] "Covered California's Second Open Enrollment Yields Strong Numbers: Nearly 500,000 New Consumers Sign up for Health Plans". Covered California News Release, March 5, 2015.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Medi-Cal Monthly Eligibles Trend Report for January 2015, Department of Health Care Services http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx
[6] "Possible Explanation Offered for Delayed Medi-Cal Termination Data". California Healthline, March 16, 2015. http://www.californiahealthline.org/capitol-desk/2015/3/possible-explanation-for-slow-medical-data

- *High Volume of Coverage Transitions* – Due to changes in income, employment and household circumstances, as many as 1 in 6 enrollees are annually expected to have their eligibility shift between Covered California and Medi-Cal.[7] Through January 2015, an estimated 100,000 individuals transitioned from Covered California to Medi-Cal. To date, no information is available on the number of individuals transitioning from Medi-Cal to Covered California.

2014-15 Open Enrollment Experiences at Community Health Centers

Select community health centers (CHCs) were asked to describe overall enrollment support experiences during the 2014-15 Open Enrollment period, key differences from the 2013-14 Open Enrollment period, Covered California and Medi-Cal renewal support experiences and strategies, and initial thinking about how to structure enrollment support services at their organizations for the long-term. The following section highlights key themes and findings from these conversations.

Demand for Enrollment Support

Big Decreases in New Enrollment Demand. Most CHC interviewees reported a 20% or greater decrease in the number of combined new Medi-Cal and Covered California enrollments processed by their agency. Several respondents also indicated that unlike the first year where there was strong early demand, enrollment activity was relatively slow until a rush during January and February. With an understanding that much of the demand in the prior year was driven by enrollment of existing patients and others highly motivated to gain coverage, CHCs reported testing new strategies, such as targeted advertising and community outreach, to generate demand. None of the respondents, however, reported a lot of success from these efforts.

Multiple Factors Contributed to Low Demand. In addition to the understanding that many of the remaining uninsured represented hard to reach populations (e.g. non-patients, mixed immigration families with fears about the process, those skeptical about the program), participating CHCs shared their perspectives about other contributing factors, including: short and ill-timed open enrollment period that straddled the winter holidays and preceded the tax season when most individuals became aware about the tax implications; decreased visibility due to reduced marketing and media coverage, and; more aggressive advertising and presence by Certified Insurance Agents seeking to provide application assistance services.

Renewal and Churn

Varied Demand for Renewal Support. CHCs reported varied levels of client demand for support with the renewal process. Not surprisingly, those CHCs that experienced more demand for renewal support in both Medi-Cal and Covered California tended to have more aggressive renewal strategies in place, such as mailings, automated calls, text message reminders and use of outbound call centers.

- *Medi-Cal Renewal Challenges* – Most CHCs shared concerns about the timeliness of communication to Medi-Cal members about the renewal process. Often pointing to overwhelmed county eligibility offices, CHCs commonly reported that many individuals and families failed to renew because they did not receive renewal packages. Others highlighted client confusion related to receiving renewal notices that were difficult to understand and complicated.

- *Covered California Needs* – Most CHCs reported minimal demand for Covered California renewal support. Those that did experience higher demand highlighted a few common client needs, such as help interpreting multiple and confusing letters, selecting new plans or understanding their options for renewing with their current plan.

[7] "The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal". UC Berkeley Center for Labor Research and Education, April 2014.

Wide Variation in Degree of Program Churn. Overall, CHCs reported a wide variation in the degree to which clients moved between Medi-Cal and Covered California. Some interviewees reported seeing more movement from Medi-Cal to Covered California, whereas others reported just the opposite. Despite the different experiences, they highlighted some important challenges:

- *Continuity of Care* – Since Covered California and Medi-Cal provider networks are not the same, some clients found that their medical provider was not contracted with their new plan. CHCs highlighted this as a big barrier in retaining continuity of care for clients.
- *Transition Challenges* – Some clients moving from Covered California to Medi-Cal were pushed into the Medi-Cal backlog resulting in a gap in coverage. On the other side, some Medi-Cal enrollees determined eligible for Covered California were unable to complete the enrollment because they still had "active" Medi-Cal cases. Due to heavy caseloads among county eligibility workers, Medi-Cal terminations were not always timely.
- *Client Concerns* – Some clients did not want to change programs. For Medi-Cal enrollees moving into Covered California, the common concern was premium cost. Some Covered California enrollees who became eligible for Medi-Cal expressed concern about moving into a government program, limited provider networks and access issues.

Evolving the Enrollment Support Model

More Client Needs. Beyond direct application assistance, clients are now seeking broader guidance on navigating health plan choices, understanding how health insurance works, paying the premium, and selecting a provider, among other needs. Stated one CHC, "enrollment support requires time-intensive education and support to obtain and maintain coverage, utilize benefits and keep their medical home". Another CHC shared that over 30% of CEC time is now dedicated to post-enrollment support for their clients.

Enrollment as a Service Entry Point. Similarly, some CHCs reported that enrollment support services are emerging as a potentially important point of contact for either providing or linking clients to other complimentary services, such as immigration guidance, social services, case management or patient education services. According to several CHC interviewees, clients come to them not just because of the enrollment services they offer but because of the relationships and trust they have built in the community. Reflected one interviewee, "the question is how can we leverage these relationships?"

More Complex Staff Responsibilities and Training Requirements. As a result of an expanded scope of work, CHCs reported they are now identifying a broader skill set required to effectively provide enrollment support services. This includes knowledge of Medi-Cal and Covered California rules and options, client case management through the application process, ability to coach and educate on insurance choices, post-enrollment support, renewal support, community outreach and effective data tracking. Remarked one CHC, "the job is different now. It's a lot more complex then it used to be."

Boom and Bust Seasonality. Most CHCs increased staffing to accommodate high enrollment demand but are now challenged to provide adequate levels of service during open enrollment while also ensuring efficient and optimized staffing during down seasons. Anticipated shorter open enrollment periods, fewer new enrollments compared to renewals and unreliability of one-time funding further exacerbate this challenge.

Re-Thinking Staffing and Service Models. The issues discussed above, such as more complex service requirements, the need for highly trained staff, seasonal demand, and uncertain future funding, among other factors, are prompting CHCs to re-evaluate staffing and service models. While some are looking to modify or expand staff roles, others are looking at alternative staffing models/levels to balance changing demands:

- *Reduced CEC Staffing* – Due to reduced new enrollment demand and concern about external enrollment funding, several CHCs reported examining potential reductions in CEC positions.
- *Temporary Staffing* – Use of temporary CEC positions during open enrollment periods can allow CHCs to meet client demand without unnecessary full time staff increases. But, it also poses challenges related to sufficient training and onboarding for a complex service.
- *Cross-Training* – Most CHCs reported cross-training CECs in other areas, such as referral coordination and Medi-Cal retention, where they dedicate additional time when open enrollment periods are over.
- *Specialization* – Given the increased complexity and scope of client needs, developing staff teams to specialize in new enrollment, Covered California vs. Medi-Cal, retention, case management and post-enrollment support ensures that the organization has clearly committed resources to meet its most critical needs and highly effective staff.

Evolving the Enrollment Workforce
Clinic Spotlight – Community Health Alliance of Pasadena

Community Health Alliance of Pasadena (ChapCare) serves more than 15,000 low-income patients at six health centers in the San Gabriel Valley region of Los Angeles. In addition to enrolling existing patients, ChapCare invested heavily in education and enrollment of the broader community through outreach/education events, education via local newspapers and radio, and the opening of stand-alone enrollment centers, among other strategies. As part of this strategy, ChapCare expanded outreach and enrollment staffing to accommodate increased enrollment volume and new activities. Looking ahead, ChapCare is evaluating the required skill sets and appropriate staffing model to provide an effective and efficient enrollment support service.

Stated the Director of Development and Marketing, "Prior to the ACA, [enrollment assisters] had the county program, full scope Medi-Cal and limited scope programs. It was a more basic job – you had to be able to communicate the basics and be trusted". Since coverage expansion, the required skill sets and scope of responsibilities for enrollment staff has expanded significantly. Aside from understanding additional coverage programs and enrollment systems, CECs also have more responsibilities related to customer service, outreach, case management, post-enrollment support and data tracking, among others. Stated the Director of Development and Marketing, "now with health insurance being a lot more complex and our choice of external enrollment centers, there really is a higher level of need for customer service and ability to retain information…. It's a lot more complex of a job." ChapCare has also found a need to adjust compensation in order to attract qualified individuals.

Covered California enrollments supported by ChapCare dropped by about 20% during the 2014-15 Open Enrollment period. With most patients already insured, lower community demand for Covered California enrollment and shorter open enrollment periods in future years, ChapCare is evaluating potential changes to its staffing levels and service approach. This may include reducing traditional outreach activities in favor of a more consistent presence through traditional media and strengthening the role and visibility of their enrollment centers. They may also pilot the use of temporary CEC staffing during open enrollment, but highlight potential challenges around timely hiring, appropriate training, certification and onboarding among other issues.

Adapting the Enrollment Support Model
Clinic Spotlight – AltaMed Health Services

AltaMed Health Services cares for over 180,000 patients in Los Angeles and Orange Counties. AltaMed was the first CHC to establish free-standing enrollment resource centers, along with a robust call center, aggressive patient in-reach campaigns, community outreach and advertising that resulted in more Covered California applications than any other Certified Enrollment Entity in California in both the 2013-14 and 2014-15 Open Enrollment periods.

During the 2014-15 Open Enrollment period, AltaMed experienced important changes in the level and type of client demand. The number of new Medi-Cal and Covered California applications processed by the agency was 28% lower than the first year. However, client support needs remained high. In addition to supporting a high volume of renewals, they reported that more than 30% of CEC appointment time was committed to post-enrollment support. Stated the Vice President, Sales and Marketing, "We saw a lot of people coming in for post enrollment support – help following up with the plans, paying the premium, finding a Spanish speaking health plan representative, a provider in the network". In large part, they see this as a result of the long-standing relationships and trust they have developed with community members.

Looking forward, AltaMed sees the need to ensure that new enrollment and retention is not crowded out by other needs. This may include developing dedicated new enrollment and retention teams. However, they also see an opportunity to leverage existing patient relationships it has developed to better address community needs and take advantage of new opportunities. This could include enhancing partnerships to support residents affected by the President's executive action or attaching other support services to the resource centers. Lastly, their second year experience highlights an intensifying need for health plans to develop more robust new member onboarding systems. Stated the Vice President, Sales and Marketing, "I feel very strongly that health plans need to develop new tools, materials and strategies to orient new members. They need to strengthen their new member onboarding."

Policy Updates

The following sections examines four policy topics, including:

- The impact of the President's 2014 immigration executive action on Medi-Cal eligibility;
- The status of California legislation to extend health insurance coverage to undocumented residents (Lara Bill);
- Status of the benefit and affordability "wrap" programs for pregnant women and newly qualified immigrants (NQIs), and;
- Expansion of full scope Medi-Cal benefits for pregnant women.

Impact of President's Immigration Executive Action on Medi-Cal Eligibility

Although undocumented residents in California are not eligible to purchase coverage through Covered California, those undocumented residents with PRUCOL status (People Residing Under Color of Law) are eligible under California law for full-scope Medi-Cal provided they meet the income, residency and other requirements.

Undocumented residents with PRUCOL status (including DACA and very likely DAPA), are eligible under California law for full scope Medi-Cal provided they meet other eligibility requirements.

Included in the PRUCOL category are those children and young adults who are eligible for the 2012 Deferred Action for Childhood Arrivals (DACA) program, or "Dreamers". If allowed to move forward, it would also include additional undocumented residents included in the DACA expansion and, according to immigration rights advocates, Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) articulated in President Obama's November 2014 Executive Action on Immigration.

Currently, up to 358,000 undocumented children and young adults in California are eligible for DACA under the 2012 program. Up to 1,215,000 additional undocumented residents could be potentially eligible under President Obama's 2014 Executive Action for DACA/DAPA status. This suggests that up to 1,572,000, or about half of all undocumented Californians could become DACA/DAPA eligible.[8] These residents could be eligible to enroll in state-funded full scope Medi-Cal provided they meet Medi-Cal income, residency and other requirements. A recent policy brief by the UC Berkeley Labor Center estimated that up to 57% of Californians eligible for DACA/DAPA had income below the Medi-Cal eligibility threshold and lacked private insurance.[9]

A more detailed description of the DACA and DAPA categories is included below:

- *2012 Deferred Action for Childhood Arrivals (DACA) Program* – Implemented in 2012, DACA provides temporary relief from deportation for young undocumented residents that meet specific age, length of stay and schooling requirements, among others. In order to receive DACA status, eligible residents must complete an application process. The UC Berkeley Labor Center estimated that 58% of DACA eligibles in California submitted applications as of December 2013.[10] Other studies have shed some light on the reasons why remaining DACA eligibles do not complete the application process. Common barriers articulated included economic limitations (e.g. application cost), missing paperwork, legal concerns and fear of sending personal information to the government.[11] If eligible residents are able to complete the application process and receive deferred action status, it is very likely that they could become eligible for Medi-Cal.

If allowed to move forward, the President's executive action on immigration could make up to 1.5 million residents, or half of California's undocumented population, eligible for DACA or DAPA deferred actions status.

[8] "National and State Estimates of Populations Eligible for DAPA and DACA Programs". Migration Policy Institute, January 2015. http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles

[9] "Health Insurance Demographics of California Immigrants Eligible for Deferred Action". UC Berkeley Harbor Center, March 2015.

[10] "Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Demographics and Health Coverage". UC Berkeley Labor Center, February 2014.

[11] "Two Years and Counting: Assessing the Growing Power of DACA". Roberto G. Gonzales and Angie M. Bautista-Chavez, American Immigration Council, Special Report, June 2014

- *Expansion of the Deferred Action for Childhood Arrivals (DACA) Program* – Included in the President's immigration executive action was an expansion of the DACA program to cover young persons who entered the U.S. before their 16th birthday and have lived continuously in the US since January 1, 2010. The expansion also makes eligible to apply those who, in the existing DACA program, had "aged out" by being older than 31 on June 15, 2012. In the expanded DACA program, deferrals and work permits would be issued for three-year renewable periods. The Migration Policy Institute estimates that about 99,000 Californians will become newly eligible under the DACA expansion.[12]

- *Creation of the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) Program* – When implemented, the DAPA program would allow undocumented persons, who have a legal permanent resident or U.S. citizen child, apply for work authorization and protection from deportation. Persons would have to demonstrate that they have been in the country since January 1, 2010. The Migration Policy Institute estimates that about 1,116,000 California parents will become eligible under the proposed DAPA program.[13]

The President's executive actions for the expanded DACA and new DAPA programs have been met with considerable political resistance. On February 16, 2015 a federal district court temporarily blocked implementation of both actions and the federal government has appealed the decision. However, if the executive actions are permitted to move forward, more than 1.2 million additional Californians could become eligible for deferred action status and thus potentially eligible for Medi-Cal.

Interviewed CHCs were asked to describe their experiences providing enrollment support to patients eligible for PRUCOL status (e.g. DACA), as well as key strategies that they think will drive success in the future. Key themes included the following:

- Community members are subject to varied and inaccurate information about PRUCOL from immigration attorneys, the media and other avenues. Confusion and mis-information in the community highlight the importance of effective education/awareness campaigns;

- Immigration enforcement fears remain potent in immigrant communities and are stoked by both the national and local environments and events. The need for trusted community agencies to lead client engagement efforts remains critical;

- Community health centers are uniquely positioned to engage clients given their role as trusted, longstanding community resources and established patient and service relationships with a large number of eligible residents;

- Intensive CEC training on immigration rules and PRUCOL-related enrollment is important given the complexity of application requirements;

- Partnerships with legal aid agencies (and other trusted agencies) can facilitate CEC training, on-site legal aid resources and collaborative community education/awareness campaigns;

- Many county eligibility workers require additional training, knowledge and awareness about PRUCOL eligibility. Strong relationships with county eligibility offices are essential to ensuring that clients receive accurate information and effective enrollment assistance.

[12] "National and State Estimates of Populations Eligible for DAPA and DACA Programs". Migration Policy Institute, January 2015. http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles

[13] Ibid.

Engaging the Immigrant Community
Clinic Spotlight – San Ysidro Health Center

San Ysidro Health Center serves (SYHC) 90,000 patients through its network of 11 clinic sites and 23 program locations throughout the Southern and Central region of San Diego. SYHC's patient population is primarily low-income Latinos (75%). According to the Director of Outreach, "we have over 45 years as a highly trusted organization among immigrant populations. In addition to conducting outreach in areas with high percentage of immigrants, our patients and community members know that they can come to any one of our clinics and get information and assistance without fear or stigma".

In the last year, SYCH implemented several new efforts to increase engagement of the immigrant community, including:

- Bilingual Hotline – The hotline provides an accessible resource for clients to receive guidance from bilingual CECs, as well as complete screening and complete appointments. It has proven very popular and successful with immigrant populations. On average, the hotline handles up to 500 calls per week during the peak of the Open Enrollment period.
- Targeted Outreach Materials – An internally developed "Immigrant Options" flyer includes detailed relevant information for immigrant clients, such as mixed-status families, individuals with sponsors, and DACA eligible. Additional materials addressing immigration enforcement fears, the Medi-Cal Recovery Program, and other topics are also distributed.
- DACA Campaign – SYHC has hired staff who have received DACA deferrals. These staff conduct outreach to young people and students attending regional community colleges to provide education and support.
- Targeted Media – SYHC runs periodic Spanish-language newspaper ads and TV/radio commercials as well as 3-5 minute interviews on popular new stations that highlight immigrant options and seek to dispel common or pervasive myths.

SYHC has also implemented overall service changes to better respond to client needs. This includes implementing a new staffing model where one caseworker is assigned to support multiple CECs by conducting follow-up calls on incomplete applications, checking Medi-Cal eligibility, tracking new Covered California applications for effectuation, and renewal reminder calls, among other tasks. In addition, SYHC's CEC's also serve as a new patient intake and resource specialist, linking patients to a medical home for the first time as well as other needed support services. Stated the Director of Outreach, "[The CECs] have become a catch-all. Once [the client] develops trust, that CEC is theirs". Looking forward, SYHC plans to develop more comprehensive patient support services including care coordination and case management.

Despite these efforts, SYHC remains concerned about high levels of misinformation by Spanish-language media and lingering immigration enforcement fears in the community. Shared the Director of Outreach, "There is still fear about repercussions of enrolling a family member in a mixed-status household. In San Diego, there continues to be anti-immigrant sentiments in addition to deportation fears due to the proximity to the border.

Partnerships to Improve Immigrant Enrollment Support
Clinic Spotlight – Clinica Sierra Vista

Clinica Sierra Vista serves over 160,000 patients in the Central Valley counties of Kern and Fresno. Seventy-four percent of Clinica patients are Latino, many of whom are immigrants and/or farmworkers. Clinica has evolved as a leader of PRUCOL-related education and enrollment services. These efforts began in 2009 when new PRUCOL application requirements were rolled out and intensified in December 2014 when Fresno's indigent program was eliminated.

Clinica has developed an important partnership with the California Rural Legal Assistance Program (CRLA) to ensure that their staff understand PRUCOL rules and clients have other resources available to them. In addition to training Clinica CECs on immigration issues, CRLA places staff at Clinica sites on a regular basis to provide support for patients. The agencies also maintain regular communication about immigration issues.

Similarly, Clinica has invested in strengthening relationships and mutual training with county eligibility agencies. Stated Clinica staff, "A lot of eligibility workers have no idea what PRUCOL is and how to identify eligibles. They need more education…. This is concerning because many individuals go directly to the counties". In one county where Clinica is present, county eligibility workers and Clinica CECs have participated in shared PRUCOL trainings. Clinica also persuaded the County eligibility office to set up a distinct group in the eligibility department to handle all of the PRUCOL applications. This ensures appropriate expertise at the county and better communication throughout the application process.

Recognizing the sensitivity of the topic, the contradictory and confusing information presented to residents by immigration attorneys and others, and their unique role as a trusted community resource, Clinica has also invested in community education. This included a large DACA / PRUCOL education campaign following the launch of the 2012 DACA program. In regards to the President's recent executive action, staff shared, "we are a trusted resource in this community and we will be ready once we have more concrete information to move forward on".

Connecting the Dots in a Changing Coverage Environment
Clinic Spotlight – Marin Community Clinics

Marin Community Clinics (MCC) provides care to over 32,000 low-income patients at several facilities throughout Marin County. An estimated 78% of patients are Latino, many of whom are monolingual Spanish speakers. Since coverage expansion, MCC has increased enrollment staffing, added dedicated enrollment hotlines and email addresses, and invested heavily in community education and collaboration with other agencies. Prompted by an impending termination of the local Healthy Kids program (with transition to the Kaiser Child Health Plan), MCC has more recently begun to develop its PRUCOL-related education and enrollment support.

- *Patient Outreach* – MCC sent letters and made calls to patient families affected by the upcoming Healthy Kids program termination to invite them in for screening and guidance around coverage options. Families are being screened for DACA eligibility, referred to other services as needed, and provided enrollment support if appropriate. In the first couple of months, more than 70 families have been assisted with PRUCOL-related coverage enrollment.
- *Community Collaboration* – MCC learned that many of the agencies that provide DACA application support or other immigration-related guidance are not aware of potential Medi-Cal eligibility for their clients. For example, one community agency assisted 900 individuals with DACA applications but did not provide any education or guidance around Medi-Cal enrollment. MCC is seeking to both increase education and information-sharing between agencies, as well as, build more coordinated approaches to client support. Stated the Outreach and Enrollment Director, "I think one of the biggest challenges is that the organizations are not working together".
- *Staff Training* – MCC is also developing training materials and resources for its staff to ensure that they are providing accurate and appropriate guidance to clients. MCC has reached out to other CHCs, consortia and counties to begin assembling training materials and is pursuing both clinic-specific and collaborative trainings with regional CHCs and other enrollment entities in the county. Additionally, MCC is exploring ways to engage the county eligibility office to ensure that all CECs and eligibility workers receive appropriate training and provide consistent guidance to applicants.

