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ACA Implementation—Monitoring and Tracking

2016 Premium Increases in the ACA Marketplaces: Not Nearly as Dramatic as You've Been Led to Believe

November 2015

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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.

INTRODUCTION

In June and July 2015, a number of articles appeared in outlets such as the *New York Times*, *CNN Money*, *Wall Street Journal*, *Forbes*, and CNBC citing extremely large premium increase requests throughout the country. The *New York Times* stated that "health insurance companies around the country are seeking rate increases of 20 to 40 percent or more." [1] Forbes stated that "after two years of relatively stable premiums across the country, rates would jump in 2016 by double-digit percentages for individual policies purchased on public exchanges under the Affordable Care Act in practically every state." [2] The *Wall Street Journal* wrote, "the biggest insurers in some states that have made the plans' requests public are seeking average increases such as 51.6 percent in New Mexico, 36.3 percent in Tennessee, and 30.4 percent in Maryland." [3] In general these articles argued that sizable rate increases reflect the fact that insurers had higher-than-expected utilization in 2014 and anticipated that this trend would continue. However, these dramatic reports do not reflect the premium changes that were occurring.

These data were based on early releases of rate increases *requested* by insurers, not approved increases. In this paper we review data on final approved premiums for 20 states—including Arkansas, California, Colorado, Connecticut, Florida, Indiana, Iowa, Maine, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Virginia, and Washington—plus the District of Columbia. Nine have state-based marketplaces using their own information technology (IT) platforms, and 12 are using the HealthCare.gov IT platform. We include the three largest rating areas in terms of population in each state with additional areas in the four largest states: California, Florida, New York and Pennsylvania. These largest rating regions sometimes include rural areas; we chose rating regions this way in order to include large segments of each state's population. We show the changes in the lowest-cost silver plans offered by each insurer, as well as the average change in insurers' lowest cost premiums across all insurers in a rating area. By providing data at the insurer level, we can observe which insurers are responsible for large or small average premium increases in a given area.

OTHER RECENT STUDIES AND THE MAIN FINDINGS OF OUR ANALYSIS

Previous Analyses

Other recent studies based on a review of preliminary premium requests reached somewhat less dire conclusions than those presented in the press. Avalere examined proposed rate filings from seven states (Connecticut, Maryland, Michigan, Oregon, Virginia, Vermont, and Washington) and the District of Columbia.[4] They constructed unweighted average premiums across the state in each year. The paper showed that rate increases for the second-lowest-cost silver plan were typically single digit in each of the states that they examined. Still, these data reflected premiums proposed by insurers, not final approved rates.

The Kaiser Family Foundation examined one major city in each of 49 states as well as the District of Columbia.[5] However, their data are a mix of insurer-proposed rates and final approved rates. The authors focused on the second-lowest-cost silver plan premium in each of the cities they studied. They found that rates were somewhat higher in 2016 than in 2015, but generally that increases were relatively modest. For the cities that they analyzed, the mix of proposed and approved rate increases averaged 3.6 percent in 2016.[6] They also found that if consumers were buying the lowest-cost silver plan in

Table 1. Changes in Lowest-Cost Silver Premiums, in 20 States and the District of Columbia, 2015 to 2016

States	Lowest-Cost Silver Plan, 2015 Premium for a 40 Year Old [1,3]	Index Lowest- Cost Premium, State Relative to Overall Average: 2015[4]	Lowest-Cost Silver Plan, 2016 Premium for a 40 Year Old [1,3]	Index Lowest- Cost Premium, State Relative to Overall Average: 2016[4]	Average Percentage Change in Lowest-Cost Silver Premiums Across All Carriers [1,2]	Percentage Change in Lowest-Cost Silver Plan Available on Marketplace [1,2]
Arkansas	$283	1.12	$297	1.15	-0.8%	4.7%
California	$271	1.07	$273	1.05	1.2%	0.7%
Colorado	$208	0.82	$278	1.07	12.6%	33.8%
Connecticut	$353	1.40	$355	1.37	2.1%	0.5%
DC	$242	not included[3]	$229	not included[3]	-4.9%	-5.2%
Florida	$268	1.06	$267	1.03	0.1%	-0.4%
Indiana	$288	1.14	$251	0.97	-10.7%	-12.5
Iowa	$223	0.88	$261	1.01	15.9%	17.2%
Maine	$298	1.18	$294	1.14	-6.3%	-1.1%
Maryland	$228	0.90	$243	0.94	8.0%	6.8%
Michigan	$224	0.89	$209	0.81	-1.7%	-6.1%
Minnesota	$192	0.76	$238	0.92	36.3%	24.4%
Nevada	$264	1.04	$278	1.08	6.7%	6.0%
New Hampshire	$238	0.94	$260	1.01	4.8%	9.3%
New Mexico	$205	0.81	$194	0.75	1.2%	-3.1%
New York	$367	not included[3]	$370	not included[3]	8.4%	0.8%
Oregon	$199	0.79	$229	0.88	18.7%	14.9%
Pennsylvania	$228	0.90	$249	0.96	7.3%	9.6%
Rhode Island	$244	0.97	$259	1.00	-4.1%	6.0%
Virginia	$266	1.05	$278	1.07	5.2%	4.6%
Washington	$236	0.94	$226	0.87	-0.8%	-4.4%
Overall Average	**$253**	**1.00**	**$259**	**1.00**	**5.6%**	**4.3%**