The Lara Bill

Legislation to expand health insurance coverage and other protections to undocumented residents is also under consideration by the California State Legislature. At the center of a 10-bill package focused on undocumented residents is SB 4, introduced by Senator Ricardo Lara. Known as the "Lara Bill", it proposes extending eligibility for full scope Medi-Cal to undocumented individuals who are otherwise eligible for Medi-Cal. The Lara Bill would also enable undocumented residents that exceed Medi-Cal income eligibility thresholds to purchase health insurance from qualified health plans with their own money through the California Health Benefit Exchange (Covered California) and "to make available premium subsidies and cost-sharing reductions to the extent funding is available". [14]

On April 15, 2015 the California Senate Health Committee voted to advance the Lara Bill to the Senate Appropriations Committee for consideration. However, the legislation does not address how the estimated $1.3 billion in annual costs will be funded. [15]

[14] SB 4, April 6, 2015 version as forwarded by the Senate Committee on Health. http://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml
[15] California Senate Committee Oks Bill for Undocumented Health Coverage", California Healthline, April 16, 2015. http://www.californiahealthline.org/articles/2015/4/16/calif-senate-committee-oks-bill-for-undocumented-health-coverage.

Benefit and Affordability "Wrap" Programs for Pregnant Women and Newly Qualified Immigrants (NQIs)

As part of ACA implementation, California created "wrap" programs to provide expanded benefits and premium and cost-sharing assistance for two specific groups that are eligible for both Medi-Cal and tax subsidies in Covered California. The wrap programs will support two populations enrolled in Covered California qualified health plans: 1) pregnant women with income from 138% to 213% FPL; and 2) newly qualified immigrant (NQI) adults – those legally present less than five years -- without dependent children up to 138% FPL. For both populations, California Senate Bill 857, signed by Governor Brown in June 2014, limits the premium and cost-sharing payments DHCS would pay as part of the "affordability" wrap to the amount necessary to pay for the second lowest cost silver plan in Covered California. Qualified health plans would be prohibited from charging or requiring an NQI or pregnant enrollee to make any payments for any services subject to these payments.

In addition, SB857 clarifies that Covered California applicants or current enrollees who are eligible for Medi-Cal based on pregnancy can remain in or enroll in Covered California coverage and receive Medi-Cal coverage for pregnancy-related and postpartum services not covered by the qualified health plan (for example, dental benefits). These enrollees will also receive payment assistance for their premiums and cost-sharing. Pregnant women may also opt to remain in or enroll in Medi-Cal and not enroll in a Covered California plan. The process and all options will be made available to women at the time of applying to the Medi-Cal program or the Exchange and during their enrollment in Medi-Cal or Exchange coverage, as applicable.

DHCS has submitted required approvals to the federal government. The functional modifications to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) are also scheduled but will not be implemented until after required eligibility changes for full-scope pregnancy coverage.

Expansion of Full Scope Medi-Cal Benefits for Pregnant Women

Senate Bill 857 also expands the income eligibility level for full-scope Medi-Cal benefits for pregnant women (with satisfactory immigration status) up to 138% of the federal poverty level (for a family of two, this is an annual income of $22,056). Prior to ACA implementation, the income eligibility cut-off for full-scope benefits in California was 60% of the federal poverty level (FPL) and pregnant women above would receive only pregnancy-related services. This change in the law was necessary to align pregnant women's income eligibility and scope of benefits with other groups' as implemented in the ACA. Eligible pregnant women will select a Medi-Cal managed care plan from which to receive services.

The Department of Health Care Services (DHCS) has submitted required State Plan and 1115 Waiver Amendments to the federal government and expects approvals by April 2015. For this eligibility change to take effect, the law requires functional modifications to CalHEERS. The numerous required modifications are underway and scheduled to roll out throughout 2015.

Conclusion

As trusted organizations that serve (and understand) low-income and vulnerable California communities, community health centers (CHCs) have played a leading role in identifying opportunities to strengthen patient enrollment/renewal experience and systems, as well as testing new strategies and approaches to educate and enroll eligible residents into coverage.

As highlighted in this brief, CHCs continue to explore options to better support the full range of client needs, including providing post-enrollment support services, facilitating medical home connections, considering options to more effectively link clients to other needed services and piloting new strategies targeting immigrant residents. CHCs are also spearheading efforts to develop highly successful enrollment services in ways that are also cost-effective. As California moves forward, CHCs will continue to play a critical role not only in enrolling and retaining individuals into health insurance, but in defining best-practices and cost-effective approaches to enrollment support.

ACA Implementation—Monitoring and Tracking

The Widespread Slowdown in Health Spending Growth

Implications for Future Spending Projections and the Cost of the Affordable Care Act

April 2015

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Robert Wood Johnson Foundation

URBAN INSTITUTE

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

SUMMARY

A recent report from the Congressional Budget Office (CBO) showed another substantial reduction in projected federal spending on the Affordable Care Act (ACA). With these projections now 25 percent lower than CBO's initial ACA estimate for the period 2014-19, there has been renewed attention to the ongoing slowdown in health spending growth. In this paper, we examine the annual health spending projections from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary from February 2010, just prior to enactment of the ACA, through October 2014. Unlike CBO estimates, which are limited to federal spending, the CMS projections include spending by all public and private payers. We consider how the CMS projections have changed since 2010 and examine the factors that have contributed to these changes, particularly the potential role of the ACA in the altered trajectory of national health spending.

In September 2010, CMS first incorporated the provisions of the ACA into its forecast, and predicted that national health expenditures would increase by $577 billion over the 2014-2019 period compared to the pre-ACA baseline (Table 1). This included the costs of public and private coverage expansions, less the reductions in Medicare and Medicaid payments. In October 2014, the current forecast suggested that national health expenditures will be $2.5 trillion less over the 2014-2019 period than under the ACA baseline forecast from September 2010. Over the 2014-2019 period, Medicare spending is now expected to be lower by $384 billion, Medicaid by $927 billion, and private health insurance expenditures by $688 billion compared to the September 2010 ACA baseline. Clearly, not all of the spending reduction is due to the ACA; much is due to the recent recession and a long period of slow income growth, the growth of high deductible private health plans, cost constraints within state Medicaid programs, and Medicare policies unrelated to the ACA (e.g. sequestration).

But it is also likely that the law contributed; though how much is impossible to estimate. The ACA reduced Medicare payments, established a managed care competition framework in the marketplaces, and imposes an excise tax on high cost health plans beginning in 2018. While the estimated impacts of these provisions on spending were incorporated in the ACA baseline and later forecasts, other effects of the ACA may have contributed to the reduction in projected spending, but have not been attributed as such. These include the impact of Medicare payment adjustments on utilization of a wide variety of services, the spillover effects of Medicare payment policies on private payers, and lower than expected premiums in marketplaces due to strong competition and intense negotiations over provider payment rates. Thus, while the exact impact of the ACA cannot be determined, it is clear that the nation has successfully expanded coverage and is now expected to spend considerably less than anticipated even before the law was enacted.

Table 1. Cumulative Spending Projections for 2014-2019

	Pre-ACA Baseline	ACA Baseline	Current Forecast	Original Estimated Impact of ACA for 2014-2019		Current Forecast (2014-2019) Relative to Pre-ACA Baseline		Current Forecast (2014-2019) Relative to ACA Baseline	
	A	B	C	B-A	% change	C-A	% change	C-B	% change
	(in $ billions)								
National Health Expenditures	22973	23550	21012	577	2.5%	-1961	-8.5%	-2538	-10.8%
Medicare	4863	4554	4170	-309	-6.4%	-693	-14.3%	-384	-8.4%
Medicaid	4003	4567	3640	564	14.1%	-363	-9.1%	-927	-20.3%
Private Health Insurance	7102	7694	7006	592	8.3%	-96	-1.3%	-688	-8.9%
Out-of-Pocket	2438	2237	2217	-202	-8.3%	-222	-9.1%	-20	-0.9%
Other	4567	4498	3979	-69	-1.5%	-587	-12.9%	-519	-11.5%

Source: CMS Office of the Actuary.

BACKGROUND

The ACA has been criticized for insufficient attention to cost containment, despite Medicare payment reductions, the managed competition framework in the marketplaces, and the excise tax on high-cost plans.[1] The law was originally forecast to add $577 billion to national health expenditures (NHE) over the 2014–19 period (from $23.0 trillion to $23.6 trillion, or 2.5 percent) (table 1). This included the cost of the coverage expansions, less the savings from reductions in Medicare and Medicaid payments.[2] Since these initial projections were made in 2010, however, national health spending has grown at historically low rates. From 2009 to 2013, national health spending grew at an average annual rate of 3.9 percent.[3] Due to the recent slowdown in spending growth, the current projection of NHE for 2014 to 2019 is $21.0 trillion which is $2.5 trillion lower than under the original ACA forecast in 2010. Both forecasts include the projected costs of the ACA coverage expansion.

The extended debate about the reasons for the recent slowdown in health spending growth has coalesced around two schools of thought. The first contends that the recession and sluggish economic recovery are the dominant reasons for the slowdown.[4,5] This view implies that when the economy rebounds, health expenditure growth will return to previous levels. The second view contends that a range of factors, including but not limited to slow economic growth and low inflation, could have contributed to the slowdown.[6] Factors other than the economy include the movement of more people from private to public insurance with its lower provider payment rates, increased use of higher deductibles and coinsurance in commercial health care plans, a shift to narrow network options in private insurance, patent expirations and increased generic substitution for prescription drugs, and reductions in Medicare payment rates as well as other Medicare initiatives, including those affecting hospital readmissions. These factors generally reduce the flow of revenues and may have caused the health system to make more permanent structural changes to reduce costs. Under this second view, in the absence of very rapid economic growth or a return to looser payment policies by public and private insurers, spending growth rates are likely to remain lower than in the past.

Despite considerable attention to the recent slowdown in spending growth, there has been little focus on how this slowdown has changed future projections of national health spending and how it relates to the cost of the ACA. Although both the original and current forecasts of health spending under the ACA include estimates of the direct effects of major ACA policies expected to affect health spending, they do not account for any potential spillover effects of ACA policies to other payers (e.g., Medicare payment policies on private payers) or other supply-side responses to the new health care environment. Thus, it is possible that the ACA has played an unmeasured role in the recent spending slowdown and the lower projected future spending.

In this paper, we examine the annual health spending projections from the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary beginning just prior to the ACA's passage and explore how those projections have changed over the past several years. We examine the legislative, regulatory, and economic factors that have contributed to changes in the projections over time and consider the potential role of the ACA in the changing trajectory of national health spending.

DATA AND METHODS

We use publicly available reports from the CMS Office of the Actuary beginning with the February 2010 NHE projections prior to the passage of the ACA and followed by projections from September 2010, August 2011, July 2012, October 2013, and October 2014.[7] CMS updates its projections each year with the most recent information on historic health spending, economic conditions, and legislative and regulatory changes. The February 2010 forecast represents the pre-ACA baseline, and the September 2010 projections are the first to include the effects of the ACA (referred to here as the "ACA baseline"). The 2014 forecast (the "current forecast") includes updated information on actual health spending through 2012 as well as legislative and other changes since the original ACA forecast.

We examine projections through 2019 as this is the last year for which we have a pre-ACA prediction. We focus on comparing the current projections for the 2014–19 period to those made just before and just after the passage of the ACA. We examine total NHE as well as Medicare, Medicaid, private health insurance, out-of-pocket (OOP) and other spending. Other spending includes other health insurance programs (Children's Health Insurance Program, US Department of Defense, Veterans Affairs); other third-party payers such as workers' compensation, maternal and child health, and school health programs; public health activity; and investment (e.g., noncommercial research, the value of new construction and new capital equipment in the medical sector). All Medicare projections include the cuts to physician payments required under the sustainable growth rate formula and will therefore understate spending levels if and when the cuts are reversed as they have been each year since 2003.

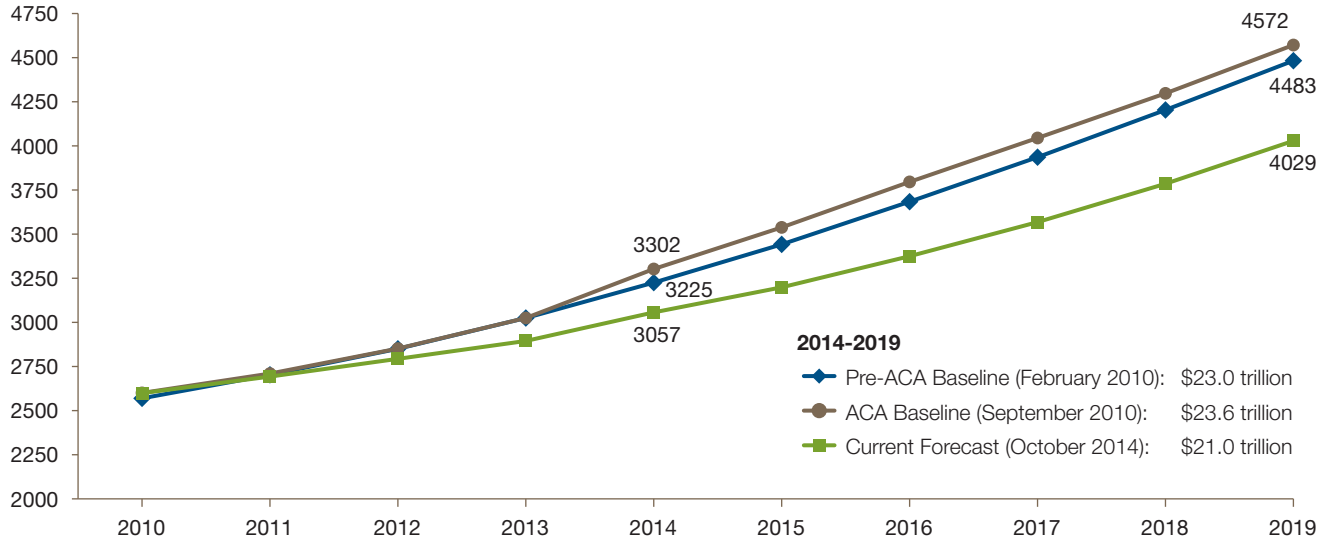
RESULTS

In February 2010, prior to the passage of the ACA, CMS actuaries projected NHE would be $3.2 trillion in 2014, $4.5 trillion in 2019, and $23.0 trillion over the entire 2014–19 period (figure 1). After incorporating estimates of the effects of the ACA, the actuaries increased their projections to $3.3 trillion in 2014, $4.6 trillion in 2019, and $23.6 trillion between 2014 and 2019. Overall, CMS estimated the ACA would increase NHE by $577 billion—or 2.5 percent—from 2014 to 2019.[8] New coverage costs in Medicaid and subsidized private insurance plans were offset somewhat by reductions in Medicare payment rates, Medicare and Medicaid disproportionate share hospital payments, and OOP spending. Under the ACA, Medicaid spending was projected to increase by $564 billion and private health insurance spending by $592 billion from 2014 to 2019, and Medicare and OOP spending were projected to decrease by $309 billion and $202 billion, respectively.

In each subsequent CMS forecast, however, NHE projections were reduced (table 2). In the current forecast, released in October 2014, the spending estimate for 2014 was $3.1 trillion, the 2019 estimate was $4.0 trillion, and the 2014–19 estimate was $21.0 trillion. For the 2014–19 period, these estimates reflect a decline of $2.0 trillion compared to the pre-ACA baseline and a decline of $2.5 trillion compared to the ACA baseline. Medicare spending from 2014 to 2019 is now projected to be $384 billion less than under the ACA baseline. Similarly, private health insurance and Medicaid spending projections for 2014 to 2019 are lower by $927 billion and $688 billion, respectively, than under the ACA baseline (table 1).

Some of these changes can be explained by new legislation and other policy developments (e.g., the Budget Control Act of 2011 and the Supreme Court decision on Medicaid expansion) that have occurred since the ACA baseline forecast in September 2010. But much of the decline in projected spending for the 2014-2019 period seems to be related to the historically low growth in actual health spending that began with the recession in 2008 and has continued to the present. For example, in 2010, health spending growth in 2013 was projected to be a robust 6.1 percent, reflecting the expected economic recovery, but actual health spending growth in 2013 was only 3.6 percent

Figure 1. National Health Expenditure Projections (in $ billions)



Source: CMS Office of the Actuary. All projections include the cuts to physician reimbursement required by the sustainable growth rate formula.

(table 2). As a result of this slow growth, the NHE estimate for 2014 in the current forecast was $246 billion less than it had been in the ACA baseline.[9]

Despite NHE growth that has been at or below gross domestic product growth between 2010 and 2013, however, CMS does not continue to project these low growth rates much beyond 2016. Instead, the current forecast assumes that NHE growth will exceed gross domestic product growth by about half a percentage point in 2016 and 2017, by 0.8 of a percentage point in 2018, and by 1.3 percentage points in 2019. By 2019, the growth in national health spending in the current forecast (6.4 percent) is expected to be the same as in the 2010 ACA baseline. Thus, much of the decline in projected spending for the 2014–19 period is due to the lower spending level in 2014 and slower growth from 2014 to 2016, but not to lower growth rates from 2017 to 2019. But the out-year growth rate projections are considerably higher than recent experience and could prove to be too high for reasons we discuss below. If so, NHE spending between 2014 and 2019 will not reach the current projection of $21.0 trillion.

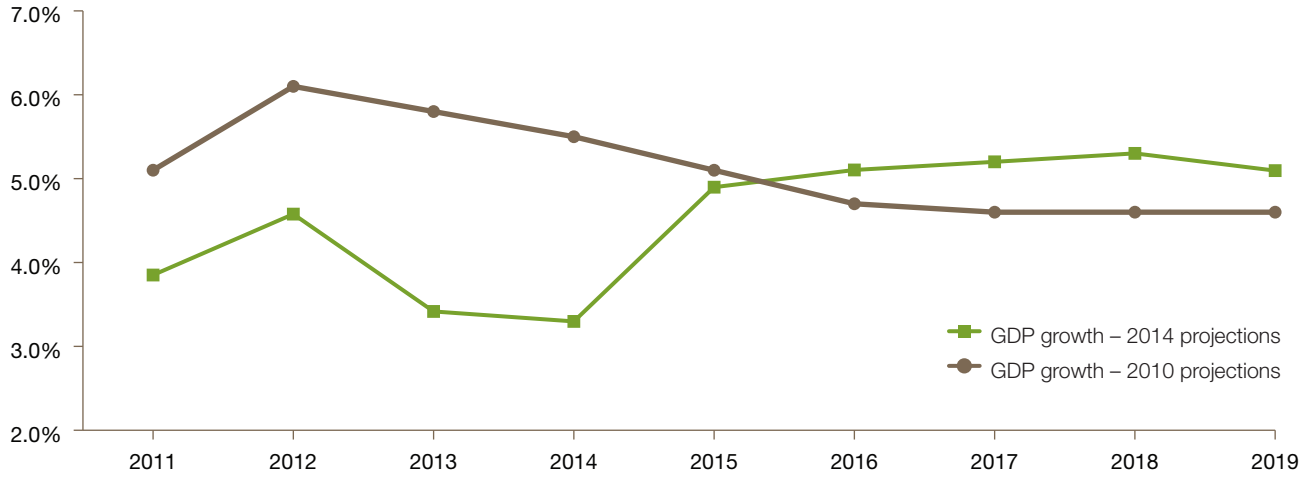
The economy clearly contributed to the observed slowdown since 2010. Gross domestic product growth from 2010 to 2014 was expected to average 5.6 percent in the ACA baseline but actually fell to 3.8 percent in the current forecast (figure 2). In addition to the economy, other likely contributors to the slowdown in health spending growth include Medicare payment and other quality improvement policies, increased prevalence of higher deductibles and narrow networks in private insurance plans, and continued shifts in coverage from employer-sponsored insurance to lower-cost public coverage. The unknown factor, however, is the extent to which the ACA has contributed to the observed slowdown in health spending beyond that incorporated in the ACA baseline.

Both actual and anticipated policy changes under the ACA, including rate reductions and the movement to new payment methods that penalize or shift risk to providers, may have caused private payers to adopt similar policies or have generated cost-cutting responses from providers. If this is true, the observed slowdown in spending growth would not have been as large in the absence of the ACA, and the resulting projections would not have declined so dramatically. To offset the original estimated increase in NHE for the 2014–19 period due to the ACA ($577 billion), the ACA would have to be responsible for approximately 23 percent of the $2.5 trillion decline in projected spending from 2014 to 2019, beyond the cost savings explicitly included in the projections. Although we cannot precisely isolate the ACA impact, it is clear that even with a significant expansion of insurance coverage, current NHE projections are $2.0 trillion less than in the pre-ACA baseline. In the sections that follow we describe some of the observable factors that have contributed to the declining projections since 2010 and consider the extent to which the ACA has also played a role.

Medicare

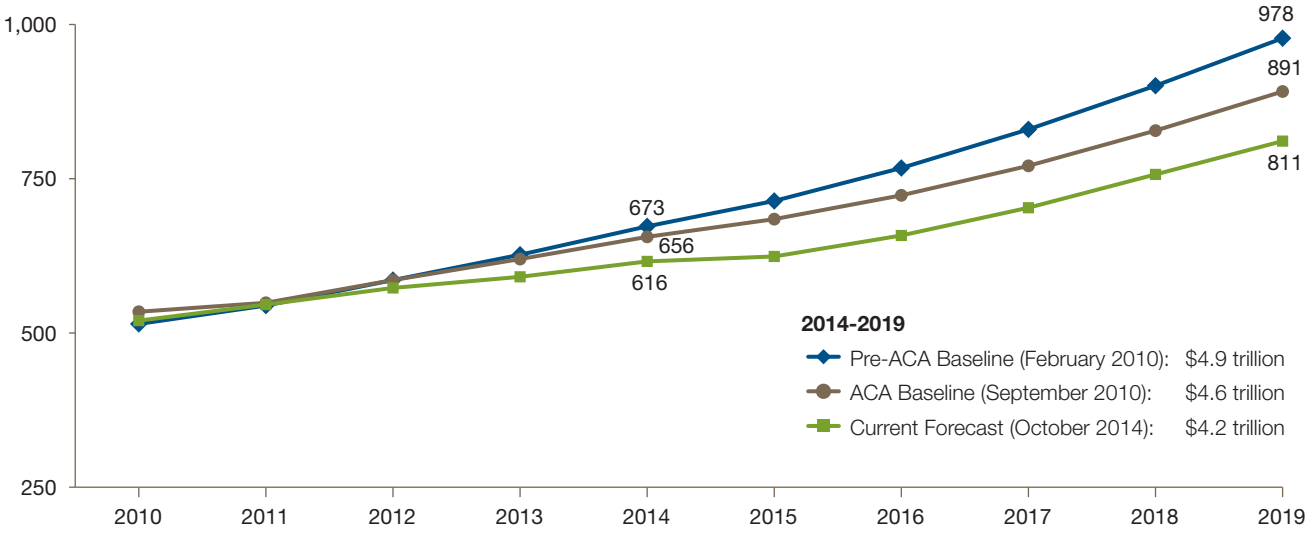
Medicare spending under the ACA was initially forecast to fall by $309 billion (from $4.9 trillion to $4.6 trillion) between 2014 and 2019 compared to the pre-ACA level (figure

Figure 2. Gross Domestic Product (GDP) Annual Growth Rate Projections, 2010-2019



Source: CMS Office of the Actuary. Estimates for 2011-2013 in the 2014 projections are observed GDP growth rates. All others are projections.

Figure 3. Medicare Expenditure Projections (in $ billions)



Source: CMS Office of the Actuary. All projections include the cuts to physician reimbursement required by the sustainable growth rate formula.

3 and table 3). This decrease was primarily due to ACA reductions in payments to Medicare Advantage plans and a requirement to reduce the annual payment updates for most institutional providers by the growth in economy-wide multifactor productivity. In the current forecast, Medicare spending is projected to be an additional $384 billion less between 2014 and 2019 than in the ACA baseline (falling from $4.6 trillion to $4.2 trillion).[10] In 2014, Medicare spending is now projected to be $616 billion, $40 billion less than in the ACA baseline. This decrease is due to lower than expected growth in Medicare spending from 2010 to 2012 which may reflect unanticipated effects of ACA policies including cuts to Medicare Advantage payments in 2011 and reductions in payments to various providers in 2012. Lower spending in 2014 also reflects the effects of the Budget Control Act of 2011 (i.e., sequestration), which required Medicare payments for all types of services to be reduced by 2 percent beginning in April 2013 (table 3). The lower rate of spending growth between 2010 and 2014 in the current forecast compared to the ACA baseline is due entirely to lower growth in spending per enrollee. Enrollment growth averages about 3 percent per year in both forecasts,

but growth in spending per enrollee from 2010 to 2014 averaged 2.3 percent in the ACA baseline compared to 1.2 percent in the current forecast (table 4).

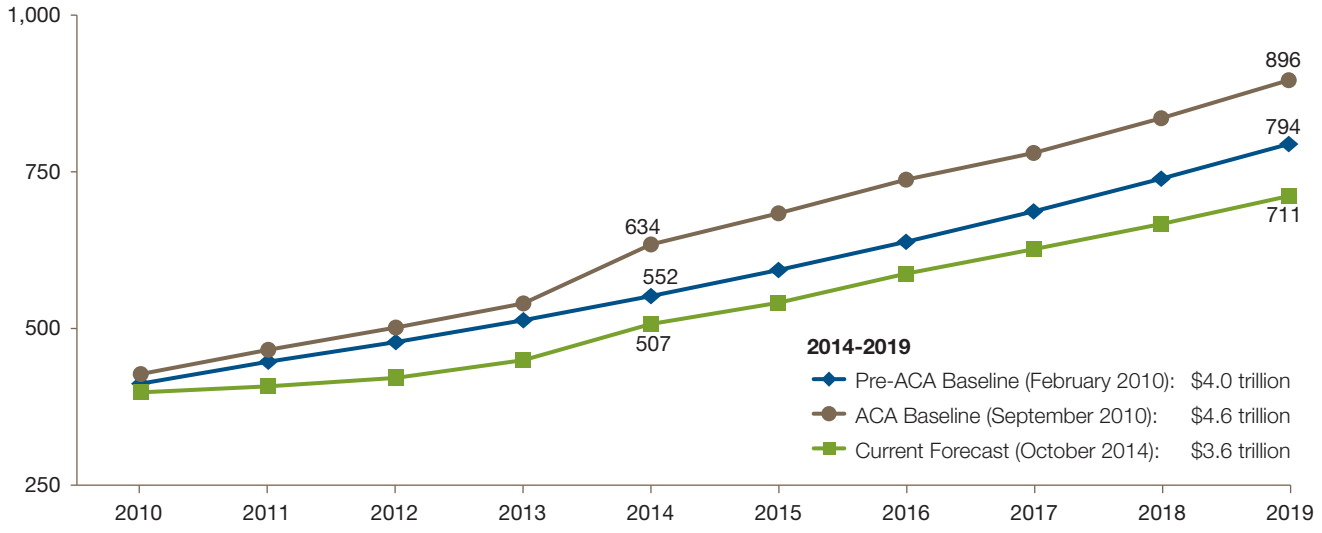
Slow growth is expected to continue in 2015 due primarily to the expiration of the Medicare Advantage Quality Bonus Payment Demonstration.[11] After 2015, however, CMS assumes that Medicare spending growth for both total spending and spending per enrollee will return to rates similar to those included in the ACA baseline. Thus, the large decline in projected spending from 2014 to 2019 in the current forecast compared to the ACA baseline is primarily a result of slow Medicare spending growth in the early part of the decade and the effects of sequestration. It does not appear that CMS assumes any lasting structural changes have contributed to the recent slowdown in Medicare spending growth, but White and colleagues suggest that unanticipated effects of the ACA have contributed to reduced home health spending, hospital readmissions, and utilization of hospital days, outpatient hospital visits, skilled nursing facility days, and advanced imaging prior to 2014.[12] If these and other effects persist and have not been incorporated in the CMS projections, the estimates of Medicare spending from 2014 to 2019 would be overstated.

Medicaid

Medicaid spending from 2014 to 2019 under the ACA was originally expected to increase by about $564 billion (from $4.0 trillion to $4.6 trillion) compared to the pre-ACA forecast (figure 4 and table 5). This increase primarily reflects the ACA expansion of Medicaid eligibility to those with incomes below 138 percent of the federal poverty level. In the current forecast, Medicaid spending is projected to be $927 billion lower than the original ACA estimate (falling from $4.6 trillion to $3.6 trillion). This difference is due in large part to much slower than anticipated spending growth from 2010 to 2012. For example, Medicaid spending grew only 2.4 percent in 2011 compared to the ACA baseline projection of 9.1 percent (table 5). CMS attributes this slow growth to the expiration of enhanced federal match rates in 2011 and state efforts to contain costs.

The Supreme Court decision allowing states to opt out of the ACA Medicaid expansion has also contributed to the drop in projected spending since 2010. The current enrollment estimate for 2014 is about 66 million, compared to approximately 79 million in the ACA baseline, but CMS also assumes continued growth in Medicaid enrollment after 2014 such that for 2019 the current enrollment projection is only 3.3 million less than in the ACA baseline (table 6). This estimate most likely reflects an assumption that many more states will adopt the ACA Medicaid expansion over time. Using the difference in annual enrollment between the current forecast and the ACA baseline and Urban Institute estimates of spending per enrollee for the expansion population, we estimate that the Supreme Court decision reduced projected spending during the 2014–19 period by about $210 billion (data not shown). Thus, most of the reduction in projected Medicaid spending is not due to lower enrollment, but to lower spending per enrollee. Mainly as a result of the slow growth from 2010 to 2012, spending per enrollee in 2019 is now projected to be $9,250, compared to $11,175 in the ACA baseline. But the projected growth in spending per

Figure 4. Medicaid Expenditure Projections (in $ billions)



Source: CMS Office of the Actuary.

enrollee from 2016 to 2019 is similar to the ACA baseline estimates, which suggests again that CMS does not assume any lasting effects from the slow growth in spending in the early part of the decade.

Private Health Insurance

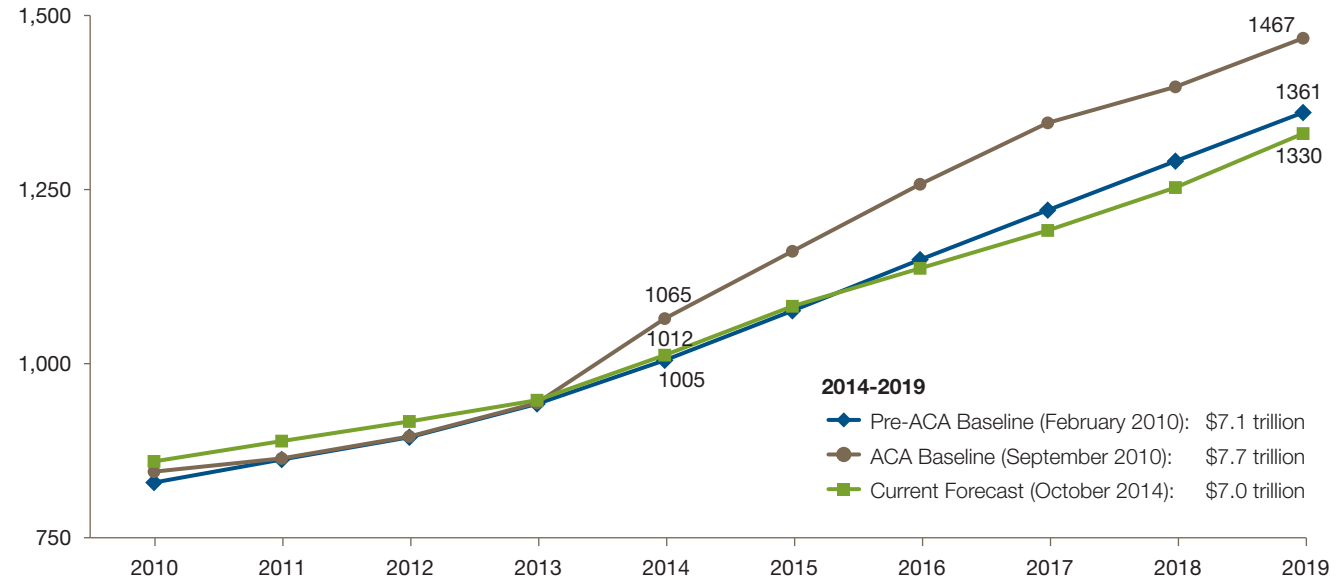
In the original ACA baseline, private health insurance spending was projected to increase by $592 billion (from $7.1 trillion to $7.7 trillion) for the 2014-2019 period compared to the pre-ACA forecast (figure 5 and table 7). This increase was due mostly to the ACA expansion of private coverage through federally subsidized exchange plans.[13] In the most recent forecast, however, private spending is projected to be $688 billion less than the ACA baseline estimate for the 2014–19 period (falling from $7.7 trillion to $7.0 trillion). This difference reflects slower expected spending growth in both the pre- and post-2014 periods (table 7). In the pre-2014 period, this slower spending growth seems to have been due to slower economic recovery than originally expected and declines in prescription drug spending related to patent expirations and increased generic substitution, as well as a shift toward higher deductibles and cost sharing in private plans. From 2010 to 2014, growth in enrollment and spending per enrollee are both lower in the current forecast than in the ACA baseline (table 8).

Both total spending and spending per enrollee are currently projected to grow faster beginning in 2014 compared to the pre-2014 period. This faster growth is due to increased enrollment in private health insurance through the exchanges as well as expanded benefits for those transitioning from the pre-ACA individual market. The continued economic recovery is also expected to spur faster growth in private spending, but this growth is tempered by the excise tax on high-cost plans and an expectation that some employers of low-wage workers will stop offering insurance. Nonetheless, the current projections are considerably lower than those in the ACA baseline. For example, average growth in spending per enrollee from 2014 to 2019 is 4.2 percent in the current forecast compared to 5.7 percent in the ACA baseline. The current estimate includes lower growth rates from 2014 to 2017 compared to the ACA baseline, but higher growth rates in 2018 and 2019 because the expected effect of the excise tax on high cost insurance plans has been reduced. It is not clear whether the forecast has been affected by lower than expected marketplace premiums. Thus, even the current projections may prove too high.

Out-of-Pocket and Other Health Spending

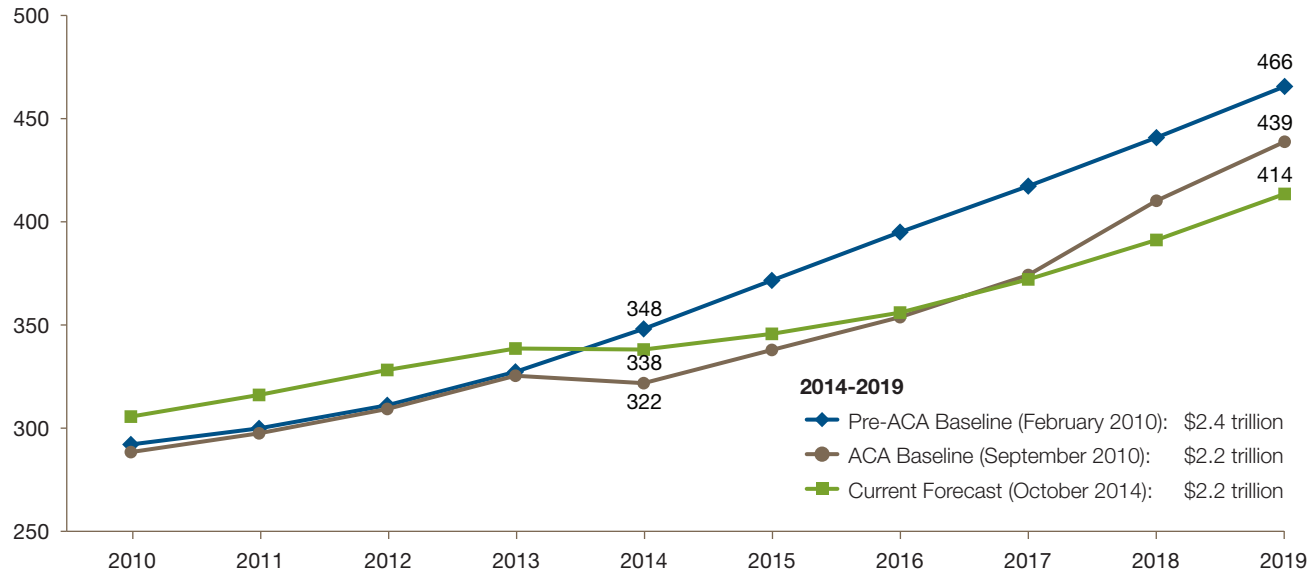
In the ACA baseline, OOP costs during the 2014–19 period were projected to fall by $202 billion (from $2.4 trillion to $2.2 trillion) compared to the pre-ACA forecast (figure 6 and table 9). This estimated decline was attributed to the coverage expansions under the ACA as well as the provision of additional cost-sharing subsidies to low-income individuals with private coverage through the marketplace. The current forecast predicts that OOP spending from 2014 to 2019 will be $20 billion lower than the ACA baseline estimate. This change reflects lower growth rates for OOP spending for most of the 2012-17 period (table 9). The effects of the 2018 excise tax on OOP spending are

Figure 5. Private Health Insurance Expenditure Projections (in $ billions)



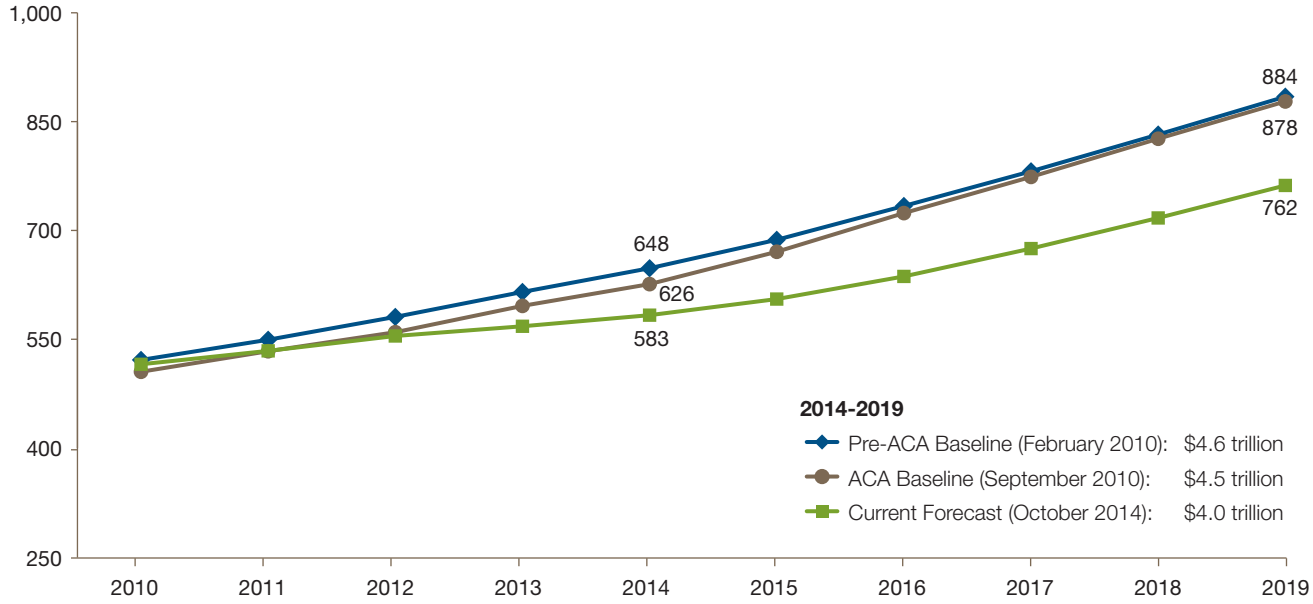
Source: CMS Office of the Actuary.

Figure 6. Out-of-Pocket Expenditure Projections (in $ billions)



Source: CMS Office of the Actuary.

Figure 7. Other Health Expenditure Projections (in $ billions)



Source: CMS Office of the Actuary.

projected to be smaller in the current forecast than in the original ACA baseline. This estimate seems to parallel the projections for private insurance spending, because lower projected private premiums will diminish the effects of the excise tax.

The residual "other" category of NHE consists of spending on a wide range of programs, including the Children's Health Insurance Program, US Department of Defense and Veterans Affairs health programs, public health activity, and investments such as new construction and capital equipment in the medical sector. The original ACA forecast predicted a relatively small ($68 billion) decline from the pre-ACA baseline in other spending during the 2014–19 period; the current forecast projects an additional reduction in other spending of $519 billion (from $4.5 trillion to $4.0 trillion) compared to the ACA baseline, much of which seems to reflect reductions in projected investment spending (figure 7 and table 10).

The slower growth in this category in the current forecast is a significant contributor to the overall decline in the NHE projections for the 2014–19 period. Given the varied components of this spending category, however, it is difficult to disentangle what might have contributed to the lower projections or whether any of the savings could be attributed to the ACA.

DISCUSSION

The ACA was originally estimated to add $577 billion to NHE over the 2014–19 period. This included the cost of the coverage expansions (over $1.1 trillion according to the CMS actuaries) less reductions in Medicare and Medicaid spending. Current projections suggest that NHE will be $2.5 trillion less than the original ACA estimate for 2014 to 2019. Much of this decrease is due to slower growth in expenditures between 2010 and 2014, but projections for spending growth between 2014 and 2019 are also lower than in the original ACA estimate, particularly for private and OOP spending.

The Congressional Budget Office (CBO) also projects declines in federal expenditures on exchange subsidies, Medicaid and the Children's Health Insurance Program, and Medicare relative to their original ACA forecast. CBO estimates are limited to the ACA expansion population, both those individuals entering the exchanges or newly enrolled in Medicaid. In 2010, CBO forecast the gross cost of the coverage provisions to be $921 billion from 2014 to 2019 (table 11). By March 2015, the forecast had been reduced to $686 billion, a reduction of 25.5 percent. In its 2010 forecast, CBO projected that exchange subsidies would be $458 billion over the 2014–19 period. In the most recent forecast, they project $333 billion, a 27.3 percent reduction. For Medicaid, CBO's original forecast was $441 billion in federal expenditures on the ACA expansion population from 2014 to 2019. In 2015, this forecast had been reduced to $347 billion. Much of this reduction is related to the Supreme Court decision. CBO also projects Medicare spending to be $443 billion lower during the 2014–19 period than in their original post-ACA forecast.

CMS does not seem to attribute any of the reduction in projected expenditures to the effects of the ACA, though they had incorporated some ACA cost containment provisions into their original projections (e.g., Medicare payment reductions, the excise tax on high-cost plans).[14] But there are several ways in which the ACA could have contributed to the slowdown in spending growth prior to 2014 and thereby to the reduced projections. First, the ACA Medicare payment adjustments that began in 2011 appear to have had a greater impact on utilization than anticipated, with reductions in hospital days, outpatient hospital visits, skilled nursing facility days, and advanced imaging prior to 2014.[15] Second, lower payment rates in Medicare may have affected payment rates by other payers. Recent research has suggested that payment policy changes by Medicare affect payments by private payers.[16] For example, commercial insurer negotiations over physician payment rates are affected by Medicare rates. Likewise, hospital payment rates by private payers also tend to reflect changes in Medicare payments, and contrary to a theory of cost shifting, private payment rates do not appear to increase in response to cuts in Medicare payments.[17] Third, other Medicare policies under the ACA, including financial penalties for hospital readmissions, may have spilled over to other payers and contributed to slower spending growth. It is unlikely that accountable care organizations, medical homes, and other delivery system reforms have played a significant role in the observed slowdown in spending growth, despite some claims to the contrary.[18] But taken together, the various components of the ACA could have contributed to a cultural shift that has affected provider behavior and, in turn, spending. Finally, the uncertainty associated with the pending implementation of various ACA provisions along with anticipated cost containment efforts by private payers may have caused providers to be more cautious with regard to investments and thereby constrained spending growth.

Components of the ACA not included in the CMS projections could result in even lower future expenditures than in the current forecast. First, premiums in marketplaces are well below expectations (due to strong competition, intense negotiations on provider payment rates, and narrower networks), and these lower premium costs should further mitigate the cost of expanded coverage.[19] Second, if the constraints on Medicare payment rates continue to reduce utilization, the current Medicare projections may be too high. Finally, in markets throughout the country, employers have offered their workers high-deductible and narrow network products that have dampened spending growth, and they are likely to continue shifting their plans in this direction. The net effect is that the $21.0 trillion estimate of national health spending for the 2014–19 period could be an overestimate.

Of course, other factors suggest the current projections will prove to be an underestimate of future spending. One such factor is the emergence of a new class of specialty pharmaceuticals, such as Sovaldi and Harvoni, which could lead to increased growth in prescription drug spending. Another is a potential backlash, both by consumers and regulatory agencies, against the narrow networks and high deductibles that have helped to hold down spending growth in recent years. Last, many of the factors that have contributed to the decline in spending projections have lowered the level of spending, but history would suggest that sustaining lower growth rates may be more difficult. Thus, if growth rates rebound faster than expected, the current forecast may be optimistic.