1: Data based on selected rating areas. See Table 2 for names of the specific rating regions studied.

2: Percentage changes weighted by population of regions studied.

3: Indices are not calculated for New York's rating regions and the state's premiums are not included in overall averages because New York premiums are community rated (they do not vary by age as the other states' premiums do). As a result, premiums in the state are not comparable to those for a 40 year old in the other states. Similarly, Washington, D.C. uses a different age rating curve than the other states, and as a consequence we exclude its premiums from the overall average and do not include it in the index either.

2015 and wanted to do the same in 2016, this would often require individuals to switch plans or insurers. Despite the more moderate findings of the Kaiser and Avalere analyses, the notion that 2016 was bringing large, double-digit premium increases to the marketplaces seems to have become conventional wisdom.[7] Kaiser recently followed up that initial analysis with a second. That study found that shoppers in 1,121 counties would have a different low-cost silver marketplace plan in 2016 than in 2015 and that marketplace enrollees in those counties could lower their 2016 premium increases appreciably by moving to the new lowest-cost plan, regardless of their eligibility for tax credits.

Our Main Findings

Our conclusions are similar to those reached by Avalere and Kaiser, though based exclusively on final approved rates and based on more rating regions per study state and providing detail by location and insurer. Rate increases in 2016 are generally modest, though higher than in 2015. The key results are summarized in Table 1, which shows the average increases across all insurers in each state and the increase in the lowest-cost premiums in each state. We find that the average increase in each insurer's lowest-cost silver plan premium across all 20 states plus the District of Columbia is 5.6 percent. If consumers in each rating region enroll in the plan with the lowest silver premium available to them in 2015, and do the same in 2016, on average they will see their premium increase by 4.3 percent. In this summary we focus on the changes in lowest-cost premiums.

In a previous paper which analyzed 2014 to 2015 changes in the lowest-cost silver premium available in every rating region in the country, we found that the increase in 2015 was 2.9 percent as compared to the 4.3 percent found here.[8] The methods in the two papers are somewhat different, but the general conclusion that most consumers have insurance options that allow them to keep premium increases low remains true. In the rating regions we study here, the lowest-cost silver plan premium available decreased on average in 2016 in six states and the District of Columbia; in five states the lowest-cost silver premium increased by less than 5 percent on average; in five states they increased between 5 and 10 percent on average, and in four states they increased by more than 10 percent on average.

Table 2. Changes in Lowest-Cost Silver Premiums, in Selected Rating Areas, 2015 to 2016

States	Rating Area	Lowest-Cost Silver Plan, 2015 Premium for a 40 Year Old [1]	Lowest-Cost Silver Plan, 2016 Premium for a 40 Year Old [1]	Average Percentage Change in Lowest-Cost Silver Premiums Across All Carriers [1,2]	Percentage Change in Lowest-Cost Silver Plan Available on Marketplace [1,2]	Change in Lowest-Cost Insurer, 2015 to 2016 (Yes/No)
Arkansas	Little Rock	$294	$307	0.8%	4.5%	Yes
	Fayetteville	$277	$290	0.5%	4.9%	Yes
	Selected Rural Counties	$273	$286	-5.4%	4.8%	Yes
California	Los Angeles East	$230	$243	0.0%	5.5%	No
	Los Angeles West	$247	$236	0.0%	-4.3%	Yes
	San Diego	$295	$286	0.8%	-3.2%	Yes
	Sacramento	$347	$374	7.2%	7.8%	Yes
	San Francisco	$356	$352	1.6%	-1.1%	No
Colorado	Denver	$207	$278	12.6%	34.6%	Yes
	Colorado Springs	$194	$257	12.0%	32.2%	Yes
	Grand Junction	$286	$372	16.0%	27.0%	No
Connecticut	Bridgeport/Stamford	$380	$389	2.7%	2.4%	Yes
	Hartford	$321	$316	1.8%	-1.4%	No
	New Haven	$355	$356	1.9%	0.4%	Yes
DC	Entire District	$242	$229	-4.9%	-5.2%	Yes
Florida	Miami	$274	$262	-3.2%	-4.4%	No
	Orlando	$288	$302	4.1%	4.9%	Yes
	Jacksonville	$271	$263	2.8%	-3.0%	Yes
	Ft. Lauderdale	$241	$265	-1.3%	10.0%	No
	Tampa	$275	$247	3.4%	-10.2%	Yes

Indiana	Indianapolis	$317	$274	-12.1%	-13.7%	Yes
	Gary	$296	$251	-11.4%	-15.0%	Yes
	Selected Rural Counties	$197	$186	-5.9%	-5.9%	No
Iowa	Cedar Rapids	$234	$269	12.4%	15.0%	No
	Des Moines	$195	$233	19.4%	19.4%	No
	Sioux City	$247	$295	19.4%	19.4%	No
Maine	Portland	$275	$279	-4.4%	1.5%	Yes
	Selected Rural Counties	$323	$305	-7.8%	-5.6%	Yes
	Augusta	$306	$308	-7.9%	0.8%	No
Maryland	Baltimore	$226	$243	7.8%	7.6%	No
	DC Suburbs	$226	$243	7.3%	7.6%	No
	Selected Rural Counties	$237	$243	10.1%	2.7%	Yes
Michigan	North of Detroit	$221	$211	-1.5%	-4.4%	No
	Detroit	$219	$209	0.2%	-4.6%	No
	Grand Rapids	$232	$206	-4.5%	-10.9%	No
Minnesota	Minneapolis - St. Paul	$181	$228	36.6%	23.9%	Yes
	Rochester	$282	$329	39.1%	16.8%	No
	Selected Rural Counties	$189	$234	31.1%	25.5%	No
Nevada	Las Vegas	$237	$256	8.6%	8.2%	No
	Carson City	$327	$343	3.8%	4.9%	Yes
	Reno	$308	$298	1.7%	-3.1%	Yes
New Hampshire	Entire State	$238	$260	4.8%	9.3%	No
New Mexico	Albuquerque	$167	$186	3.4%	11.2%	Yes
	All Rural Counties	$243	$201	-0.8%	-17.4%	Yes
	Las Cruces	$210	$203	0.3%	-3.2%	Yes
New York	New York City	$372	$368	8.9%	-1.0%	Yes
	Long Island	$372	$385	10.9%	3.6%	Yes
	Buffalo	$337	$352	2.0%	4.3%	Yes
	Syracuse	$361	$378	6.8%	4.7%	No
Oregon	Portland	$196	$226	18.0%	15.2%	No
	Selected Rural Counties	$207	$237	23.6%	14.3%	Yes
	Salem	$202	$231	16.7%	14.0%	No
Pennsylvania	Philadelphia	$267	$276	0.3%	3.4%	Yes
	Pittsburgh	$170	$187	12.7%	9.9%	No
	Reading/Lancaster	$225	$253	9.3%	12.7%	Yes
	Scranton/Wilkes Barre	$224	$281	17.1%	25.9%	Yes
Rhode Island	Entire State	$244	$259	-4.1%	6.0%	Yes
Virginia	DC Suburbs	$273	$270	4.6%	-0.9%	Yes
	Virginia Beach/Norfolk	$273	$301	7.2%	10.2%	Yes
	Richmond	$241	$264	3.9%	9.2%	No
Washington	Seattle	$235	$224	-2.0%	-4.5%	No
	Selected Rural Counties	$251	$240	1.1%	-4.1%	No
	Spokane	$219	$209	0.5%	-4.3%	No

1: Data based on selected rating regions.

2: Percentage changes weighted by population in the selected rating regions.