To offset the original $577 billion ACA cost estimate for 2014 to 2019, the ACA would have to be responsible for approximately 23 percent of the $2.5 trillion decline in projected spending during that period, beyond the ACA cost savings that have already been included in the projections. Although it is impossible to quantify how much the ACA has truly contributed to the reduced spending projections over time, it is clear that NHE levels through 2019 are projected to be substantially lower than the levels forecast just a few years ago and that this decline in projected spending has occurred along with a successful coverage expansion.

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8. Although the ACA baseline forecast (September 2010) incorporates a few other policy changes that occurred after the pre-ACA baseline (February 2010), the difference between the two sets of projections is almost entirely due to the ACA.
9. The current forecast was released at the end of 2014, but it is based on actual data through 2012. Thus, the 2013 and 2014 estimates are projections.
10. Because the ACA baseline forecast included the cuts to physician payments required under the sustainable growth rate (SGR) formula, we use a version of the current forecast that also includes the SGR cuts. If the SGR cuts were not included in the current forecast, Medicare spending for the 2014–19 period would increase by $57 billion.
11. The 2015 estimate also includes the 21.2 percent reduction in physician payments required by the SGR formula.
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Table 2. National Health Expenditure Projections 2010-2019

	National Health Spending ($ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 *(AAGR)*	Cumulative Spending 2014-2019 *(AAGR)*
A. Pre-ACA Baseline (Feb. 2010)	2570	2703	2850	3025	3225	3442	3684	3936	4204	4483	14373	22973
Growth rate		*5.2%*	*5.4%*	*6.1%*	*6.6%*	*6.7%*	*7.0%*	*6.8%*	*6.8%*	*6.6%*	*5.8%*	*6.8%*
B. ACA Baseline (Sept. 2010)	2600	2710	2852	3025	3302	3538	3796	4045	4298	4572	14489	23550
Growth rate		*4.2%*	*5.2%*	*6.1%*	*9.2%*	*7.1%*	*7.3%*	*6.6%*	*6.3%*	*6.4%*	*6.2%*	*6.7%*
C. August 2011 Forecast	2584	2708	2824	2980	3227	3418	3632	3850	4080	4347	14324	22553
Growth rate		*4.8%*	*4.3%*	*5.5%*	*8.3%*	*5.9%*	*6.3%*	*6.0%*	*6.0%*	*6.5%*	*5.7%*	*6.1%*
D. July 2012 Forecast	2594	2695	2809	2916	3130	3308	3514	3723	3952	4207	14143	21835
Growth rate		*3.9%*	*4.2%*	*3.8%*	*7.4%*	*5.7%*	*6.3%*	*5.9%*	*6.2%*	*6.5%*	*4.8%*	*6.1%*
E. October 2013 Forecast	2600	2701	2807	2915	3078	3258	3442	3643	3870	4121	14100	21412
Growth rate		*3.9%*	*3.9%*	*3.9%*	*5.6%*	*5.8%*	*5.7%*	*5.8%*	*6.2%*	*6.5%*	*4.3%*	*6.0%*
F. Current Forecast (Oct. 2014)	2599	2693	2793	2895	3057	3199	3375	3568	3785	4029	14037	21012
Growth rate		*3.6%*	*3.7%*	*3.6%*	*5.6%*	*4.6%*	*5.5%*	*5.7%*	*6.1%*	*6.4%*	*4.1%*	*5.7%*
GDP in Current Forecast	14958	15534	16245	16800	17354	18204	19133	20128	21195	22275	80891	118289
GDP Growth Rate		*3.9%*	*4.6%*	*3.4%*	*3.3%*	*4.9%*	*5.1%*	*5.2%*	*5.3%*	*5.1%*	*3.8%*	*5.1%*
ACA Baseline Relative to Pre-ACA Baseline												
Difference (B–A)	31	7	1	0	77	96	112	109	94	89	116	577
Percent change	1.2%	0.3%	0.0%	0.0%	2.4%	2.8%	3.0%	2.8%	2.2%	2.0%	0.8%	2.5%
Current Forecast Relative to Pre-ACA Baseline												
Difference (F–A)	29	-10	-57	-130	-169	-243	-309	-368	-418	-454	-336	-1,961
Percent change	1.1%	-0.4%	-2.0%	-4.3%	-5.2%	-7.1%	-8.4%	-9.3%	-9.9%	-10.1%	-2.3%	-8.5%
Current Forecast Relative to ACA Baseline												
Difference (F–B)	-1	-17	-58	-130	-246	-340	-421	-477	-512	-543	-452	-2,538
Percent change	0.0%	-0.6%	-2.0%	-4.3%	-7.4%	-9.6%	-11.1%	-11.8%	-11.9%	-11.9%	-3.1%	-10.8%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate. All projections include the cuts to physician reimbursement required by the SGR formula.

Table 3. Medicare Expenditure Projections, 2010-2019

	Medicare Spending ($ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 *(AAGR)*	Cumulative Spending 2014-2019 *(AAGR)*
A. Pre-ACA Baseline (Feb. 2010)	515	544	586	627	673	714	767	830	901	978	2944	4863
Growth rate		*5.8%*	*7.6%*	*7.0%*	*7.3%*	*6.1%*	*7.5%*	*8.2%*	*8.5%*	*8.5%*	*6.9%*	*7.8%*
B. ACA Baseline (Sept. 2010)	534	549	586	620	656	685	723	771	828	891	2945	4554
Growth rate		*2.7%*	*6.7%*	*5.8%*	*5.8%*	*4.4%*	*5.6%*	*6.6%*	*7.4%*	*7.7%*	*5.3%*	*6.3%*
C. Current Forecast (Oct. 2014)	520	546	573	591	616	624	658	703	757	811	2846	4170
Growth rate		*5.0%*	*4.8%*	*3.3%*	*4.2%*	*1.3%*	*5.4%*	*6.9%*	*7.7%*	*7.1%*	*4.3%*	*5.7%*
ACA Baseline Relative to Pre-ACA Baseline												
Difference (B–A)	20	5	0	-7	-17	-30	-44	-59	-73	-86	0	-309
Percent change	3.8%	0.8%	0.0%	-1.1%	-2.5%	-4.1%	-5.8%	-7.1%	-8.1%	-8.8%	0.0%	-6.4%
Current Forecast Relative to Pre-ACA Baseline												
Difference (C–A)	6	2	-13	-36	-57	-90	-110	-127	-143	-166	-98	-693
Percent change	1.1%	0.3%	-2.3%	-5.7%	-8.5%	-12.6%	-14.3%	-15.3%	-15.9%	-17.0%	-3.3%	-14.3%
Current Forecast Relative to ACA Baseline												
Difference (C–B)	-14	-3	-13	-29	-40	-61	-65	-68	-71	-80	-99	-384
Percent change	-2.7%	-0.5%	-2.3%	-4.6%	-6.1%	-8.8%	-9.0%	-8.8%	-8.5%	-9.0%	-3.3%	-8.4%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate. All projections include the cuts to physician reimbursement required by the SGR formula.

Table 4. Medicare Spending, Enrollment and Spending Per Enrollee Projections, 2010-2019

	Medicare Spending and Enrollment											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Spending/ Enrollment 2010-2014 *(AAGR)*	Average Spending/ Enrollment 2014-2019 *(AAGR)*
Medicare Spending ($ billions)												
ACA Baseline	534	549	586	620	656	685	723	771	828	891	589	759
Growth rate		*2.7%*	*6.7%*	*5.8%*	*5.8%*	*4.4%*	*5.6%*	*6.6%*	*7.4%*	*7.7%*	*5.3%*	*6.3%*
Current Forecast	520	546	573	591	616	624	658	703	757	811	569	695
Growth rate		*5.0%*	*4.8%*	*3.3%*	*4.2%*	*1.3%*	*5.4%*	*6.9%*	*7.7%*	*7.1%*	*4.3%*	*5.7%*
Medicare Enrollment (millions)												
ACA Baseline	46.8	47.9	49.3	50.9	52.4	53.9	55.4	57.1	58.8	60.5	49	56
Growth rate		*2.4%*	*2.9%*	*3.2%*	*2.9%*	*2.9%*	*2.8%*	*3.1%*	*3.0%*	*2.9%*	*2.9%*	*2.9%*
Current Forecast	46.6	47.7	49.7	51.0	52.7	54.4	56.0	57.7	59.4	61.1	50	57
Growth rate		*2.4%*	*4.2%*	*2.6%*	*3.3%*	*3.2%*	*2.9%*	*3.0%*	*2.9%*	*2.9%*	*3.1%*	*3.0%*
Medicare Spending Per Enrollee ($)												
ACA Baseline	11,419	11,459	11,880	12,177	12,515	12,699	13,052	13,501	14,082	14,734	11,890	13,431
Growth rate		*0.4%*	*3.7%*	*2.5%*	*2.8%*	*1.5%*	*2.8%*	*3.4%*	*4.3%*	*4.6%*	*2.3%*	*3.3%*
Current Forecast	11,163	11,451	11,519	11,592	11,687	11,471	11,748	12,187	12,751	13,280	11,482	12,187
Growth rate		*2.6%*	*0.6%*	*0.6%*	*0.8%*	*-1.9%*	*2.4%*	*3.7%*	*4.6%*	*4.1%*	*1.2%*	*2.6%*

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate. All projections include the cuts to physician reimbursement required by the SGR formula.

Table 5. Medicaid Expenditure Projections, 2010-2019

	Medicaid Spending ($ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 *(AAGR)*	Cumulative Spending 2014-2019 *(AAGR)*
A. Pre-ACA Baseline (Feb. 2010)	412	447	478	513	552	593	638	687	739	794	2402	4003
Growth rate		*8.5%*	*7.0%*	*7.3%*	*7.5%*	*7.5%*	*7.6%*	*7.6%*	*7.6%*	*7.5%*	*7.6%*	*7.6%*
B. ACA Baseline (Sept. 2010)	427	466	502	540	634	684	738	780	836	896	2569	4567
Growth rate		*9.1%*	*7.6%*	*7.7%*	*17.4%*	*7.8%*	*7.9%*	*5.8%*	*7.1%*	*7.3%*	*10.4%*	*7.2%*
C. Current Forecast (Oct. 2014)	398	408	421	450	507	541	588	627	667	711	2184	3640
Growth rate		*2.4%*	*3.3%*	*6.7%*	*12.8%*	*6.7%*	*8.6%*	*6.6%*	*6.4%*	*6.7%*	*6.2%*	*7.0%*
ACA Baseline Relative to Pre-ACA Baseline												
Difference (B–A)	15	19	23	27	82	91	99	93	97	102	167	564
Percent change	3.7%	4.3%	4.9%	5.2%	14.9%	15.3%	15.5%	13.6%	13.1%	12.8%	6.9%	14.1%
Current Forecast Relative to Pre-ACA Baseline												
Difference (C–A)	-14	-39	-57	-64	-45	-52	-51	-60	-72	-83	-219	-363
Percent change	-3.4%	-8.8%	-11.9%	-12.4%	-8.1%	-8.8%	-8.0%	-8.8%	-9.8%	-10.4%	-9.1%	-9.1%
Current Forecast Relative to ACA Baseline												
Difference (C–B)	-29	-58	-80	-91	-127	-143	-150	-154	-169	-185	-385	-927
Percent change	-6.8%	-12.5%	-16.0%	-16.8%	-20.0%	-20.9%	-20.3%	-19.7%	-20.2%	-20.6%	-15.0%	-20.3%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 6. Medicaid Spending, Enrollment and Spending Per Enrollee Projections, 2010-2019

	Medicaid Spending and Enrollment											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Spending/ Enrollment 2010-2014 *(AAGR)*	Average Spending/ Enrollment 2014-2019 *(AAGR)*
Medicaid Spending ($ billions)												
ACA Baseline	427	466	502	540	634	684	738	780	836	896	514	761
Growth rate		*9.1%*	*7.6%*	*7.7%*	*17.4%*	*7.8%*	*7.9%*	*5.8%*	*7.1%*	*7.3%*	*10.4%*	*7.2%*
Current Forecast	398	408	421	450	507	541	588	627	667	711	437	607
Growth rate		*2.4%*	*3.3%*	*6.7%*	*12.8%*	*6.7%*	*8.6%*	*6.6%*	*6.4%*	*6.7%*	*6.2%*	*7.0%*
Medicaid Enrollment (millions)												
ACA Baseline	54.9	56.0	56.6	57.2	78.8	78.3	78.1	78.3	79.4	80.2	61	79
Growth rate		*2.0%*	*1.1%*	*1.1%*	*37.8%*	*-0.6%*	*-0.3%*	*0.3%*	*1.4%*	*1.0%*	*9.5%*	*0.4%*
Current Forecast	53.1	57.1	57.7	58.0	65.9	69.7	74.4	75.5	76.4	76.9	58	73
Growth rate		*7.5%*	*1.1%*	*0.5%*	*13.6%*	*5.8%*	*6.7%*	*1.5%*	*1.2%*	*0.7%*	*5.5%*	*3.1%*
Medicaid Spending Per Enrollee ($)												
ACA Baseline	7,783	8,321	8,860	9,441	8,047	8,733	9,443	9,963	10,523	11,175	8,491	9,647
Growth rate		*6.9%*	*6.5%*	*6.5%*	*-14.8%*	*8.5%*	*8.1%*	*5.5%*	*5.6%*	*6.2%*	*0.8%*	*6.8%*
Current Forecast	7,497	7,140	7,300	7,750	7,697	7,763	7,897	8,298	8,726	9,250	7,477	8,272
Growth rate		*-4.8%*	*2.2%*	*6.2%*	*-0.7%*	*0.9%*	*1.7%*	*5.1%*	*5.2%*	*6.0%*	*0.7%*	*3.7%*

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 7. Private Health Insurance Expenditure Projections, 2010-2019

	Private Health Insurance Spending ($ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 *(AAGR)*	Cumulative Spending 2014-2019 *(AAGR)*
A. Pre-ACA Baseline (Feb. 2010)	829	862	894	942	1005	1076	1149	1220	1291	1361	4533	7102
Growth rate		*4.0%*	*3.7%*	*5.4%*	*6.6%*	*7.1%*	*6.8%*	*6.2%*	*5.8%*	*5.4%*	*4.9%*	*6.3%*
B. ACA Baseline (Sept. 2010)	845	864	895	944	1065	1161	1258	1346	1398	1467	4613	7694
Growth rate		*2.2%*	*3.6%*	*5.4%*	*12.8%*	*9.1%*	*8.3%*	*7.0%*	*3.8%*	*5.0%*	*6.0%*	*6.6%*
C. Current Forecast (Oct. 2014)	860	889	917	948	1012	1082	1137	1191	1253	1330	4625	7006
Growth rate		*3.4%*	*3.2%*	*3.3%*	*6.8%*	*6.9%*	*5.0%*	*4.8%*	*5.2%*	*6.2%*	*4.2%*	*5.6%*
ACA Baseline Relative to Pre-ACA Baseline												
Difference (B–A)	16	2	1	1	60	86	108	125	107	107	80	592
Percent change	1.9%	0.2%	0.1%	0.1%	6.0%	7.9%	9.4%	10.3%	8.3%	7.8%	1.8%	8.3%
Current Forecast Relative to Pre-ACA Baseline												
Difference (C–A)	30	27	23	5	7	7	-13	-29	-38	-30	92	-96
Percent change	3.7%	3.1%	2.5%	0.6%	0.7%	0.6%	-1.1%	-2.4%	-2.9%	-2.2%	2.0%	-1.3%
Current Forecast Relative to ACA Baseline												
Difference (C–B)	15	25	22	4	-53	-79	-121	-155	-145	-137	13	-688
Percent change	1.7%	2.9%	2.4%	0.4%	-4.9%	-6.8%	-9.6%	-11.5%	-10.3%	-9.3%	0.3%	-8.9%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 8. Private Health Insurance Spending, Enrollment and Spending Per Enrollee Projections, 2010-2019

	Private Health Insurance Spending and Enrollment											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Average Spending/ Enrollment 2010-2014 *(AAGR)*	Average Spending/ Enrollment 2014-2019 *(AAGR)*
Private Health Insurance Spending ($ billions)												
ACA Baseline	845	864	895	944	1065	1161	1258	1346	1398	1467	923	1282
Growth rate		*2.2%*	*3.6%*	*5.4%*	*12.8%*	*9.1%*	*8.3%*	*7.0%*	*3.8%*	*5.0%*	*6.0%*	*6.6%*
Current Forecast	860	889	917	948	1,012	1,082	1,137	1,191	1,253	1,330	925	1168
Growth rate		*3.4%*	*3.2%*	*3.3%*	*6.8%*	*6.9%*	*5.0%*	*4.8%*	*5.2%*	*6.2%*	*4.2%*	*5.6%*
Private Health Insurance Enrollment (millions)												
ACA Baseline	189.2	187.1	188.4	190.7	198.1	200.6	203.7	206.4	206.5	207.1	191	204
Growth rate		*-1.1%*	*0.7%*	*1.2%*	*3.9%*	*1.3%*	*1.5%*	*1.3%*	*0.0%*	*0.3%*	*1.2%*	*0.9%*
Current Forecast	186.3	187.3	188.0	188.5	190.0	197.0	199.1	200.1	201.7	203.2	188	199
Growth rate		*0.5%*	*0.4%*	*0.3%*	*0.8%*	*3.7%*	*1.1%*	*0.5%*	*0.8%*	*0.7%*	*0.5%*	*1.4%*
Private Spending Per Enrollee ($)												
ACA Baseline	4,466	4,617	4,753	4,948	5,375	5,790	6,174	6,520	6,768	7,085	4,832	6,285
Growth rate		*3.4%*	*2.9%*	*4.1%*	*8.6%*	*7.7%*	*6.6%*	*5.6%*	*3.8%*	*4.7%*	*4.7%*	*5.7%*
Current Forecast	4,614	4,745	4,878	5,027	5,327	5,494	5,710	5,954	6,212	6,547	4,918	5,874
Growth rate		*2.8%*	*2.8%*	*3.1%*	*6.0%*	*3.1%*	*3.9%*	*4.3%*	*4.3%*	*5.4%*	*3.7%*	*4.2%*

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 9. Out-of-Pocket Expenditure Projections, 2010-2019

	Out-of-Pocket Spending ($ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 *(AAGR)*	Cumulative Spending 2014-2019 *(AAGR)*
A. Pre-ACA Baseline (Feb. 2010)	292	300	311	327	348	372	395	417	441	466	1579	2438
Growth rate		*2.7%*	*3.7%*	*5.2%*	*6.4%*	*6.8%*	*6.3%*	*5.6%*	*5.6%*	*5.6%*	*4.5%*	*6.0%*
B. ACA Baseline (Sept. 2010)	288	298	309	325	322	338	354	374	410	439	1542	2237
Growth rate		*3.2%*	*4.0%*	*5.2%*	*-1.1%*	*5.0%*	*4.7%*	*5.8%*	*9.6%*	*7.0%*	*2.8%*	*6.4%*
C. Current Forecast (Oct. 2014)	306	316	328	339	338	346	356	372	391	414	1627	2217
Growth rate		*3.4%*	*3.8%*	*3.2%*	*-0.1%*	*2.2%*	*3.0%*	*4.5%*	*5.1%*	*5.7%*	*2.6%*	*4.1%*
ACA Baseline Relative to Pre-ACA Baseline												
Difference (B–A)	-4	-2	-2	-2	-26	-34	-41	-43	-31	-27	-36	-202
Percent change	-1.3%	-0.8%	-0.6%	-0.6%	-7.6%	-9.1%	-10.4%	-10.3%	-6.9%	-5.8%	-2.3%	-8.3%
Current Forecast Relative to Pre-ACA Baseline												
Difference (C–A)	14	16	17	11	-10	-26	-39	-45	-50	-52	48	-222
Percent change	4.6%	5.4%	5.5%	3.5%	-2.9%	-7.0%	-9.9%	-10.8%	-11.3%	-11.2%	3.0%	-9.1%
Current Forecast Relative to ACA Baseline												
Difference (C–B)	17	19	19	13	16	8	2	-2	-19	-25	84	-20
Percent change	6.0%	6.3%	6.1%	4.1%	5.1%	2.3%	0.6%	-0.6%	-4.6%	-5.8%	5.5%	-0.9%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 10. Other Health Expenditure Projections, 2010-2019

	Other Health Spending ($ billions)											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Cumulative Spending 2010-2014 *(AAGR)*	Cumulative Spending 2014-2019 *(AAGR)*
A. Pre-ACA Baseline (Feb. 2010)	521.5	549.3	580.8	615.2	647.9	687.1	733.7	781.5	832.2	884.4	2915	4567
Growth rate		*5.3%*	*5.7%*	*5.9%*	*5.3%*	*6.1%*	*6.8%*	*6.5%*	*6.5%*	*6.3%*	*5.6%*	*6.4%*
B. ACA Baseline (Sept. 2010)	505.2	533.5	559.7	596.0	626.0	670.6	723.9	773.8	826.4	877.8	2820	4499
Growth rate		*5.6%*	*4.9%*	*6.5%*	*5.0%*	*7.1%*	*7.9%*	*6.9%*	*6.8%*	*6.2%*	*5.5%*	*7.0%*
C. Current Forecast (Oct. 2014)	515.5	534.0	554.5	567.9	583.2	605.4	636.6	675.0	717.2	762.0	2755	3979
Growth rate		*3.6%*	*3.8%*	*2.4%*	*2.7%*	*3.8%*	*5.2%*	*6.0%*	*6.3%*	*6.2%*	*3.1%*	*5.5%*
ACA Baseline Relative to Pre-ACA Baseline												
Difference (B–A)	-16	-16	-21	-19	-22	-17	-10	-8	-6	-7	-94	-68
Percent change	-3.1%	-2.9%	-3.6%	-3.1%	-3.4%	-2.4%	-1.3%	-1.0%	-0.7%	-0.7%	-3.2%	-1.5%
Current Forecast Relative to Pre-ACA Baseline												
Difference (C–A)	-6	-15	-26	-47	-65	-82	-97	-107	-115	-122	-160	-587
Percent change	-1.2%	-2.8%	-4.5%	-7.7%	-10.0%	-11.9%	-13.2%	-13.6%	-13.8%	-13.8%	-5.5%	-12.9%
Current Forecast Relative to ACA Baseline												
Difference (C–B)	10	1	-5	-28	-43	-65	-87	-99	-109	-116	-65	-519
Percent change	2.0%	0.1%	-0.9%	-4.7%	-6.8%	-9.7%	-12.1%	-12.8%	-13.2%	-13.2%	-2.3%	-11.5%

Source: CMS Office of the Actuary.

Note: AAGR is average annual growth rate.

Table 11: Congressional Budget Office Expenditure Projections, 2010 and 2015

	2010 Report: 2014–2019 ($ Billions)	2015 Report: 2014–2019 ($ Billions)	Difference (2010-2015)	
			$	%
Outlays				
Exchange Subsidies & Related Spending	458	333	-125	-27.3%
Medicaid and CHIP Outlays	441	347	-94	-21.3%
Gross Cost of Coverage Provisions	921	686	-235	-25.5%
Medicare				
Total Mandatory Outlays	4485	4,042	-443	-9.9%
Net Mandatory Outlays	3816	3,378	-438	-11.5%

Sources: Congressional Budget Office, The Budget and Economic Outlook: an Economic Update, August 2010. Congressional Budget Office, Updated Budget Projections: 2015 to 2025.

Notes: CHIP is Children's Health Insurance Program. Estimates are for federal spending and revenues only. Medicaid and CHIP estimates only include ACA expansion population.

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Health Care Coverage and Access in the Nation's Four Largest States

Results from the Commonwealth Fund Biennial Health Insurance Survey, 2014

Toplines

(#)	43% of people in FL and TX skipped care because of costs, compared to 30% in NY and CA
(#)	Survey highlights link btw state policies & access to health care in CA, FL, NY & TX

Abstract

Across the country's four largest states, uninsured rates vary for adults ages 19 to 64: 12 percent of New Yorkers, 17 percent of Californians, 21 percent of Floridians, and 30 percent of Texans lacked health coverage in 2014. Differences also extend to the proportion of residents reporting problems getting needed care because of cost, which was significantly lower in New York and California compared with Florida and Texas. Similarly, lower percentages of New Yorkers and Californians reported having a medical bill problem in the past 12 months or having accrued medical debt compared with Floridians and Texans. These differences stem from a variety of factors, including whether states have expanded eligibility for Medicaid, the state's uninsured rate prior to the Affordable Care Act taking effect, differences in the cost protections provided by private health insurance, and demographics.

OVERVIEW

The Affordable Care Act has had profound implications for health insurance coverage in the United States. More than 25 million Americans now have coverage under its provisions, which include the expansion of Medicaid eligibility, subsidized private plans purchased in the health insurance marketplaces, and—for young adults up to age 26—the opportunity to enroll in a parent's plan.[1] A recent analysis of the Commonwealth Fund Biennial Health Insurance Survey indicates that the percentage of uninsured adults has dropped from 20

percent in 2010 to 16 percent in 2014.[2] The law, however, gives states flexibility in implementing its provisions, including the choice of operating their own health insurance marketplace or leaving that task to the federal government. Moreover, in 2012, the U.S. Supreme Court gave states the power to decide whether or not to expand Medicaid eligibility to more lower-income adults. States' policy choices, combined with each state's unique demographic characteristics and history, have resulted in a wide range of experiences among Americans since the law took effect. In this brief we use data from the Biennial Survey to examine differences in health insurance coverage, cost-related problems getting needed care, and medical bill problems and debt among adults ages 19 to 64 in the nation's four largest states.

The four largest states in the U.S.—California, Florida, New York, and Texas—fall into two distinct categories. The first group is represented by California and New York, both of which are operating their own health insurance marketplaces and have expanded eligibility for Medicaid to adults who earn at or below 138 percent of the federal poverty level—about $16,000 for an individual or $32,000 for a family of four.[3] Florida and Texas, the second group, are using the federal marketplace to enroll residents in health plans and have declined to expand Medicaid eligibility. In this new analysis of data from the Commonwealth Fund Biennial Health Insurance Survey, we find that, in 2014, there were larger shares of uninsured adults in Florida and Texas compared with California and New York. In addition, adults in Florida and Texas were more likely to report not getting needed care because of cost and to report having problems paying medical bills.

SURVEY FINDINGS IN DETAIL

Texas Has Highest Uninsured Rate of the Four Largest States

Among the four states, the proportion of working-age adults without health coverage in 2014 was highest in Florida and Texas, at 21 percent and 30 percent, respectively (Exhibit 1). California's uninsured rate was 17 percent, while New York's was 12 percent.[4,5,6] While this study did not examine trends at the state level, federal survey data indicate that since the Affordable Care Act's passage, uninsured rates declined in all four states, with California registering the greatest decrease.[7]

Young adults have experienced the largest gains in coverage nationally. According to the survey, by 2014, the national uninsured rate for 19-to-34-year-olds was 19 percent. This was down from 27 percent in 2010, the year adult children became eligible to remain on parents' health plans to age 26.[8] There are differences among the four states. In New York, 14 percent of young adults were uninsured in 2014, compared with 34 percent in Texas, 26 percent in Florida, and 23 percent in California.

How Florida and Texas Are Implementing the Affordable Care Act

Neither Florida nor Texas has expanded eligibility for Medicaid under the Affordable Care Act. Both states opted to use the federal marketplace, HealthCare.gov, to enroll individuals in private plans. For their existing Medicaid programs, both states have very low income eligibility thresholds. In Florida, adults who are parents of dependent children are eligible for Medicaid if they make less than 34 percent of the poverty level—an annual income of about $8,000 for a family of four—

but there is no coverage for childless adults.[9] There is also no Medicaid coverage for childless adults in Texas and the eligibility threshold for parents is even lower at 19 percent of poverty, or an annual income of about $4,475 for a family of four.[10]

Both Florida and Texas have had successful enrollment in their marketplaces: about 1.6 million people have selected a 2015 marketplace plan in Florida and more than 1.2 million have done so in Texas.[11] Both states have also seen increases in their Medicaid enrollment since October 2013, as more people have become aware that they are eligible for coverage: Florida's Medicaid and Children's Health Insurance Program enrollment has grown by about 300,000 people and Texas' enrollment has grown by about 210,000.[12]

There are also significant differences in coverage rates for adults with low incomes. Adults with incomes below 100 percent of the federal poverty level—that is, $11,490 for an individual or $23,550 for a family of four—are faring best in New York and California (Table 1). Thirteen percent of low-income New Yorkers and 23 percent of low-income Californians are uninsured, compared with 33 percent of low-income adults in Florida and 51 percent in Texas. Even before the passage of the Affordable Care Act, both New York and California had established Medicaid eligibility levels that were more generous than most states. And under the health reform law, both states expanded eligibility for Medicaid up to 138 percent of poverty, while Florida and Texas did not.

In addition to policy decisions, demographics also likely contribute to differences in insurance coverage rates, although they do not explain the state differences completely. For example, undocumented immigrants are ineligible for subsidized coverage or Medicaid under the law. In Texas, adults below 100 percent of poverty are much more likely to be foreign-born than are adults with incomes between 100 percent and 399 percent of poverty (35% vs. 26%) (data not shown). People born outside the United States but who reside here now are much more likely to be uninsured than those born in the U.S. (31% vs. 12%) (data not shown).[13]

New York and California: Lower Rates of Problems in Getting Needed Health Care Because of Cost

Across the country, expanded insurance coverage is helping people get the care they need by reducing financial barriers to care. The survey asked adults about delaying or skipping needed care because of cost in the past 12 months. About three of 10 New Yorkers (30%) and Californians (31%) reported having at least one cost-related access problem, compared with 43 percent of Floridians and Texans (Exhibit 2).[14] These differences remain statistically significant even after taking into account the states' demographic profiles.

There was variation between states in all four cost-related areas asked about in the survey. In New York and California, 18 percent of residents reported having a medical problem but not going to a doctor or clinic because of cost, versus 29 percent in Florida and 26 percent in Texas. Residents in New York and California reported not getting needed specialist care at about half the rate as people in Florida and Texas.

There are likely a range of factors contributing to this variation, with insurance coverage playing a large role. Across the U.S., insured adults have historically reported cost-related access problems at much lower rates than uninsured adults.[15] To some degree, California and New York's higher rates of coverage likely translate into lower rates of reported problems. But the quality of health insurance coverage—particularly, how much people have to pay out-of-pocket relative to their income—also makes a difference. Insured adults in New York (27%) and California (28%) reported lower rates of problems getting needed care in the past 12 months than did insured adults in Texas (36%) and Florida (39%) (data not shown). These differences persisted across the income distribution. One factor may be deductibles and other cost-sharing aspects of people's insurance policies. Research has shown that people with high deductibles relative to their income are much more likely to report not getting needed care because of cost than those with lower deductibles.[16] The survey found that a smaller share of insured Californians and New Yorkers (9 percent and 7 percent, respectively) had deductibles that were 5 percent or more of their income compared with Texans (18%) and Floridians (17%) (data not shown). Moreover, a recent analysis of federal data found that more people have health plans with deductibles in Florida and Texas: in 2013, 62 percent of employees with single-person insurance plans in New York and California had a deductible, compared with 84 percent in Florida and 90 percent in Texas.[17]

How New York and California Are Implementing the Affordable Care Act

California was the first state to pass legislation to establish a state-based marketplace. The marketplace is an active purchaser, meaning it evaluates proposed plans based on factors like affordability and access to high-quality care, and may choose to limit the number of plans offered.[18] The state also has a long history of setting more generous eligibility levels for Medicaid coverage than federal mandates and does not require a five-year waiting period for legal immigrants to be eligible for coverage, although the state pays all the costs of providing care for this population. The state also created the Low Income Health Program under a Section 1115 waiver, which provided coverage to adults under 200 percent of poverty in participating counties from July 2011 to December 2013.[19] After that, 650,000 enrollees transitioned into the state's expanded Medicaid program and more than 25,000 people purchased private plans offered through the state's marketplace, Covered California.[20] In the past year more than 1.4 million people have selected private plans through Covered California for 2015; more than 3 million individuals have gained Medicaid coverage since October 2013.[21]

New York has also expanded eligibility for Medicaid and is operating its own marketplace, the New York State of Health. New York has had more generous Medicaid eligibility levels than many states since it passed the Health Care Reform Act of 2000, well before national health reform was passed. The state's Family Health Plus program expanded Medicaid eligibility to parents with incomes up to 150 percent of poverty and childless adults up to 100 percent of the poverty level.[22] New York's Medicaid program does not require a five-year waiting period for legal immigrants to be eligible for coverage, although the state does not receive any federal matching funds for this population. The 2000 law also created the Healthy NY program, which provided affordable health insurance options to small business owners and their employees. Under the Affordable Care Act, these programs have rolled their enrollees into expanded Medicaid or subsidized private plans from New York State of Health.[23] About 570,000 individuals have enrolled in Medicaid since October 2013 and more than 400,000 have selected private coverage through the marketplace for 2015.[24]

New York and California: Lower Rates of Medical Bill and Debt Problems

There were notable state variations in the percentage of adults reporting medically related financial difficulties in 2014. Fewer adults in New York and California said they had problems paying their medical bills in the past 12 months, or were paying off medical debt, than did adults in Florida and Texas (Exhibit 3). Twenty-nine percent of New Yorkers and 24 percent of Californians said that, in the past 12 months, they had a problem or were unable to pay their medical bills, had been contacted by a collection agency for unpaid medical bills, had to change their way of life to pay medical bills, or were paying off medical bills over time. Rates were much higher in Florida and Texas: more than two of five adults in each state reported at least one of these problems.[25] These differences remained after taking into account variations in the demographic compositions of the states' populations. As with the cost-related access problems, states' decisions that enhanced access to affordable health insurance coverage both before and after the Affordable Care Act as well as insurance design and cost-sharing likely contribute to differences.

CONCLUSION

The analysis suggests that the health policy decisions made by state leaders matter. Of the four states studied, New York has had the longest history of legislation aimed at enhancing the availability of affordable coverage. California also implemented an early expansion of Medicaid eligibility and, based on federal survey data, both states began achieving declines in their adult uninsured rate earlier than other states.[26] Both have taken advantage of opportunities granted by the Affordable Care Act to further expand the reach of coverage and access. Alternatively, Florida and Texas, while experiencing robust enrollment in private plans through the federal health insurance marketplace, have not expanded Medicaid eligibility and have made less headway in reducing their uninsured populations.

While there have been significant declines in the number and share of uninsured adults since the major provisions of the Affordable Care Act went into effect in 2014, coverage gaps are leaving millions uninsured and without access to affordable coverage. An estimated 3.7 million people have fallen into the Medicaid coverage gap in states that have not yet expanded eligibility for Medicaid.[27]

In addition, the law does not provide access to any new coverage options for unauthorized immigrants. They are ineligible for Medicaid coverage and cannot purchase private plans through the marketplace, either subsidized or unsubsidized. The Congressional Budget Office estimates that by 2020, 30 percent of the remaining uninsured will be unauthorized immigrants, or about 9 million people.[28] Another part of the law that is leaving people uninsured is the so-called "family coverage glitch," which defines affordability—and eligibility for subsidies—based on the cost of individual, rather than family, coverage. Currently, an estimated 2 million to 4 million people are uninsured because of this issue.[29]

The analysis also indicates that expanded coverage is necessary to improve access to care and reduce medical financial burdens among U.S. families. But the quality and comprehensiveness of coverage across all sources of insurance (marketplace plans, individual plans, employer-provided coverage, and Medicaid), will ultimately determine the degree to which these problems are lessened for U.S. families.

Methodology

The Commonwealth Fund Biennial Health Insurance Survey, 2014, was conducted by Princeton Survey Research Associates International, with a general population sample collected from July 22 to December 14, 2014, and an oversampling of the four largest states, California, Florida, New York, and Texas, collected until December 27, 2014. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial (RDD) samples was used to reach people.

The general sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. The majority of this report looks at adults ages 19 to 64 in the four largest states (California sample=758, Florida=659, New York=710, and Texas=714). Statistical results are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. Each state sample is weighted to match population parameters for sex by age, sex by education, age by education, race/ethnicity, population density, household telephone use, household size, and region, using the U.S. Census Bureau's 2012 American Community Survey data.

The resulting weighted general population sample is representative of the approximately 182.8 million U.S. adults ages 19 to 64 and has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The California sample has a margin of error of +/– 4.2 percentage points at the 95 percent confidence level; the Florida sample margin of sampling error is +/– 4 percentage points; the New York sample margin of sampling error is +/– 4.1 percentage points; and the Texas sample margin of sampling error is +/– 3.9 percentage points. The landline portion of the survey achieved an 11.5 percent response rate and the cellular phone component achieved an 11.3 percent response rate.

Notes

[1] D. Blumenthal, *The Affordable Care Act at Five Years (http://www.commonwealthfund.org/publications/testimonies/2015/mar/aca-at-five-years)*, Invited testimony, Senate Finance Committee, United States Senate, March 19, 2015.

[2] S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014 (http://www.commonwealthfund.org/publications/issue-briefs/2015/jan/biennial-health-insurance-survey)* (New York: The Commonwealth Fund, Jan. 2015).

[3] Dollar estimates are based on 2013 federal poverty guidelines, which were used by the government to calculate subsidy levels for 2014 marketplace plans and in the biennial survey to calculate respondents' federal poverty level.

[4] The margin of sampling error for each state was between 3.9 and 4.2 percentage points at the 95 percent level. The estimates from the Biennial Health Insurance Survey, 2014, were similar to those reported by the Centers for Disease Control and Prevention's National Health Interview Survey (NHIS) for the period of January–September 2014. NHIS reported uninsured rates for 18–64-year-olds in California as 16.8%, in Florida as 23.8%, in New York as 13.5%, and in Texas as 26.8% (http://www.cdc.gov/nchs/nhis/released201503.htm (http://www.cdc.gov/nchs/nhis/released201503.htm)).

[5] All reported differences are statistically significant at the $p \leq 0.05$ level or better unless otherwise noted.

[6] Gallup recently reported state by state uninsured rates for adults age 18 and older and also found significant declines between 2013 and 2014 in California's uninsured rate. Florida, Texas, and New York saw much more modest declines, but New York had the lowest uninsured rate of the four states at 10.1 percent in 2014. D. Witters, *Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate* (Washington, D.C.: Gallup, Feb. 24, 2015), http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx (http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx).

[7] This analysis does not draw comparisons between 2012 and 2014 state-level data, as we did not oversample in the the four states in 2012 and the state sample sizes in 2012 were smaller. The confidence intervals around the estimates are wider in 2012 than in 2014, thus porentially underestimating the state-by-state change year over year and the differences between states in 2012 relative to 2014. R. A. Cohen, M. E. Martinez, and B. W. Ward, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2009" (Washington, D.C.: Centers for Disease Control and Prevention, June 2010), http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201006.pdf (http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201006.pdf); and M. E. Martinez and R. A. Cohen, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2014" (Washington, D.C.: Centers for Disease Control and Prevention, March 2015), http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201503.pdf (http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201503.pdf).

[8] Collins, Rasmussen, Doty et al., *Rise in Health Care Coverage,* 2015.

[9] *Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women as of January 2015* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Feb. 2, 2015), http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ (http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/).

[10] There are different eligibility levels for pregnant women in these states. Ibid.

[11] *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report,* ASPE Issue Brief (Washington, D.C.: U.S. Department of Health and Human Services, March 10, 2015), http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf (http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf).

[12] Florida Medicaid overview: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/florida.html (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/florida.html); Texas Medicaid overview: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/texas.html (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/texas.html).

[13] Although differences in immigration status do not fully explain the differences between the states, when respondents who are foreign-born and do not have permanent residency in the U.S. or a green card are excluded from the analysis, the uninsured rates for the states decrease by 2 to 6 percentage points. New York's uninsured rate decreases from 12% to 9%, California's rate decreases from 17% to 13%, Florida's rate decreases from 21% to 19%, and Texas' rate decreases from 30% to 24%.

[14] The reported weighted (unadjusted) estimates are similar to regression-adjusted estimates.

[15] Collins, Rasmussen, Doty et al., *Rise in Health Care Coverage,* 2015.

[16] S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Too High a Price: Out-of-Pocket Health Care Costs in the United States (http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/out-of-pocket-health-care-costs)* (New York: The Commonwealth Fund, Nov. 2014).

[17] C. Schoen, D. Radley, and S. R. Collins, *State Trends in the Cost of Employer Health Insurance Coverage, 2003–2013 (http://www.commonwealthfund.org/interactives-and-data/maps-and-data/employer-health-insurance-premiums)* (New York: The Commonwealth Fund, Jan. 2015).

[18] S. Dash, K. W. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges (http://www.commonwealthfund.org/publications/fund-reports/2013/jul/design-decisions-for-exchanges)* (New York: The Commonwealth Fund, July 2013).

[19] E. C. Lytle, D. H. Roby, L. Lucia et al., *Promoting Enrollment of Low Income Health Program Participants in Covered California,* Policy Note (Los Angeles: UCLA Center for Health Policy Research, April 2013), http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/Documents/LIHP_PN3.pdf (http://healthpolicy.ucla.edu/programs/health-economics/projects/coverage-initiative/Documents/LIHP_PN3.pdf).

[20] Ibid.

[21] California Medicaid overview: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/california.html); New York Medicaid overview: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Jan2015/ib_2015jan_enrollment.pdf

(http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Jan2015/ib_2015jan_enrollment.pdf).

[22] New York State Department of Health, "13ADM-03—Medicaid Eligibility Changes Under the Affordable Care Act (ACA) of 2010" (Albany, N.Y.: NYS DOH, Sept. 25, 2013), http://www.health.ny.gov/health_care/medicaid/publications/adm/13adm3.htm (http://www.health.ny.gov/health_care/medicaid/publications/adm/13adm3.htm).

[23] Ibid.

[24] New York Medicaid overview: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-york.html (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-york.html); *Health Insurance Marketplaces 2015 Open Enrollment Period,* 2015.

[25] The reported weighted (unadjusted) estimates are similar to regression-adjusted estimates.

[26] Cohen, Martinez, and Ward, "Health Insurance Coverage: Early Release, 2009," 2010; and Martinez and Cohen, "Health Insurance Coverage: Early Release, January–September 2014," 2015.

[27] Individuals fall into the Medicaid coverage gap if they are not eligible for Medicaid in their state and have incomes below 100 percent of poverty, the lower limit for subsidized private coverage through the marketplace. See: State Health Facts, "Number of Poor Uninsured Nonelderly Adults in the ACA Coverage Gap" (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, accessed April 8, 2015), http://kff.org/health-reform/state-indicator/number-of-poor-uninsured-nonelderly-adults-in-the-aca-coverage-gap/# (http://kff.org/health-reform/state-indicator/number-of-poor-uninsured-nonelderly-adults-in-the-aca-coverage-gap/#).

[28] Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (Washington, D.C.: CBO, Jan. 2015), https://www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf (https://www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf).

[29] T. Brooks, "Health Policy Brief: The Family Glitch," *Health Affairs,* Nov. 10, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129 (http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129).

Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks

Toplines

(#)	States are using the ACA's national standards to make sure patients have good access to providers
(#)	How states are ensuring narrow network plans meet patients' needs

Abstract

Health plans with relatively narrow provider networks have generated widespread debate, mainly concerning the level of regulatory oversight necessary to ensure plans provide consumers meaningful access to care. The Affordable Care Act creates the first federal standard for network adequacy in the commercial insurance market for plans offered through the law's insurance marketplaces. However, states continue to play a primary role in setting and enforcing network rules. This brief examines state network adequacy standards for marketplace plans in the 50 states and District of Columbia. We identify state requirements in effect at the outset of marketplace coverage, focusing on quantitative measures of network sufficiency and rules designed to ensure the delivery of accurate and timely provider directories. We then explore the extent to which those standards evolved for 2015. Though regulatory changes were limited in year one, states were most likely to act to promote network transparency and enhance oversight.

OVERVIEW

"Narrow network plans"—that is, health plans with limited networks of providers—were common on the Affordable Care Act's (ACA's) health insurance marketplaces in 2014. By one measure, almost half of all marketplace plan networks were "narrow" and nearly all consumers had access to buy such a plan if they

chose.[1] These narrow network plans are not new nor are they unique to the ACA's marketplaces; for years, insurers have used limited networks as a way to constrain costs and regain leverage in contract negotiations with providers.[2] At the same time, elements of the ACA that encourage insurers to compete on price—for example, marketplaces that allow consumers to compare plans based on premiums and increased standardization of benefits and cost-sharing—appear to have spurred many carriers to design health plans for 2014 that combined an attractive premium with a more restricted choice of providers.[3]

Narrow network plans may offer value to many consumers if their comparatively lower upfront costs are coupled with meaningful access to a sufficient array of providers. Flexibility to contract selectively also may allow insurers to build networks of providers who can satisfy measures of quality and efficiency, which may lead to higher-value care. But these plans also pose risks. If a network is too narrow, it may jeopardize consumers' ability to obtain critical services or expose them to the often significant financial costs of out-of-network care. If the design is not transparent—that is, if consumers do not receive accurate and timely information about participating providers—it may be impossible for consumers to make an informed decision about whether the plan's combination of network and price is right for them.