3: "Selected Rural Counties" refers to a specific state defined rating region that includes rural areas. The rating region number is specified in the state-specific tables below.

Table 2 shows results for each study state and rating region. Out of 63 rating regions, 23 (more than one-third) have a reduction in the lowest-cost silver plan premium available in 2016 compared to 2015. Of those rating regions where there was an increase in the lowest silver plan premium available, 14 had premium increases of less than 5 percent, nine had increases between 5 and 10 percent, and 17 regions had increases of 10 percent or greater. We also found that, in 35 of the 63 rating regions (56 percent of regions studied), consumers enrolled in 2015's lowest-premium silver plan have to switch insurers in 2016 in order to continue to pay the lowest silver premium available to them.

The largest increases in lowest-cost silver plan premiums were concentrated in four states, Colorado, Iowa, Minnesota, and Oregon. These seem to be due to the 2015 lowest-cost insurers setting low premiums in 2015 and then adjusting them upward substantially in 2016. In one case (Colorado) the lowest–cost insurer exited the marketplace; those insurers which became the lowest-cost had significantly higher premiums. Of the 17 rating regions with large (10 percent or more) increases in 2016 in their lowest-cost premiums, all but two had 2015 lowest-cost silver premiums below the national average of $264 per month.[9] In general insurers in these regions increased rates substantially.

States with small increases generally had fairly competitive insurance markets. Which types of insurers are responsible for keeping premiums low varies by state. While some Blue Cross plans had very large rate increases, many including Anthem, have been aggressive in pricing. Blue Cross plans have been among the lowest-cost options in the District of Columbia, Indiana, Nevada, Pennsylvania, Rhode Island, Virginia, and Florida. Blue Cross insurers have often offered a more limited network plan with lower premiums than their other non-marketplace commercial products. National Medicaid plans such as Molina, Ambetter, and Coordinated Care have been strong competitors in at least some markets in states such as California, Florida, Indiana, Michigan, and Washington. Local Medicaid plans have been among the lowest-cost silver plans in New York, Minnesota and Rhode Island. Provider sponsored plans organized by hospital systems have been the lowest-cost plans in some Virginia markets, New York City and Long Island, Michigan and Oregon. Kaiser Permanente is among the lowest-cost plans in California, Maryland, Oregon, Colorado, the District of Columbia and some areas in Virginia. Aetna, Humana, and United Healthcare have been very competitive in some markets, but often are not. Co-Ops, while failing in Oregon, New York, and Colorado, have been among the lowest-cost plans in New Hampshire, New Mexico, and Maryland.

While larger 2016 increases suggest higher-than-expected utilization of services and claims costs, overall, premium increases are still modest by historical standards. It is essential to remember that insurers operating in the marketplaces have been facing a fundamental change in their incentive structure under the ACA. With tax credits tied to the second-lowest-cost silver plan (the "benchmark" plan), individuals who choose a more expensive plan must pay the full marginal cost. With consumers having full transparency of plan options and premiums and seeking to pay no more than necessary, beginning in 2014, insurers had strong incentives to price aggressively. This is despite the fact that in the initial years they had limited information on the health care needs of those who would enroll. Insurers that choose to price high because of fear of high utilization risk losing market share; consequently, some appeared to have erred on the side of lower-than-necessary premiums and are now correcting for that as the health care profiles of their enrollees becomes clearer.

The reality is if they are to be successful, insurers must price based on future expectations, not past experience. In the initial years of coverage expansion and the ACA's reforms, the steady state composition of the nongroup insurance risk pools in marketplaces has been and remains somewhat uncertain. Early enrollment growth has been somewhat below expectations, particularly for those eligible for lower amounts of financial assistance to purchase coverage. As enrollment increases—perhaps as the penalties for not obtaining coverage increase and as information about new insurance options become more widely known and understood—insurance pools could attract increasing numbers of lower-risk individuals.[10] At the same time, year-to-year variation in expected average health care costs for any particular insurer should fall and stabilize, but the process may take another two or three years to settle down. The elimination of the so-called grandmothered plans, those that are not ACA-compliant but were in place prior to 2014 and extended in many states through their 2016 plan years, should significantly improve the ACA compliant risk pools. These plans disproportionately enrolled people in relatively good health, and once the policies end, most of these enrollees will seek coverage in the ACA-compliant, nongroup insurance markets.