To help ensure that plans offered on the marketplaces serve the needs of enrollees, the ACA established a national standard for network adequacy.[4] Marketplace plans must maintain "a network that is sufficient in number and types of providers" so that "all services will be accessible without unreasonable delay," and are required to disclose their provider directories to the marketplace for online publication.[5]

These provisions offer consumers federal protections where previously none existed. Yet the federal framework also gives states significant latitude to determine whether an insurer has complied with the requirements, as well as the power to enforce additional, state-specific network rules if desired.[6] Prior to the ACA, most states had some standards governing plan networks. Heading into 2014 and the first year of marketplace coverage, these state rules, depending on their scope, began to apply to some offerings on the marketplaces. Meanwhile a minority of states took steps to create new requirements for marketplace coverage.

This brief describes the network adequacy standards applicable to marketplace plans in each of the 50 states and the District of Columbia at the outset of marketplace coverage in 2014.[7] In particular, we focus on quantitative standards that states have set to test the sufficiency of provider networks, and on requirements designed to ensure that consumers have access to updated provider directories. Then we identify the extent to which those requirements evolved in preparation for year two.

FINDINGS

In the First Year of Coverage, About Half of States Had One or More Quantitative Standards to Measure the Adequacy of Marketplace Plan Networks

By January 2014, nearly all states had rules intended to promote the sufficiency of health plans' provider networks. In general, these standards seek to ensure that enrollees have reasonable access to in-network providers who perform the health services covered by their insurance policy. However, the particulars of these requirements vary substantially. In many states the rules apply only to a subset of plans—for example, health maintenance organizations (HMOs)—that use a specific network design. The timing and frequency with which these standards are applied differ, as well. In many states, regulators conduct network adequacy reviews only when an insurer initially seeks licensure, upon notice of a significant change in a plan's network, or in response to complaints. Oversight on an ongoing basis is much less common.[8]

Twenty-one states had qualitative standards to assess the adequacy of plans' provider networks. For example, Maryland requires carriers to maintain a panel of in-network providers that is "sufficient in numbers and types of available providers to meet the health care needs of enrollees."[9]

Kansas uses a similar formulation, requiring a "sufficient" mix of in-network providers so enrollees can access all covered services "without unreasonable delay."[10] These approaches, variations of which are common in other states, resemble key provisions of a 1996 model law developed by the National Association of Insurance Commissioners (NAIC).[11]

In contrast, 27 states had rules requiring at least some network-based marketplace plans to satisfy one or more quantitative measures of sufficiency (Exhibit 1). These standards took different forms (Exhibit 2). Most frequently, states specified the maximum amount of time and/or distance an enrollee must travel to access covered services. Twenty-three states had such requirements in place at the start of 2014, including New Jersey, which obligates its managed care plans to have available at least two primary care physicians within 10 miles or 30 minutes driving or public transit time of 90 percent of its enrollees.[12]

Eleven states impose limits on how long enrollees can be made to wait for appointments for services. Montana, for example, requires managed care plans to ensure access to urgent care within 24 hours; nonurgent care with symptoms within 10 days; immunizations within 21 days; and routine or preventive services within 45 days.[13] Nearly as many—10 states—have standards prescribing minimum ratios of providers to enrollees. Nevada requires that its marketplace plans adhere to ratios for internal medicine providers (at least one for every 2,500 covered persons) and for certain specialized services (e.g., one cardiology provider for every 7,500 enrollees).[14] Less common are rules requiring plans to ensure access to providers at flexible times or during extended office hours. California was one of just seven states with such requirements, obligating certain network plans to include providers that offer nonemergency services until 10 p.m. at least one day per week, or for at least four hours each Saturday.[15]

In 2014, 10 States Required Insurers to Update Provider Directories at Least Semiannually

Federal regulations require marketplace plans to make their provider directories available to the marketplace for online publication and to potential enrollees in hard copy upon request.[16]

Heading into the first year of marketplace coverage, a minority of states were enforcing rules of their own that augmented the federal standard by specifying the frequency with which insurers must update their provider lists. Nine states required network plans to provide updated directories at fixed intervals throughout the year. In addition, Arkansas mandated that insurers submit an updated directory within 14 days of any change (Exhibit 3).[17]

Though Few States Made Significant Changes to Network and Provider Directory Standards for 2015, More Acted to Increase Oversight

In 2014, policymakers in most states considered whether and how to adjust their regulatory approach to network adequacy. But by January 2015, few states had yet charted a substantially different course. In three states, regulators developed new quantitative requirements.[18] Arkansas officials issued regulations obligating network plans offered inside and outside the marketplaces to adhere to time and distance standards beginning in 2015.[19] Regulators in the California Department of Insurance filed emergency rules that adopted appointment wait time standards similar to those already applicable to plans regulated by the state's Department of Managed Health Care.[20] Meanwhile, in Washington, authorities revised the state's framework to incorporate more detailed and concrete network standards. These additions include time and distance requirements, a specified ratio of primary care providers to plan enrollees, and maximum wait times for primary care and specialist appointments.[21]

A somewhat larger number of states set rules intended to increase the transparency of plan networks. Six states tightened requirements for plans to update provider directories (Exhibit 4).[22] For example, as part of its broader overhaul of network standards, Washington included a requirement for plans to update their directories on a monthly basis.[23] New York's legislature imposed a still more stringent standard, mandating that online directories be made current within 15 days of the addition or termination of a provider from the network or a change in a physician's hospital affiliation.[24] Illinois and Maine passed legislation promoting timely disclosures of directory information.[25] This new legal authority will make it easier for regulators in those states to develop more specific requirements in the future, should they choose.

In addition, at least six states, including Arkansas, California, Mississippi, New Hampshire, New York, and Washington, acted to bolster the ability of regulators to oversee and enforce marketplace plan standards. California, for example, enacted a bill that requires regulators to perform annual reviews of plans'

compliance with state standards and to post their findings, including any waivers or alternative standards that regulators approved, online.[26] Mississippi issued regulations that require carriers to provide, for each of their managed care plans, a detailed filing describing the plan's network and the insurer's processes and procedures for complying with the state's network adequacy rules. The new regulation also establishes explicitly that regulators have authority to enforce the state's network standards in the event of a violation.[27]

DISCUSSION

The first year of marketplace coverage triggered widespread interest in how health plans design provider networks. This attention has reignited debate—largely dormant since the proliferation of managed care plans in the 1990s—about the degree to which those networks meet the needs of consumers and the level of regulatory oversight appropriate to ensure they do.

The ACA addresses these issues by establishing the first-ever federal standard for network adequacy in the commercial insurance market, applicable nationwide to plans available through the insurance marketplaces. The federal rules that implement this standard create a flexible regulatory framework that defines "network adequacy" qualitatively. Health plans are not required to meet more rigorous quantitative standards—a decision by officials at the U.S. Department of Health and Human Services (HHS) made partly in deference to the "historical flexibility and responsibility" enjoyed by states in this area.[28] In addition, to encourage insurer participation in the marketplaces and make it more likely that consumers would have a broader choice of plans, state and federal officials gave insurers further flexibility to satisfy network standards in 2014.[29]

In response to feedback and ongoing public discussion about the benefits and risks of narrow networks, federal regulators sought to increase oversight for the second year of coverage. Officials are now evaluating plans that seek certification on the federally facilitated marketplaces using a "reasonable access" standard that focuses on provider practice areas that have historically raised network adequacy concerns.[30] HHS also recently adopted more stringent requirements for provider directories, including an obligation for insurers to update those lists online at least once each month.[31] Meanwhile, the NAIC is considering revisions to its existing network adequacy model law.[32] The current version served as a template for federal network adequacy rules and HHS has indicated it will await the results of the NAIC's work before proposing significant changes to the federal framework.[33]

As these developments unfolded, many state policymakers weighed whether to revisit their states' standards. Prior to 2014, nearly all states had erected some sort of regulatory framework for network adequacy. As a practical matter, however, oversight processes were highly uneven both across and within states. In many instances, adequacy requirements applied only to certain types of network designs. Moreover, because assessing compliance with network standards can be complex and resource-intensive, fairly few states conducted regular reviews of plan networks after an insurer had been granted its state license.

In the first year of marketplace coverage, most states maintained these rules as-is or made only incremental

changes. Two states, Arkansas and Washington, joined the ranks of those that use a quantitative measure to evaluate the adequacy of plan networks, bringing the total number to 29 states by January 2015. More states prioritized efforts to improve the accuracy and timeliness of provider directories—14 now require directory updates at least semiannually or within a specified interval from any change—or to bolster the authority of regulators to oversee and enforce their network rules.

The relatively deliberate pace of regulatory change at the state level in 2014 is not altogether surprising. To grapple with recent developments in network design, states must balance competing considerations: consumer (and provider) interest in broad access to in-network care on one hand, and consumer (and insurer) interest in flexible health plan designs that facilitate more affordable premiums on the other. There is evidence that some states may have been reluctant to act too aggressively or too quickly in the absence of robust market data and feedback from consumers and stakeholders about their experiences with narrow network marketplace plans.[34] Others have begun to solicit stakeholders' input with an eye toward developing new rules or oversight mechanisms in the future.[35]

As the process of refining regulatory approaches to narrow networks moves forward on multiple tracks—in individual states, at the NAIC, and at the federal level—it is possible that more states will pursue policies similar to those that proved popular among state officials in 2014. More may seek to enhance network transparency, so consumers can better understand the trade-offs posed by these plans, and to strengthen oversight authority, so regulators may more effectively monitor compliance with existing standards. This latter approach may also include efforts to collect and process data that illustrate how networks are working for consumers, including information on use of out-of-network services and claims appeals.[36] As the marketplaces move through their second year, continued tracking and analysis of these developments will be essential to understanding how consumers are experiencing their coverage.

Notes

[1] N. Bauman, E. Coe, J. Ogden et al., Hospital Networks: Updated National View of Configurations on the Exchanges (New York: McKinsey Center for U.S. Health System Reform, June 2014).

[2] S. Corlette, J. Volk, R. Berenson et al., Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care (Washington, D.C.: Georgetown University Center on Health Insurance Reforms, May 2014).

[3] Bauman, Coe, Ogden et al., Hospital Networks, 2014.

[4] Pub. L. 111-148, 124 Stat. 782 (2010) § 1311(c)(1)(B) (codified at 42 U.S.C. § 18031(c)(1)(B)).

[5] 45 C.F.R. § 156.230. In addition, the health law requires marketplace plans to include within their networks a sufficient number and geographic distribution of "essential community providers" that serve predominantly low-income, medically underserved individuals. Pub. L. 111-148, 124 Stat. 782 (2010) § 1311(c)(1)(C) (codified at 42 U.S.C. § 18031(c)(1)(C); 45 C.F.R. § 156.235. For analysis of how some states have implemented the essential community providers requirement, see S. Rosenbaum, N. Lopez, D. Mehta et al., Realizing Health Reform's Potential: How Are State Insurance Marketplaces Shaping Health Plan Design? (New York: The Commonwealth Fund, Dec. 2013); S. McCarty and M. Farris, ACA Implications for State Network Adequacy Standards (Princeton, N.J.: State Health Reform Assistance Network, Aug. 2013).

[6] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final

Rule, Interim Final Rule, 77 Fed. Reg. 18310, 18418-20 (Mar. 27, 2012) (the "ACA Exchange Standards Final Rule").

[7] State network adequacy standards may apply broadly, to all network plans, or more narrowly, to specified network designs (e.g., health maintenance organizations (HMOs)) or plan types (e.g., marketplace plans). Our analysis focuses on state standards that apply to marketplace plans in either of two ways: 1) through state action that specifically identifies the requirements for marketplace plans; or 2) to the extent a marketplace plan uses a network design (e.g., HMO) that is regulated by the state standard. Thus, in a given state, a standard may apply to some, but not necessarily all, marketplace plans, depending on its scope.

[8] Consumer Representatives to the National Association of Insurance Commissioners, "Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market," (Kansas City, Mo., NAIC, Nov. 2014), http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf (http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf).

[9] Md. Code Regs. 31.10.34.04.

[10] Kan. Stat. Ann. § 40-4607. In Kansas, and in many other states with similarly drafted requirements, insurers can establish compliance with their regulatory obligations by reference to "any reasonable criteria" of the carrier's choosing. These may include but are not limited to many of the quantitative measures of adequacy identified in this brief.

[11] National Association of Insurance Commissioners, "Managed Care Plan Network Adequacy Model Act #74" (Kansas City, Mo.: NAIC) http://www.naic.org/store/free/MDL-74.pdf (http://www.naic.org/store/free/MDL-74.pdf).

[12] N.J. Admin. Code § 11:24A-4.10.

[13] Mont. Admin. R. 37.108.227.

[14] Nevada Silver State Health Insurance Exchange, "Network Adequacy Standards for Qualified Health Plans Marketed in the Silver State Health Insurance Exchange," 2013, http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Resources/Final_Exchange_Network_Adequacy_Standards.pdf (http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Resources/Final_Exchange_Network_Adequacy_Standards.pdf).

[15] Cal. Code Regs. tit. 10 § 2240.1.

[16] 45 C.F.R. § 156.230. Under the federal rules, provider directories must also identify those in-network providers who are not accepting new patients.

[17] Arkansas Insurance Department, "Bulletin No. 11A-2013: Network Adequacy Requirements for Health Plan Certification in Arkansas Federally-Facilitated Marketplace," May 14, 2013, http://www.insurance.arkansas.gov/Legal/Bulletins/11A-2013.pdf (http://www.insurance.arkansas.gov/Legal/Bulletins/11A-2013.pdf).

[18] A third state, Illinois, revised existing quantitative standards specifying maximum travel times and distances and provider-to-enrollee ratios to make them more strict for 2015. Illinois Department of Insurance, "Network Adequacy Checklist," 2014, http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/documents/NETWORKadequacydocument.pdf (http://insurance.illinois.gov/LAH_HMO_IS3_Checklists/documents/NETWORKadequacydocument.pdf). In Minnesota, legislation enacted in 2013 to apply quantitative requirements to all network plans—previously, the state had such requirements for health maintenance organizations, only—took effect in January 2015. Minn. Stat. Ann. § 62K.10.

[19] Ark. Code R. 054.00.106-5.

[20] Cal. Code Regs. tit. 10 § 2240.15.

[21] Wash. Admin. Code 284-43-200.

[22] Connecticut Health Insurance Exchange, "Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace," May 19, 2014, http://www.ct.gov/hix/lib/hix/QHP_Solicitation_051914_Amended.pdf (http://www.ct.gov/hix/lib/hix/QHP_Solicitation_051914_Amended.pdf); Nevada Division of Insurance, "Bulletin 14-005: Network Adequacy Standards for Certain Health Benefit Plans—2015 Transitional Year," June 30, 2014, http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notices/Bulletins/14-005.pdf (http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notices/Bulletins/14-005.pdf); N.Y. S.B. 6914; Wash. Admin. Code 284-43-204.

[23] Wash. Admin. Code 284-43-204.

[24] N.Y. S.B. 6914.

[25] Ill. H.B. 3638; Me. H.B. 1199.

[26] Cal. S.B. 1964.

[27] Miss. Admin. Code 19-3:16.05, 19-3:16.10.

[28] ACA Exchange Standards Final Rule, 77 Fed. Reg. 18310, 18419 (Mar. 27, 2012).

[29] Center for Consumer Information and Insurance Oversight, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges," Apr. 5,

2013 (Washington, D.C.: CCIIO), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf); J. Holahan, R. Peters, K. Lucia et al., Cross-Cutting Issues: Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States (Washington, D.C.: The Urban Institute, July 2013).

[30] Center for Consumer Information and Insurance Oversight, "2015 Letter to Issuers in Federally-facilitated and Marketplaces," Mar. 14, 2014 (Washington, D.C.: CCIIO), http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf; see also Center for Consumer Information and Insurance Oversight, "FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces," Feb. 20, 2015 (Washington, D.C.: CCIIO), http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf (http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf). Regulators have indicated that their areas of focus may include hospital systems, mental health providers, oncology providers, primary care providers, and, in 2016, dental providers, if applicable.

[31] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule. 80 Fed. Reg. 10750, 10830 (Feb. 27, 2015) (the "ACA Benefit and Payment Parameters for 2016 Final Rule").

[32] See, for example, S. Hansard, "State Insurance Regulators Consider New Regulations for Health Insurance Networks," Bloomberg BNA, Nov. 20 2014, accessed Dec. 3, 2014, http://www.bna.com/state-insurance-regulators-b17179912142/ (http://www.bna.com/state-insurance-regulators-b17179912142/).

[33] ACA Exchange Standards Final Rule, 77 Fed. Reg. 18310, 18418-19 (Mar. 27, 2012); ACA Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10750, 10830 (Feb. 27, 2015).

[34] S. Corlette, K. Lucia, and S. Ahn, Implementation of the Affordable Care Act: Cross-Cutting Issues Six-State Case Study on Network Adequacy (Washington, D.C.: The Urban Institute, Sept. 2014).

[35] By January 2015, several jurisdictions, including the District of Columbia, Maryland, Nevada, New Hampshire, and Oregon, had begun the rulemaking process or convened working groups to evaluate options for forthcoming regulatory action.

[36] Gaining access to such data is made easier by the existence of broad insurance company disclosure requirements contained in the ACA. See J. Giovannelli, K. Lucia, and S. Dash, "The Affordable Care Act's Disclosure Rules: Can They Improve Coverage, Raise Care Quality, and Cut Costs?" (/publications/blog/2014/jan/insurer-transparency) The Commonwealth Fund Blog, Jan. 15, 2014.

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An Early Look At SHOP Marketplaces: Low Premiums, Adequate Plan Choice In Many, But Not All, States

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ABSTRACT **The Affordable Care Act created the Small Business Health Options Program (SHOP) Marketplaces to help small businesses provide health insurance to their employees. To attract the participation of substantial numbers of small employers, SHOP Marketplaces must demonstrate value-added features unavailable in the traditional small-group market. Such features could include lower premiums than those for plans offered outside the Marketplace and more extensive choices of carriers and plans. More choices are necessary for SHOP Marketplaces to offer the "employee choice model," in which employees may choose from many carriers and plans. This study compared the numbers of carriers and plans and premium levels in 2014 for plans offered through SHOP Marketplaces with those of plans offered only outside of the Marketplaces. An average of 4.3 carriers participated in each state's Marketplace, offering a total of forty-seven plans. Premiums for plans offered through SHOP Marketplaces were, on average, 7 percent less than those in the same metal tier offered only outside of the Marketplaces. Lower premiums and the participation of multiple carriers in most states are a source of optimism for future enrollment growth in SHOP Marketplaces. Lack of broker buy-in in many states and burdensome enrollment processes are major impediments to success.**

With little publicity, the Small Business Health Options Program (SHOP) began operations in 2014. Created by the Affordable Care Act (ACA), SHOP Marketplaces are online Marketplaces where small employers (those with fifty or fewer full-time-equivalent employees) can purchase coverage from multiple carriers and plans. In 2016, companies with a hundred or fewer employees will be able to participate. The Congressional Budget Office has estimated that SHOP enrollment will reach three million people in 2017.[1] The Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight has not disclosed SHOP enrollment in federally facilitated Marketplaces, but the Government Accountability Office has reported 78,000 people were enrolled in state-based SHOP exchanges in June 2014.[2]

SHOP aims to help small businesses offer affordable coverage to their employees and to provide individual employees with choices among plans and issuers. Prior to the passage of the ACA, the small-group insurance market was in decline in many states and was characterized by medical underwriting (the use of an individual's health status to determine the cost of, or to deny, coverage) and unexpected premium changes from year to year.[3] Between 2002 and 2014 the percentage of firms with three to nine workers that offered health benefits declined from 58 per-

cent to 44 percent.[4] For the smallest employers (those with 1–9 workers), premiums for similar benefit levels averaged 18 percent more than for large employers (1,000 or more workers) in 2002.[5]

Brokers play a major role in the workings of the small-group market and will likely continue to do so with the SHOP Marketplaces. Eighty percent of small employers use a broker or an agent, who often serves as a de facto benefit manager. Eight-four percent of brokers select health plans, 79 percent enroll employees, and 59 percent provide customer service such as claims adjudication.[6] Brokers' resistance to SHOP Marketplaces can represent a major obstacle to the use of exchanges, as discussed below.

Under the ACA, states can establish and administer their own SHOP Marketplaces, and seventeen states and the District of Columbia have decided to do so. States can also decide to participate instead in the federally facilitated Marketplace, managed by the Department of Health and Human Services, or to operate a SHOP Marketplace in partnership with the federal government, with each party assuming some responsibilities.[7]

SHOP Marketplaces can adopt one of two general models: the "employer model" or the "employee choice model." In the employer model, the employer chooses a single plan, and all employees who opt for coverage can enroll only in that plan.

In the employee choice model, the employer makes a fixed contribution toward plan offerings in the SHOP Marketplace based on a designated metal tier. States offer different variants of this model.

One approach allows employees to choose plans from all tiers, while another allows employees to choose plans only from the employer's designated metal tier (in 2014 nine states allowed employees to select plans from multiple insurers and multiple tiers).[8] In either case, employees must pay for higher-cost plans out of pocket to make up any difference between the premium for their chosen plan and the employer's contribution. In 2014 all but one state-based SHOP Marketplace used the employee choice model, while states relying on the federally facilitated or federal-state partnership approach used the employer model.[9]

Health insurance exchanges for small employers are not a new idea. Over the past twenty-five years a number of states—including California, Colorado, Connecticut, Florida, Kansas, Kentucky, North Carolina, and Washington—attempted to build what were termed "health insurance purchasing cooperatives," but none enjoyed widespread success.[10]

There are clear lessons from these earlier attempts. The first is that underwriting rules must be the same for plans inside and outside the cooperatives or similar organizations.[11] In earlier models, many states prohibited medical underwriting within the health insurance purchasing cooperative pools but allowed it outside them. The inevitable result was adverse selection, which in turn led to high medical claims, expenses, and premiums.