DATA AND METHODS

Our analysis focuses on comparing each insurer's lowest-cost silver marketplace plan premium for a 40-year-old, non-tobacco-using individual in selected rating areas within 20 states and the District of Columbia in 2015 and 2016. Relative changes in premiums for a 40-year-old are identical to those for any other age because of the fixed-age rating curves required under the ACA. We gathered 2016 premium data for the study states and regions from publicly available rate filings posted on the websites of state departments of insurance. We obtained the 2015 premiums from either Healthcare.gov or the respective state based marketplace website.[11]

We analyze the full premiums charged by insurers. Most marketplace enrollees (those with household incomes between 100 [12] and 400 percent of the federal poverty level (FPL) who do not have affordable offers of employer based insurance) do not pay the full premium. They pay a percentage of income plus or minus the difference between the premium of the plan they choose and the benchmark plan's premium. We analyze the full premium here as it is the best way to assess the price competition in each market, eliminating variation in the distribution of income in each area as a confounding factor. Within the parameters of the ACA, insurers can lower premiums through a variety of strategies, for example, limiting provider networks to lower cost hospitals and physicians, adjusting cost-sharing requirements on different types of services, and using various utilization management techniques. We do not assess these different cost-saving strategies here.

We selected only states that, as of early October 2015, had completed the rate review process and closed the filings for all of the insurers participating in the marketplace for 2015. Additionally, after the public release of the 2016 premium rates on Healthcare.gov in October 2015, we added Florida and New Hampshire. The states are a representative mix in terms of size and geographic diversity. For our selected states, we studied the three largest rating areas by total population. In the cases of California, New York, Pennsylvania and Florida we included more than three rating areas given the large populations of these states. Two of our study states—New Hampshire and Rhode Island—plus the District of Columbia have only one rating area, which spans the entire nongroup marketplace.

We analyze silver level plans because that tier of coverage is used to determine the size of advanced premium tax credits supporting the purchase of health insurance coverage through the marketplaces. In addition, the silver plans are the most frequently purchased and are the only options that allow subsidized individuals to utilize cost-sharing reductions for which they may be eligible. We study the lowest-cost silver option offered by each insurer as these are their most competitive plans in this tier and best allow an analysis of competitive dynamics in the market.

We compiled the premium price for the lowest-cost silver plan available from each insurer in each selected rating region for a 40-year-old nonsmoker for 2015, along with the lowest-cost silver plan premiums approved for each insurer participating in 2016. We then calculated the percentage change in these two premiums for each insurer. In some cases, we were unable to calculate the percentage change for one of the following reasons: (a) the insurer was a new entrant to the marketplace in 2016, (b) the insurer expanded its service into a new rating area in 2016, or (c) the insurer left the marketplace in 2016. In some cases, particular plans may only be offered in a portion of a rating area. This is not taken into account in the calculations provided.

In addition to computing the relative change in lowest-cost silver plans between 2015 and 2016 for each insurer by rating region, we computed the average change in these premiums for each rating area and across the rating areas studied in a state. In each rating area, we also calculated the relative change in the lowest-cost silver plan premium offered by any marketplace insurer in 2015 to the lowest-cost silver plan that is available for the 2016 plan year. This provides an indicator of whether the silver tier of coverage is getting more or less expensive in a particular area. As is shown in the results, in some rating regions, the lowest-cost insurer in 2015 is different than the lowest-cost insurer in 2016. When calculating averages across rating regions, we weight using rating region population as we do not have marketplace enrollment data by rating region.

In the state specific tables we have also included the insurer type (Blue Cross Blue Shield affiliate, provider sponsored, previously Medicaid only, national, regional/local, co-op) to allow us to analyze whether insurer type appears to have an effect on pricing strategy and competitive positioning in 2016. We define Medicaid insurers as those that only offered public insurance (Medicaid with or without Medicare) plans before the 2014 nongroup open enrollment period. If an

insurer offered Medicaid plans in addition to individual, small-group or large-group plans prior to 2014, then the insurer is classified according to its other characteristics. The co-ops were established under the ACA, and all members are listed on the National Alliance of State Health Co-Ops web site. The provider-sponsored insurers are those that are directly affiliated with a provider system (generally a hospital system). Blue Cross Blue Shield insurers are those that are members of the Blue Cross Blue Shield Association.

Our results by state also include an index of average premiums in 2015 and 2016 in order to facilitate an understanding of how the lowest-cost silver plans in each study state compare to the group of 21 and how each state's relative position changed in 2016. We exclude New York from this index because New York's premiums are community rated as opposed to the fixed age-curve the other 20 states use, so its comparison to the others in this way would be somewhat distorted. We use this index to showcase how states relate to the national average.

INDIVIDUAL STATE RESULTS

In this section we summarize the major changes in marketplace lowest-cost silver premiums in each study state in 2016. We focus on which insurers are responsible for significant changes, be they increases or decreases. The analysis includes only the lowest-premium silver plans offered by each marketplace participating insurer in each of the 63 rating regions studied in 20 states and the District of Columbia. In each state specific table, we show:

1. The 2015 to 2016 change in premium for the lowest-cost silver plan each insurer offers in each rating region studied (referred to below as the change in insurer premium);
2. The average of these changes (from 1. above) within each rating region across all insurers (referred to below as the rating region average change in insurer premiums);
3. The percentage difference in the lowest-cost silver premium offered in 2016 from the lowest-cost silver premium offered in 2015 in that rating region, taking all insurers in that region into account (referred to below as the change in the region's lowest-premium option);
4. The average insurer change (from 1. above) across all regions studied in the state (referred to below as the state average change in insurer premiums);
5. The average change in the lowest silver premium (from 3. above) across all regions studied in the state (referred to below as the state average change in lowest-premium option) .

Arkansas

Arkansas' state average change in insurer premiums was a decrease of 0.8 percent in 2016 across the Little Rock, Fayetteville and rural rating regions studied (Table 3). The state average change in the lowest-premium option was an increase of 4.7 percent. These changes were relatively consistent across the three rating regions. The rating region average change in insurer premiums was an increase of less than 1 percent in both Little Rock and Fayetteville, and the rating region average decreased by 5.4 percent in the rural counties. In each of these regions, the change in the lowest-premium option ranged from 4.5 to 4.9 percent. United Healthcare entered each of these marketplace regions in 2016; no insurers exited.

At the insurer level, the most interesting finding is that the Arkansas Blue Cross Blue Shield (BCBS)– by the far the largest insurer in the state—was the lowest-cost insurer in 2015, but had the highest relative premium increases in 2016. Arkansas BCBS's lowest-cost silver premium increased by 19.0 percent in Little Rock, by 17.2 percent in Fayetteville, and by 17.1 percent in the selected rural counties. As a result of these large increases, it is no longer the lowest-cost insurer in 2016. However the multi-state plan offered by Arkansas Blue Cross Blue Shield reduced its rates by about 3 percent in each of these regions and became the lowest-cost silver option in each location. These dynamics could reflect high utilization among the BCBS enrollees in 2015 that the insurer did not expect to be recouped via the risk adjustment, reinsurance, and risk corridor mechanisms.

Other insurers in the state, particularly Ambetter, had small increases or reductions in rates and now have premiums close to those of the Arkansas BCBS multistate plan. United Healthcare entered the marketplace in 2016, but their premiums were relatively high in two of these three rating regions. QC Life and Health and Qualchoice lowered their premiums significantly in the selected rural counties, correcting for the very high premiums they charged in 2015 and making them more competitive in that rating region this year.

California

In California, the state average increase in insurer premiums across the five rating regions we examined (East Los Angeles, West Los Angeles, San Diego, Sacramento, and San Francisco) was 1.2 percent (Table 4). The state average increase in the lowest-premium option was 0.7 percent. Rate increases were