Another lesson from the failure of cooperatives was that large insurers often did not want to participate because they feared that they would lose market share to smaller insurers with greater and more transparent choice of carriers. Without the participation of large insurers, brokers and small employers viewed the cooperatives as an inferior source of coverage. Fearing adverse selection, insurers also were reluctant to offer preferred provider organization (PPO) plans because sicker people were more likely to enroll in them, seeking a broader choice of providers.[12]

If SHOP Marketplaces are to succeed where health insurance purchasing cooperatives failed and enroll substantial numbers of small employers, they must not only address these problems but also demonstrate value-added features not available in the traditional small-group insurance market. First, insurance carriers can set premiums for plans offered in the SHOP Marketplace that are lower than the premiums they offer outside it. Second, employers with fewer than twenty-five workers can receive tax credits if they purchase plans in a SHOP Marketplace.[13] Third, the Marketplaces can enhance employee choice. When using the employee choice model, employers can make a defined contribution and allow employees to select from plans among multiple carriers and, in some states, multiple metal tiers—instead of being able to select just one plan from one carrier. Fourth, with defined contributions, employers can reduce the financial risk of future increases in premiums.

In this study we examined evidence that the SHOP Marketplaces have laid the groundwork for their success in providing the value-added features noted previously. First, we compared premiums for plans sold in the Marketplaces with premiums for plans sold only outside of them. Insurers participating in Marketplaces such as these customarily offer some plans only outside of the Marketplaces as well. According to the rules promulgated by the Center for Consumer Information and Insurance Oversight, plans offered in the SHOP Marketplaces must also be sold outside of them but underwritten as if they were one plan.

Second, we assessed the availability of plans offered in the SHOP Marketplaces by metal tier and number of carriers to determine whether there are sufficient numbers for the employee choice model to offer meaningful different alternatives. To our knowledge, this study provides the first comparison of plan choices in and outside of the SHOP Marketplaces and the first comparison of the costs of coverage for plans from the same metal tier in and outside of the Marketplaces.

Concentration In The Small-Group Market

A major concern of the Obama administration was whether sufficient numbers of carriers would sell plans in the SHOP Marketplaces. The small-group market is heavily concentrated, with the largest insurer—usually a Blue Cross and Blue Shield plan—holding 50 percent or more of the market in twenty-six states.[14] To encourage large carriers to participate in the SHOP Marketplaces in each state, in 2014 the Center for Consumer Information and Insurance Oversight applied a "tying" provision in states with federally facilitated Marketplaces. The provision, which remains in effect for 2015, requires insurers with a share of at least 20 percent in the small-group market to participate in the SHOP Marketplace as a condition for participating in the larger and potentially more profitable individual Marketplace in the same state.[15]

In 2014 the Department of Health and Human Services did not implement key features of SHOP Marketplaces in federally facilitated Marketplaces. These features included online enrollment through the SHOP website and employee choice. As a result, the initial appeal of the SHOP Marketplace was limited.

In 2015 employee choice is still not available in eighteen of the thirty-two states with federally facilitated or partnership Marketplaces.[16] In states where employee choice is offered in the federal SHOP Marketplace, choices are limited to plans available at a single metal tier (bronze, silver, gold, or platinum) chosen by the employer. Thus, the ultimate ability of the federal SHOP Marketplace to attract employers is likely to remain unclear for several years.

We interviewed officials at nine insurance carriers to elicit their views about the SHOP Marketplaces. The carriers were a mixture of large and small and of publicly traded, nonprofit, and cooperative carriers. The officials agreed that the primary reasons employers would purchase health insurance for their employees through the SHOP Marketplace were to obtain the tax credit and to offer employee choice. But the officials believed that the tax credit would not induce many small employers to change how they obtained insurance because the credit was too small, was available for too short a time, and required too much paperwork.

The officials also expressed some concern that brokers may have deliberately downplayed the benefit of the tax credit to small employers, discouraging some employers from applying for the credit. In general, officials believed that most brokers do not feel "plugged in" to the SHOP concept and view it as competition. Officials also noted that in 2014 the federally facilitated SHOP Marketplace was not user-friendly or transparent, and that most enrollments had to be done on paper. (Employers could view choices online but needed to contact a broker or insurer to complete the transaction.) At the very least, the officials said, small employers need to be able to shop for products and complete the enrollment process online.

In the past few years, benefit consulting firms and insurers have built an alternative to SHOP Marketplaces—private exchanges—that can offer both a defined- contribution model and multiple plans from multiple carriers. Private exchanges currently account for about 3 percent of enrollment in employer-based health insurance.[4] Hence, ease of enrollment in SHOP Marketplaces must be comparable not only to that outside the Marketplaces, but also to that in private exchanges.

Study Data And Methods

DATA AND SAMPLE DESIGN Data presented in this article are from twenty-six states (counting the District of Columbia as a state), which collectively offered more than 6,000 plans in and outside of the SHOP Marketplaces. Fifteen states in the sample had their own state-based Marketplaces (all but one of those states—Rhode Island—used the employee choice model), while eleven used the federally facilitated Marketplace or the partnership model (and the employer model; Exhibit 1). States with state-based SHOP Marketplaces accounted for more than 4,200 plans, and states with federally facilitated and partnership SHOP Marketplaces accounted for more than 1,800.

The availability of data determined which states were in our sample. We selected all states with state-based, federally facilitated, or partnership SHOP Marketplaces that had publicly accessible data on their state insurance department websites about plans offered, premiums, and cost-sharing provisions.

Within each state the sample included all plans offered in the SHOP Marketplace (regardless of

the carrier) and all plans offered outside of the Marketplace from a sample of carriers that had at least 1 percent of market share. This prevented legacy or other small carriers from skewing the estimates. A legacy carrier is one that no longer sells to new buyers but whose long-term members have been grandfathered into plans first offered years ago.

Through searches of both state insurance department websites and state SHOP websites, we collected data for plans not offered in the SHOP Marketplaces in federally facilitated or partnership states and for both plans in the SHOP Marketplaces and plans outside of them in states with state-based SHOP Marketplaces. For federally facilitated or partnership states, all information about plans in the Marketplaces was gathered from the Qualified Health Plan SHOP Medical Landscape File made public by Center for Consumer Information and Insurance Oversight.

Within each state, we sampled three geographic rating regions. These rating areas corresponded to an urban metropolitan area, a suburban area or medium-size city, and a rural area in each state. We used rating area information from the Center for Consumer Information and Insurance Oversight[17] and data from the Area Health Resources Files[18] to randomly select three rating areas in each state for analysis. For multivariate analysis, we also used the Area Health Resources Files to provide information on population, the percentage of uninsured patients, and median family income for each rating area, based on an aggregation of the characteristics of its component counties.

Among the variables downloaded from state insurance department and SHOP websites were state, carrier, data source, whether a plan was available in the SHOP Marketplace, product type (health maintenance organization [HMO], exclusive provider organization [EPO], PPO, point-of-service [POS] plan, indemnity plan, or high-deductible health plan [HDHP]), plan identification number, metal tier, plan name, premium in the sampled urban region, premium in the sampled suburban region, and premium in the sampled rural region.

WEIGHTING AND AGGREGATION The Center for Consumer Information and Insurance Oversight has not published SHOP enrollment data by plan or carrier. As a result, our study used data from 2013 enrollments and business volume to identify characteristics of carriers such as Blue Cross Blue Shield affiliation or new entrants into the small-group market (which were not listed in the 2013 records). But we did not consider 2013 enrollments by carrier for the small-group market to be an accurate proxy for enrollment in plans through the SHOP Marketplaces.[19]

Consequently, we elected to begin from the assumption that carriers in the SHOP Marketplace start on an equal footing. Thus, the weighting model did not take a carrier's characteristics into account.

However, we found significant variation in the number of options a carrier offered, from a single plan to more than 700. We considered a number of options for weighting the observations. We could weight each plan equally, by state or nationally. This would have the undesirable effect of crowding out data for smaller carriers, particularly most of the new entrants (including the cooperative carriers), in favor of the few carriers with hundreds of plans. At the other extreme, we could weight each carrier equally, dividing the carrier's weight equally among its plan offerings. This model effectively assumes that there is no value created by offering more than one plan, which is similarly undesirable.

Instead, we elected to use a weighting scheme that took the number of plan options a carrier offered into account but that heavily "discounted" carriers offering hundreds of plans. A carrier's weight within its state was therefore the log of the number of plans it offered, with a floor of 1.

ANALYSIS To address our study's research questions, we used both descriptive and multivariate analyses. To display the availability of plans in the SHOP Marketplaces, we present data on the number of carriers and plans offered in and outside of the Marketplace by tier level. To examine comparative premiums in and outside of the Marketplace, we first display descriptive statistics by metal tier for the twenty-six states in our study. We present premiums for a forty-year-old nonsmoker to standardize data across plans.

In the multivariate analysis, with premiums as the dependent variable, we estimated a generalized linear model for a pooled sample of plans in and outside of the Marketplace. There were two questions of primary interest: Is the plan offered in or outside of the Marketplace? And does the carrier participate in the Marketplace or not?

The control variables include whether the state was using the employee choice model or the employer model; characteristics of the carrier, including whether it was a tied carrier (that is, a carrier with a share of at least 20 percent of the small-group market in 2012) or a new entry and what share of the small-group market it had in 2013; characteristics of the rating area such as per capita income and percentage of the population that was uninsured; characteristics of the plan, including plan type (HMO or EPO, PPO, HDHP with a savings option, or indemnity plan) and metal tier; measures of competition such as

the number of carriers selling in the rating area in the small-group market; and a dummy variable for each state. The dummy variable for each state was intended to control for unobserved variables associated with each state, such as state regulatory requirements. Online Appendix Table 1[20] displays the means and standard errors for each independent variable used in the multivariate analysis.

LIMITATIONS The major limitations of the analysis are related to the availability of some data elements. First, it is not possible from carriers' filings with their state insurance department to determine whether a plan has a broad or narrow network of providers. Our information on networks was from the carriers' websites, and, more often than not, the providers listed were carrier specific instead of plan specific.

Second, metal tiers reflect the actuarial value of each plan based on the essential benefits required by the state. If a plan offered benefits beyond the essential ones, those data were not available to us for analysis.

Third, ideally our regression model would have included some metrics for competition in the hospital and physician markets. However, because of the complexity of the rating areas and geographic provider markets, we were not able to measure provider concentration.

Finally, our analysis was limited to twenty-five states and the District of Columbia. States whose websites did not present data on plans offered outside of the SHOP Marketplace were not included in the sample.

EXHIBIT 1

Number Of Plans In And Outside Of The Small Business Health Options Program (SHOP) Marketplaces, By State And Metal Tier

	Number of plans					
	In SHOP Marketplace			Not in SHOP Marketplace		
State/model	Bronze	Silver	Gold	Bronze	Silver	Gold
EMPLOYEE CHOICE MODEL STATES						
All	126	278	265	644	1,139	1,142
CA	4	8	2	34	49	59
CO	16	24	15	7	16	8
CT	8	12	7	8	5	12
DC	14	89	110	1	1	—[a]
HI	—[a]	3	8	—[a]	—[a]	—[a]
KY	6	8	8	14	67	39
MD	23	33	32	27	93	103
MN	9	17	19	28	87	72
NV	3	8	7	63	113	136
NY	15	18	12	314	406	438
OR	13	17	12	112	199	175
UT	9	33	28	21	46	33
VT	5	6	4	1	—[a]	—[a]
WA	1	2	1	14	57	67
Average	9.0	19.9	18.9	46.0	81.4	81.6
EMPLOYER MODEL STATES						
All	82	145	144	235	498	533
AL	4	5	5	5	13	19
FL	—[a]	2	2	—[b]	—[b]	—[b]
KS	2	3	2	—[a]	1	—[a]
ME	3	3	2	24	28	9
MI	9	19	22	7	28	45
MT	6	10	5	—[b]	—[b]	—[b]
OH	24	33	54	73	86	122
PA	13	34	24	24	75	66
RI	2	5	5	12	21	47
TN	1	4	4	39	94	58
VA	12	12	9	45	134	147
WI	6	15	10	6	18	20
Average	6.8	12.1	12.0	19.6	41.5	44.4
ALL STATES						
Total	208	423	409	879	1,637	1,675
Average	8.0	16.3	15.7	33.8	63.0	64.4

SOURCE Authors' analysis of data from state health insurance department websites, state Marketplace websites, and the Qualified Health Plan SHOP Medical Landscape File made public by the Center for Consumer Information and Insurance Oversight. **NOTE** Catastrophic and platinum plans are excluded from this exhibit because of space, but data from catastrophic and platinum plans were included in the regression analyses. [a]Insufficient sample size. [b]No data on plans sold outside of the SHOP Marketplace are available for Florida or Montana.

Study Results

AVAILABILITY OF PLANS In our sample, the average number of carriers per state was 4.3, offering a total of forty-seven plans to choose from (Appendix Table 2).[20] On average, 3.2 carriers in each state did not offer plans in the SHOP Marketplace but sold insurance to small employers only outside of the Marketplace. And in the average state, 201.1 plans were sold only outside of the Marketplace, roughly 4.3 times as many as were available in the Marketplace.

There was substantial variation across states. Only one insurer participated in Washington State's SHOP Marketplace. In seven states (Alabama, Florida, Hawaii, Kansas, Maine, Tennessee, and Vermont) only two carriers sold plans in the SHOP Marketplace. In contrast, there were ten insurers that offered plans in the SHOP Marketplace in Maryland; nine in Michigan, New York, and Pennsylvania; and seven in Ohio.

Nationally, an average of eight bronze, sixteen silver, and sixteen gold plans were available in a state's SHOP Marketplace (Exhibit 1). Among plans sold only outside of the Marketplace, the average numbers were thirty-four bronze, sixty-three silver, and sixty-four gold plans. In general, states using the employee choice model offered more plans both in SHOP Marketplaces and outside of them, compared to states using the employer model.

PREMIUMS FOR PLANS IN AND OUTSIDE OF MARKETPLACES The average monthly premium for single coverage for plans sold in the SHOP Marketplaces was $299 for bronze plans, $352 for silver plans, and $414 for gold plans

(Exhibit 2). Comparing plans in the same metal tier, the average premium for plans sold in the SHOP Marketplaces was lower than that for plans sold outside them by 5 percent for bronze and silver plans and by 4 percent for gold plans. All differences were significant ($p<0.05$).

Employee choice model states and employer model states showed different patterns, however. In the employer model states, premiums for bronze and silver plans in the SHOP Marketplaces were slightly higher than premiums for plans in those tiers offered only outside of the Marketplaces. In contrast, in the employee choice model states, plans in the SHOP Marketplaces had lower premiums for all metal tiers, compared to plans outside of the Marketplaces.

Kansas had the lowest premiums for bronze plans, and Hawaii had the lowest premiums for silver and gold plans in the SHOP Marketplaces, with Kansas and Alabama having the lowest premiums for silver and gold plans, respectively, outside the Marketplaces. New York had the highest premiums for bronze, silver, and gold plans.

When we looked at all study states together, we found that HMO and EPO plans in the SHOP Marketplaces had lower average premiums for all metal tiers than plans sold only outside of them—19 percent lower for bronze and 9 percent lower for silver and gold plans (Exhibit 3). In contrast, PPO and POS plans had comparatively higher premiums for bronze plans in the SHOP

EXHIBIT 2

Monthly Premiums Of Plans In And Outside Of The Small Business Health Options Program (SHOP) Marketplaces, By State And Metal Tier

	Average premiums ($)					
	In SHOP Marketplace			Not in SHOP Marketplace		
State/model	Bronze	Silver	Gold	Bronze	Silver	Gold
EMPLOYEE CHOICE MODEL STATES						
Average	315.73**	363.59**	429.38**	339.32	391.19	446.99
CA	304.14	368.67	460.59	320.42	397.68	478.05
CO	302.16	360.42	440.21	288.67	345.14	427.57
CT	342.31	418.87	504.33	349.75	423.47	526.27
DC	245.94	310.52	392.43	237.16	338.09	—[a]
HI	—[a]	254.93	297.01	—[a]	—[a]	—[a]
KY	284.40**	304.42**	346.19**	323.92	441.69	441.13
MD	316.08**	381.83**	453.09**	425.83	478.63	523.69
MN	281.74	332.49	384.97	267.64	328.06	388.98
NV	336.75	322.46	377.75	318.38	368.98	423.41
NY	367.60**	448.22**	531.13**	446.85	506.26	554.53
OR	304.84	390.67**	464.19**	291.18	351.98	396.37
UT	251.87	306.33**	335.43**	258.00	324.08	377.52
VT	353.06	418.09	498.21	341.95	—[a]	—[a]
WA	328.45	357.10	451.12	271.77	360.09	407.30
EMPLOYER MODEL STATES						
Average	277.83**	340.61**	398.29	267.84	331.17	403.74
AL	260.99	319.71**	373.11**	261.14	277.69	311.87
FL	—[a]	405.48	454.73	—[b]	—[b]	—[b]
KS	220.82**	267.53	305.20	208.76	245.10	321.28
ME	304.37**	347.76	436.64	266.49	339.58	415.72
MI	280.33	348.76**	394.79	260.98	305.90	388.91
MT	277.27	330.99	389.07	—[b]	—[b]	—[b]
OH	279.63**	355.07**	409.91**	291.51	392.61	473.85
PA	278.20**	314.29	362.35**	233.19	297.37	335.64
RI	263.13	308.37**	397.91**	268.18	323.13	378.45
TN	239.15**	308.37	367.11**	258.63	318.70	402.64
VA	260.62	310.14	353.73**	259.14	319.78	390.98
WI	308.94**	378.83**	452.15**	384.49	451.35	508.52
ALL STATES						
Average	298.98**	351.60**	413.90**	313.62	370.17	431.01

SOURCE Authors' analysis of data from state health insurance department websites, state Marketplace websites, and the Qualified Health Plan SHOP Medical Landscape File made public by the Center for Consumer Information and Insurance Oversight. **NOTE** Significance indicates difference between premiums for plans in the SHOP Marketplaces and those for plans outside them. [a]Insufficient sample size. [b]No data on plans sold outside of the SHOP Marketplace are available for Florida or Montana. **$p<0.05$

EXHIBIT 3

Average Monthly Premiums, By Product Type, For Plans Sold In And Outside Of The Small Business Health Options Program (SHOP) Marketplaces, By Metal Tier

	Average premiums ($)					
	In SHOP Marketplace			Not in SHOP Marketplace		
Product type/model	Bronze	Silver	Gold	Bronze	Silver	Gold
EMPLOYEE CHOICE MODEL STATES						
HMO/EPO	308.11**	351.45**	426.39**	368.57	389.54	466.27
PPO/POS	322.72	381.63	434.01	312.48	389.94	433.86
Indemnity	—[a]	—[a]			583.33	—[a]
HDHP	332.35	336.34	—[a]	305.63	325.93	340.95
EMPLOYER MODEL STATES						
HMO/EPO	261.48	326.58	380.09	257.86	321.12	375.61
PPO/POS	287.43**	351.11**	413.93**	272.32	331.86	401.27
Indemnity	—[a]	—[a]	—[a]	—[a]	484.52	1,050.40
HDHP	—[a]	—[a]	—[a]	250.96	327.49	420.61
ALL STATES						
HMO/EPO	291.46**	339.78**	406.49**	346.54	369.46	443.36
PPO/POS	303.11**	363.48	422.44	293.90	367.88	420.03
Indemnity	—[a]	—[a]	—[a]	—[a]	544.76	1,050.40
HDHP	332.35**	336.34	—[a]	281.49	326.43	404.30

SOURCE Authors' analysis of data from state insurance department websites, state Marketplace websites, and the Qualified Health Plan SHOP Medical Landscape File made public by the Center for Consumer Information and Insurance Oversight. **NOTES** Significance indicates the difference between premiums for plans in the SHOP Marketplaces and those for plans outside them. HMO is health maintenance organization. EPO is exclusive provider organization. PPO is preferred provider organization. POS is point of service plan. HDHP is high-deductible health plan. [a]Insufficient sample size. **$p<0.05$

Marketplaces, with no significant difference for silver and gold plans.

MULTIVARIATE ANALYSIS A host of intervening variables may explain why premiums are higher for plans outside of the Marketplaces. For example, it may be that such plans are more heavily concentrated in high-cost states and rating areas. To hold other factors constant, we conducted a multivariate analysis that pooled all plans in and outside of the Marketplaces (Appendix Table 3). Appendix Table 4[20] shows elasticities for continuous variables and marginal effects for binary variables.

When we held other factors constant, we found that plans sold in the SHOP Marketplaces had premiums that were 7 percent lower than plans sold only outside of the SHOP Marketplaces (see Appendix Table 4).[20] The premiums of carriers not participating in the Marketplaces were 2 percent higher than those of participating carriers.

For each additional carrier competing in a rating area, premiums for plans in and outside the SHOP Marketplaces declined substantially. Plans offered by cooperative plans and Medicaid plans had premiums that were 2 percent and 11 percent lower, respectively, than commercial plans. Overall, premiums in rural areas were 3 percent higher than in urban areas, but there was no difference in cost between urban and suburban areas. PPO and POS plans had premiums that were 3 percent higher than those for HMO and EPO plans, and high-deductible plans with a savings option had premiums that were 9 percent higher than those for HMO or EPO plans.

Discussion

To succeed in enrolling large numbers of small employers, SHOP Marketplaces must offer value-added features not available in the conventional small-group insurance market. Potential value-added features include lower premiums, tax credits, more employee choice of different carriers and metal tiers, and a defined-contribution model for employers that limits the risk of future premium increases. This study presents evidence with regard to the first three features.

In 2015 thirty-three states are expected to use some variation of the employee choice model.[8] However, if few carriers participate, and if those that do offer limited numbers of plans, then employees' selections of carriers and plans will be little different than would be the case with the employer model.

In our study we found that an average of 4.3 carriers offered plans in the SHOP Marketplaces, with an average of forty-seven plans to choose from in total. Three carriers per state on average did not participate in a SHOP Marketplace. The

Customer service—including ease of enrollment—in SHOP Marketplaces must be roughly comparable to that provided by private exchanges.

average number of carriers should be enough to offer a sufficient number of plans to make the employee choice and defined-contribution models feasible. However, some states are well below that average. For example, Washington State had only one carrier selling plans in its SHOP Marketplace, and seven states had just two carriers. We believe that those numbers are insufficient for the employee choice and defined-contribution models to function.