Table 3. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Arkansas

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Little Rock				
Arkansas Blue Cross Blue Shield	Blue	$294	$350	19.0%
Arkansas Blue Cross Blue Shield - MSP	Blue	$317	$307	-3.2%
Ambetter	Medicaid	$332	$344	3.6%
QC Life and Health	Provider	$372	$332	-10.8%
Qualchoice	Provider	$372	$354	-4.8%
UnitedHealthcare	National	N/A	$331	N/A
Percentage Change in Region's Lowest-Premium Option				**4.5%**
Rating Area Average - Change in Insurer Premium [1]				**0.8%**
Rating Area 3: Fayetteville				
Arkansas Blue Cross Blue Shield	Blue	$277	$324	17.2%
Arkansas Blue Cross Blue Shield - MSP	Blue	$298	$290	-2.8%
Ambetter	Medicaid	$304	$291	-4.3%
QC Life and Health	Provider	$335	$312	-6.8%
Qualchoice	Provider	$335	$333	-0.6%
UnitedHealthcare	National	N/A	$377	N/A
Percentage Change in Region's Lowest-Premium Option				**4.9%**
Rating Area Average - Change in Insurer Premium [1]				**0.5%**
Rating Area 2: Selected Rural Counties				
Arkansas Blue Cross Blue Shield	Blue	$273	$320	17.1%
Arkansas Blue Cross Blue Shield - MSP	Blue	$295	$286	-2.9%
Ambetter	Medicaid	$288	$302	4.8%
QC Life and Health	Provider	$410	$305	-25.5%
Qualchoice	Provider	$410	$325	-20.5%
UnitedHealthcare	National	N/A	$386	N/A
Percentage Change in Region's Lowest-Premium Option				**4.8%**
Rating Area Average - Change in Insurer Premium [1]				**-5.4%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**4.7%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**-0.8%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

low in each of the rating regions we examined except for Sacramento, where the rating area average change in insurer premiums was 7.2 percent. Anthem, Blue Shield, Health Net and Kaiser Permanente participate in each of the five regions in 2016. There are two new entrants this year in these five ration regions, Oscar in West Los Angeles and Health Net in Sacramento (Health Net had previously offered coverage in other Covered California regions). There were no exits of insurers in 2016.

The lowest-premium option in East Los Angeles in both 2015 and 2016 is HealthNet. They remain the lowest-cost insurer in 2016 despite a 5.5 percent increase in their lowest-priced silver plan. They are followed closely by Blue Shield, Molina Health Care (a large national Medicaid chain) and L.A. Care, creating a highly competitive, tightly priced market. In the West Los Angeles region, HealthNet was the lowest-cost insurer in 2015 and increased its lowest-cost silver premium by a small amount (3.4 percent) in 2016. Molina Health Care reduced their lowest premium by 9.0 percent in 2016, however, and became the lowest-cost insurer in that region.

In San Diego, Health Net was the lowest-priced silver insurer in 2015 and the premium for its most price-competitive plan was essentially unchanged in 2016. But Molina reduced the premium for its lowest-cost silver plan by 9.0 percent, making it the San Diego region's lowest-cost 2016 insurer. Anthem was the lowest-cost insurer in Sacramento in 2015, but increased its premium by about 11 percent in 2016. Kaiser had a much smaller premium increase (5.1 percent) in 2016, allowing it to become the lowest-cost insurer in Sacramento this year; the difference in premiums across these insurers remains small. In San Francisco, the premiums in both years are higher than the other regions studied in the state. The Chinese Community Health Plan remains by far the lowest-cost insurer. California Blue Shield is the region's second lowest-cost insurer in 2016. Both had small reductions in their lowest premium offerings this year.

Table 4. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, California

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 15: East Los Angeles				
Anthem	Blue	$257	$274	6.5%
Blue Shield	Blue	$270	$245	-9.3%
Health Net	Regional	$230	$243	5.5%
Kaiser Permanente	Provider	$287	$298	3.9%
L.A. Care	Regional	$265	$254	-4.3%
Molina Healthcare	Medicaid	$259	$253	-2.3%
Percentage Change in Region's Lowest-Premium Option				**5.5%**
Rating Area Average - Change in Insurer Premium [1]				**0.0%**
Rating Area 16: West Los Angeles				
Anthem	Blue	$270	$278	2.9%
Blue Shield	Blue	$308	$318	3.4%
Health Net	Regional	$247	$255	3.4%
Kaiser Permanente	Provider	$300	$312	3.9%
L.A. Care	Regional	$278	$266	-4.3%
Molina Healthcare	Medicaid	$259	$236	-9.0%
Oscar	Regional	N/A	$298	N/A
Percentage Change in Region's Lowest-Premium Option				**-4.3%**
Rating Area Average - Change in Insurer Premium [1]				**0.0%**