Many insurers participating in the SHOP Marketplaces offered a larger number of plans available only outside of the Marketplaces. Nationally, there were more than four plans offered outside of the SHOP Marketplaces for every plan offered in them.

In both descriptive and multivariate analyses, we found that plans in the SHOP Marketplaces had lower premiums than plans sold only outside of the Marketplaces. Multivariate results indicated that, on average, plans sold outside of the SHOP Marketplaces had premiums that were 7 percent higher than plans offered in the Marketplaces from the same metal tier. Carriers declining to participate in SHOP Marketplaces had premiums that were 2 percent higher than premiums of participating carriers.

Plans sold in rural rating areas had premiums that were 3 percent higher than premiums of plans sold in urban and suburban areas. This likely reflects insurers' difficulty obtaining discounts from rural hospitals and doctors in monopolistic or oligopolistic provider markets. We found that for each additional carrier competing in a rating area, premiums fell by 3 percent. Plans offered by cooperative plans and Medicaid plans had lower premiums than those sold by commercial carriers.

What do our findings suggest about the future of SHOP Marketplaces? Lower premiums should spark greater interest in the Marketplaces. But plans sold in the Marketplaces are also sold outside of them. Thus, tax credits or the availability of multiple choice of carriers and plans must be compelling selling points to employers. In some states—chiefly states that have state-based Marketplaces, use the employee choice model, and have sufficient numbers of carriers and plans—SHOP Marketplaces have a greater chance of succeeding, compared to the situation in states using the employer model with few carriers participating in the rating areas. In states with federally facilitated or partnership Marketplaces, and in those with state-based Marketplaces that have only a few carriers participating—as in Washington State, where there was just one carrier—greater participation by carriers is necessary for SHOP Marketplaces to have a chance to flourish.

Equally important for the Marketplaces' future growth is the commitment of brokers. If SHOP information technology remains clunky or nonexistent, if enrollment through the SHOP Marketplaces requires considerably more broker time than enrolling outside of them, and if broker compensation is lower for enrolling through the Marketplaces than outside of them, brokers will largely shun the Marketplaces. They may even view them as business and political adversaries. Simultaneously, customer service—including ease of enrollment—in SHOP Marketplaces must be roughly comparable to that provided by private exchanges.

Conclusion

No change in health care occurs instantaneously. Many innovations in health insurance such as HMOs, PPOs, health savings accounts, and health reimbursement accounts initially grew slowly but eventually became major insurance products. The health insurance purchasing cooperatives that preceded the SHOP Marketplaces and did not succeed often had to compete in small-group markets that had different underwriting rules than the remainder of the fully insured market. The fact that SHOP Marketplaces do not face such daunting disadvantages provides reason for optimism. ■

Jon Gabel testified before the House Small Business Subcommittee on Health and Technology on September 18, 2014. Some of the article's findings were included in his testimony. The authors thank Dean Mohs and Doug Pennington of the Center for Consumer Information and Insurance Oversight for their helpful comments.

NOTES

1 Congressional Budget Office. Insurance coverage provisions of the Affordable Care Act—CBO's March 2015 baseline [Internet]. Washington (DC): CBO; 2015 Mar. Table 3, Enrollment in, and budgetary effects of, health insurance exchanges; [cited 2015 Mar 16]. Available from: https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf

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9 States may use different variations of the employee choice model, which provides different breadths of plan options to employees, such as requiring them to choose from plans within a metal tier or from those offered by a single carrier. However, some states supported only limited choice for plan year 2014. These variations could be incorporated into future multivariate analyses.

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

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

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

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

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

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

The ACA And Insurance Marketplaces

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

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

Network Adequacy Under The ACA

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

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

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

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

Study Data And Methods

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

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

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

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

EXHIBIT 1

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

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

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

Permanente hospitals unless stated otherwise.

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

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

Study Results

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

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

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

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

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

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

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

EXHIBIT 2

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

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

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

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

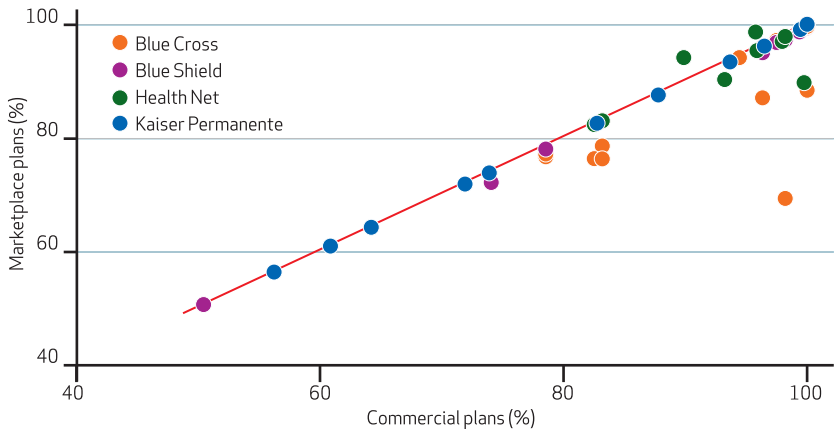
On average, 92 percent of residents were within at least one hospital market area in Marketplace plans. The number was slightly higher for commercial networks, which reached about 93 percent of people. Overall, thirty-one Marketplace networks and thirty-three commercial networks (out of seventy each)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

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

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

EXHIBIT 3

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



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

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

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

Discussion

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

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

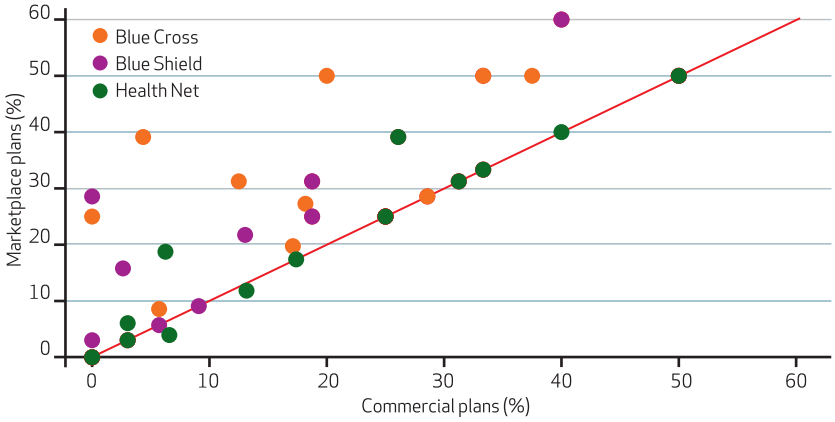
What do we know about why insurers seek to restrict hospital choice? Insurers have used a variety of tools to rein in rapidly increasing health care costs for decades, including consumer cost sharing,[24] product tiering,[24] and managed care.[25] In response to the recent wave of vertical and horizontal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

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

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

EXHIBIT 4

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



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

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

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

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

Conclusion

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

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By Katherine G. Carman, Christine Eibner, and Susan M. Paddock

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DATAWATCH

Trends In Health Insurance Enrollment, 2013–15

We examined insurance transitions between September 2013 and February 2015, before and after the Affordable Care Act's coverage-related provisions took effect in 2014. We found that 22.8 million people gained coverage and that 5.9 million people lost coverage, for a net increase of 16.9 million people with insurance.

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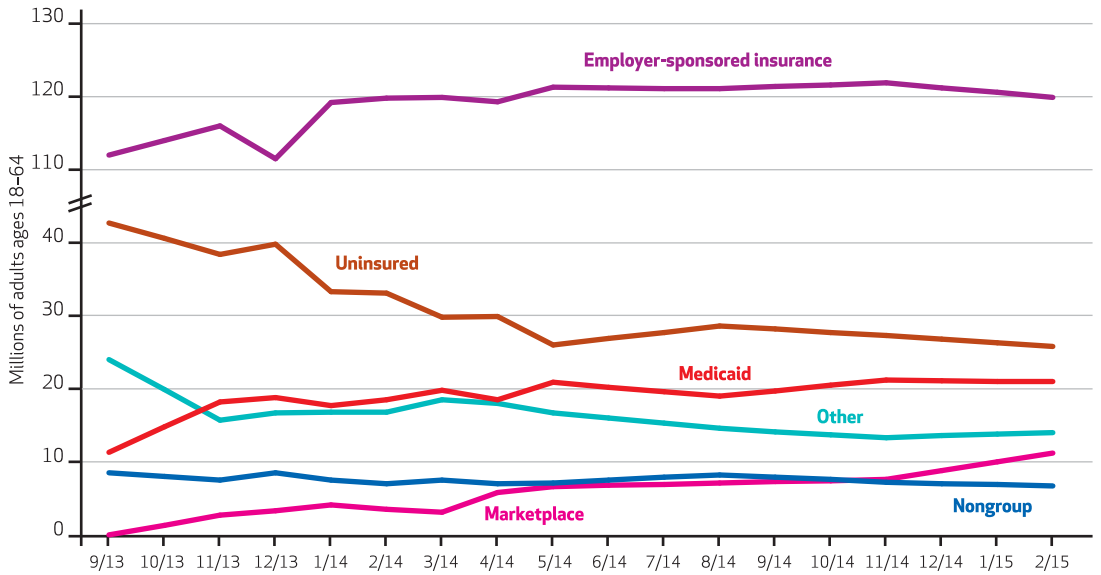
There is by now substantial evidence that approximately ten million people gained health insurance coverage following the first Affordable Care Act (ACA) open enrollment period, which occurred between October 2013 and April 2014.[1–3] Despite these gains, roughly 16 percent of the US population remained uninsured.[1] Policy makers and the Congressional Budget Office anticipated that rates of insurance coverage would continue to increase following subsequent open enrollment periods. In this analysis we investigated changes in insurance coverage following the ACA's second open enrollment period, which occurred between November 2014 and February 2015. We used longitudinal data from the RAND Health Reform Opinion Study, which enabled us to estimate transitions across types of insurance coverage. Our study focused on adults ages 18–64, the group most likely to have been affected by ACA's coverage expansions.

Exhibit 1 shows changes in insurance coverage between September 2013 and February 2015. The number of adults without insurance fell by 16.9 million, and most of this decline occurred between September 2013 and May 2014. Simultaneously, we found increased enrollment in employer-sponsored insurance, Medicaid, and the ACA's Marketplaces. By the end of February 2015, we estimate that there were 11.2 million Marketplace enrollees, a number close to the federal

EXHIBIT 1

Trends In Insurance Coverage Among US Adults Ages 18–64, By Type Of Coverage, September 2013–February 2015



SOURCE Authors' analysis. **NOTE** Because of the difference in the size of the population covered by employer-sponsored coverage relative to that of the other insured groups, the *y* axis is compressed between 40 million and 110 million.

government's reported 11.7 million enrollees as of February 22, 2015.[4] We estimate that 9.6 million people enrolled newly in Medicaid, a figure that is also close to the federal government's tally of 10.8 million additional Medicaid and Children's Health Insurance Program (CHIP) enrollees as of December 2014.[5]

While the net change in insurance was positive, we estimate that there were declines in enrollment in nongroup plans and in "other" coverage, such as non-Medicaid public coverage.

These estimates provide a first look at how the ACA has affected health insurance enrollment, with a particular focus on insurance transitions. Many of our estimates were close to those reported by the administration and by other early look surveys. However, an important limitation of these data is that our survey had a low cumulative response rate. This may have led to bias in our estimates. Surveys with higher response rates such as those conducted by the federal government are typically available only with a substantial lag. The data we collected provide a timely estimate of the effects of the ACA.

Study Data And Methods

DATA SOURCE We tracked insurance transitions using the RAND Health Reform Opinion Study, a longitudinal survey that followed a cohort of people from September 2013 through February 2015. By focusing on this time period, we were able to follow people starting immediately before the ACA's first open enrollment period and track how their insurance changed through the end of the ACA's second open enrollment period.

This ongoing survey is conducted using the RAND American Life Panel, a nationally representative panel of people who regularly participate in surveys. Invited to participate were 2,953 panel members ages 18–64 recruited using probability sampling methods. We focused our analysis on 1,589 invited participants who responded in both September 2013 and February 2015 and provided information about their source of insurance. We conducted twelve surveys during the period. The response rate among those invited to participate ranged from 60 percent to 70 percent. Following previous work in the American Life Panel, we estimate that the cumulative response rate among all people invited to participate in the panel was 9 percent.[6] As in other rapid-turnaround surveys, our cumulative response rate was much lower than the response rate for government surveys.

METHODS We used sample weights to make our September 2013 sample representative of the population, benchmarking key demographic characteristics to the 2013 Current Population Survey (CPS), a national survey conducted by the Census Bureau and the Bureau of Labor Statistics.[7] Furthermore, we adjusted our weights to address nonresponse to the 2015 survey among those responding in 2013 by dividing by the propensity of response to the 2015 survey among those who responded to the 2013 survey. More detailed information about the methods is available in the online Appendix.[8]

LIMITATIONS These data provide a unique opportunity to study insurance transitions since September 2013. However, there were some limitations. First, the sample contained only 1,589 observations, which reduced the precision of our estimates. Second, some respondents may have incorrectly reported the type of insurance coverage they had. In particular, Medicaid and nongroup coverage were difficult to measure in survey data because of confusion among consumers over the names of these programs. Furthermore, people may have had difficulty distinguishing Marketplace coverage from Medicaid and other nongroup coverage as a result of confusion over the definition of "Marketplace" and because qualified applicants may have been directed to Medicaid through a Marketplace website.[9]

Third, as previously mentioned, the response rate for our survey, around 9 percent, was low. Nonresponse especially in web-based surveys may bias estimates of enrollment in web-based Marketplaces. Despite weighting to match the CPS as closely as possible, this low response rate may indicate that the results were not nationally representative. Fourth, one concern with panel data was that participation in later waves may be influenced by the variables of interest—in this case, that insurance choices may influence the decision to participate in later waves of the survey. To address this concern, our survey weights adjusted for nonresponse associated with factors that are observable in our data. A strength of the longitudinal approach is that it avoids recall bias that might occur when respondents are asked to retrospectively report about prior insurance coverage.

Study Results

In November 2013 and December 2013, respondents were asked about their expected insurance coverage for 2014. In later surveys, respondents were asked about current coverage. The percentage of respondents with insurance coverage grew consistently from November 2013 through May 2014 (Exhibit 1). Among those purchasing insurance on the Marketplaces, we observed the most growth in April and May 2014, consistent with the surge in enrollment reported by the

Department of Health and Human Services. We observed additional growth during the second open enrollment period.

We estimate that between September 2013 and February 2015, on net, enrollment in Medicaid increased by 9.6 million; in Marketplace plans, 11.2 million; and in employer-sponsored insurance, 8.0 million (Exhibit 2). (A fuller version of Exhibit 2 with confidence intervals is available in Appendix Exhibit A2.)[8] The confidence intervals are large, in large part because of the small sample size. See the Appendix for ranges for each estimate.[8] The Medicaid enrollment increases were driven by both people becoming newly insured and people switching from one type of insurance to another. Coverage through nongroup policies and other sources (such as Medicare, military insurance, and other state policies) declined by 1.9 million and 10.0 million, respectively. Those losing coverage became uninsured or switched to another type of plan. A number of factors contributed to the large decrease in other coverage, but we lacked the information needed to definitively parse out the causes. One contributing factor may have been the elimination of state safety-net programs that coincided with the increase in Medicaid eligibility. In total, a net 16.9 million additional people became insured during the study period; the number of uninsured people declined from 42.7 million in September 2013 to 25.8 million in February 2015.

Of the 42.7 million who were uninsured in 2013, 22.8 million gained insurance and 19.9 million remained uninsured. Of 155.8 million who were insured in 2013, 5.9 million lost insurance (Exhibit 3). (A fuller version of Exhibit 3 with confidence intervals is available in Appendix Exhibit A3.)[8] The number of people gaining insurance was more than three times as large as the number losing coverage. A total of 149.9 million people were consistently insured in both time periods.

Transitions in health insurance coverage occur for many reasons; with the exception of Marketplace enrollment, which could not have occurred before the ACA, we cannot distinguish between changes caused by the ACA and changes caused by other factors. Among those gaining coverage, most (9.6 million) enrolled in employer plans, followed by Medicaid (6.5 million), the Marketplaces (4.1 million), other insurance sources (1.5 million), and nongroup plans (1.2 million) (Exhibit 4). (A fuller version of Exhibit 4 with confidence intervals is available in Appendix Exhibit A4.)[8] Among those starting out with insurance, 2.4 million people transitioned from employer coverage to uninsured status, 0.6 million transitioned from Medicaid to uninsured status, and 2.3 million transitioned from other sources of coverage to uninsured status. Despite concerns about plan cancellations, only 600,000 people starting out with nongroup coverage became uninsured. Of the 155.8 million people with insurance in September 2013, 80 percent experienced no changes in the source of their insurance during the study period. Among those who were uninsured at baseline, 47 percent remained uninsured at follow-up.

Of the 11.2 million people estimated to have Marketplace coverage in 2015, 4.1 million (37 percent) were uninsured in September 2013. Of the estimated 12.6 million new enrollees in Medicaid, 6.5 million (52 percent) were uninsured in September 2013 (Exhibit 4).

EXHIBIT 2

Net Changes In Insurance Coverage Among US Adults Ages 18–64 (Millions), 2013 And 2015

	Number of people		
Type of coverage	**2013**	**2015**	**Difference**
Insured			
Employer	111.9	119.9	8.0***
Medicaid	11.3	21.0	9.6****
Nongroup	8.5	6.7	−1.9*
Marketplace	—[a]	11.2	11.2****
Other	24.1	14.0	−10.0****
Subtotal	155.8	172.7	16.9****
Uninsured	42.7	25.8	−16.9****

SOURCE Authors' analysis of survey data. **NOTE** A bootstrap methodology was used to identify statistical significance, accounting for the correlation in behavior over time. [a]Marketplaces did not exist in 2013. *$p<0.10$ ***$p<0.01$ ****$p<0.001$

Discussion

Our results suggest that insurance coverage has continued to increase since the ACA's major provisions took effect. We estimate that 22.8 million people became newly insured and that 5.9 million lost coverage, for a net increase of 16.9 million with insurance as of February 2015. The net

EXHIBIT 3

Transitions In Insurance Coverage Among US Adults Ages 18–64 (Millions), September 2013 To February 2015

	Coverage in 2015		
Coverage in 2013	**Uninsured**	**Insured**	**2013 totals**
Uninsured	19.9[a]	22.8[b]	**42.7**
Insured	5.9[b]	149.9[a]	**155.8**
2015 totals	**25.8**	**172.7**	**198.5[c]**

SOURCE Authors' analysis of survey data. [a]No change from 2013 to 2015 (that is, people who experienced no transition). [b]Number of transitions from 2013 to 2015. [c]Weighted to the same population totals in 2013 and 2015, using characteristics of adults ages 18–64 from the 2013 Current Population Survey. As a result, changes in population size attributable to death, aging, and migration are excluded.

EXHIBIT 4

Transitions Across Insurance Categories Among US Adults Ages 18–64 (Millions), September 2013 To February 2015

	Source of coverage in 2015						
Source of coverage in 2013	**None**	**ESI**	**Medicaid**	**Nongroup**	**Marketplace**	**Other**	**2013 totals**
None	19.9[a]	9.6	6.5	1.2	4.1	1.5	**42.7**
ESI	2.4	102.3[a]	1.1	1.1	3.6	1.4	**111.9**
Medicaid	0.6	1.1	8.4[a]	0.03	0.6	0.6	**11.3**
Nongroup	0.6	2.0	0.1	4.1[a]	1.6	0.1	**8.5**
Other	2.3	4.9	4.9	0.2	1.3	10.4[a]	**24.1**
2015 totals	**25.8**	**119.9**	**21.0**	**6.7**	**11.2**	**14.0**	**198.5[b]**

SOURCE Authors' analysis of survey data. **NOTE** ESI is employer-sponsored insurance. [a]No change from 2013 to 2015 (that is, people who experienced no transition). [b]Weighted to the same population totals in 2013 and 2015, using characteristics of eighteen- to sixty-four-year-olds from the 2013 Current Population Survey. As a result, changes in population size attributable to death, aging, and migration are excluded.

increase in insurance that we observed is slightly higher than a recent estimate from the federal government, which found 14.1 million newly insured adults since 2013.[10] However, given the large confidence intervals in both surveys, we cannot reject the hypothesis that our estimates are equivalent.

Among the 22.8 million people who gained insurance, most enrolled in employer-sponsored insurance, followed by Medicaid and the Marketplaces. Employer coverage is by far the largest source of insurance among Americans younger than age sixty-five, and the ACA creates new incentives for people to take up employer policies. Specifically, while the ACA mandates that most people must enroll in insurance, people are ineligible for Marketplace subsidies if they have an affordable offer of coverage from their employer. Gains in employer coverage were also found following Massachusetts's health reform.[11,12] However, other nationally representative surveys did not show an increase in employer coverage between 2013 and 2014.[13,14] It is possible that the increases in employer coverage that we observed were idiosyncratic to our small sample, rather than a true representation of changes in coverage at the population level.

While the vast majority of those previously insured experienced no change in their source of coverage, 5.9 million people lost coverage over the period studied, and 24.6 million moved from one source of coverage to another. Transitions in health insurance coverage are common in the United States and occur for a variety of reasons, including job changes and family transitions.[15] Recent estimates suggest that the share of people losing coverage between 2013 and 2014 was no higher than the share of people who lost coverage in prior years.[16]

One concern frequently cited by public officials and the media was that people may have lost individual market coverage as a result of plan cancellations. We found that the vast majority of those with individual market insurance in 2013 remained insured in 2015, which suggests that even among those who had their individual market policies canceled, most found coverage through an alternative source. Others who had their policies canceled may have become eligible for the ACA's tax credits, potentially making Marketplace plans more affordable than their previous nongroup policies.

80%

Saw no change

Of the 155.8 million people with insurance in September 2013, 80 percent saw no changes in the source of their insurance during the study period.

Conclusion

The ACA has greatly expanded health insurance coverage in the United States with little change in the source of coverage for those who were insured before the major provisions of the law took effect. Furthermore, the law has expanded coverage using all parts of the health insurance system, including employer-sponsored insurance, Medicaid, and the newly created Marketplaces. While these data have limitations, especially due to the low response rate, they provide an early look at how the ACA has affected insurance enrollment. ■

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NOTES

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