Rating Area 19: San Diego				
Anthem	Blue	$333	$361	8.5%
Blue Shield	Blue	$343	$342	-0.2%
Health Net	Regional	$295	$296	0.2%
Kaiser Permanente	Provider	$314	$329	4.8%
Sharp	Provider	$329	$344	4.7%
Molina Healthcare	Medicaid	$314	$286	-9.0%
Percentage Change in Region's Lowest-Premium Option				**-3.2%**
Rating Area Average - Change in Insurer Premium [1]				**0.8%**
Rating Area 3: Sacramento				
Anthem	Blue	$347	$386	11.2%
Blue Shield	Blue	$357	$388	8.7%
Western Health Advantage	Provider	$381	$395	3.7%
Kaiser Permanente	Provider	$356	$374	5.1%
Health Net	Regional	N/A	$408	N/A
Percentage Change in Region's Lowest-Premium Option				**7.8%**
Rating Area Average - Change in Insurer Premium [1]				**7.2%**
Rating Area 4: San Francisco				
Anthem	Blue	$414	$455	9.9%
Blue Shield	Blue	$401	$388	-3.2%
CCHP	Regional	$356	$352	-1.1%
Health Net	Regional	$449	$438	-2.4%
Kaiser Permanente	Provider	$393	$413	5.0%
Percentage Change in Region's Lowest-Premium Option				**-1.1%**
Rating Area Average - Change in Insurer Premium [1]				**1.6%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**0.7%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**1.2%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 5. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Colorado

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 3: Denver				
Kaiser Permanente	Provider	$240	$283	17.8%
Humana	National	$244	$278	13.7%
Colorado Health OP	Co-op	$207	N/A	N/A
Denver Health Medical Plan	Provider	$318	$363	13.8%
Colorado Choice Health Plan	Regional	$308	$287	-6.8%
Rocky Mountain Health Plans	Regional	$345	$459	33.2%
Cigna	National	$339	$296	-12.4%
HMO Colorado (Anthem)	Blue	$316	$402	27.0%
All Savers	National	$349	$331	-5.1%
New Health Ventures (Access Health Colorado)	Regional	$274	N/A	N/A
United Healthcare of CO	National	N/A	$319	N/A
Percentage Change in Region's Lowest-Premium Option				**34.6%**
Rating Area Average - Change in Insurer Premium [1]				**12.6%**
Rating Area 5: Grand Junction				
Rocky Mountain Health Plans	Regional	$293	$372	27.0%
HMO Colorado (Anthem)	Blue	$359	$373	4.0%
Colorado Health OP	Co-op	$317	N/A	N/A
New Health Ventures (Access Health Colorado)	Regional	$396	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**27.0%**
Rating Area Average - Change in Insurer Premium [1]				**16.0%**
Rating Area 2: Colorado Springs				
Humana	National	$233	$267	15.0%
Colorado Choice Health Plan	Regional	$276	$257	-7.0%
Kaiser Permanente	Provider	$257	$259	1.0%
Rocky Mountain Health Plans	Regional	$312	$451	45.0%
HMO Colorado (Anthem)	Blue	$296	$320	8.0%
Colorado Health Op	Co-op	$194	N/A	N/A
New Health Ventures (Access Health Colorado)	Regional	$251	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**32.2%**
Rating Area Average - Change in Insurer Premium [1]				**12.0%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**33.8%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**12.6%**

1. Average across selected rating areas is weighted by population in the rating regions studied.

2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 6. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Connecticut

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Bridgeport/Stamford				
ConnectiCare Benefits Inc.	Regional	$395	$389	-1.4%
Anthem Blue Cross and Blue Shield	Blue	$422	$429	1.6%
UnitedHealthcare	National	$407	$416	2.3%
HealthyCT Inc.	Co-op	$380	$412	8.4%
Percentage Change in Region's Lowest-Premium Option				**2.4%**
Rating Area Average - Change in Insurer Premium [1]				**2.7%**
Rating Area 2: Hartford				
ConnectiCare Benefits Inc.	Regional	$321	$316	-1.4%
Anthem Blue Cross and Blue Shield	Blue	$334	$339	1.6%
UnitedHealthcare	National	$386	$381	-1.4%
HealthyCT Inc.	Co-op	$333	$360	8.3%
Percentage Change in Region's Lowest-Premium Option				**-1.4%**
Rating Area Average - Change in Insurer Premium [1]				**1.8%**
Rating Area 5: New Haven				
Anthem	Blue	$365	$371	1.6%
HealthyCT Inc.	Co-op	$355	$383	7.9%
UnitedHealthcare	National	$370	$373	0.9%
ConnectiCare	Regional	$362	$356	-1.4%
Percentage Change in Region's Lowest-Premium Option				**0.4%**
Rating Area Average - Change in Insurer Premium [1]				**1.9%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**0.5%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**2.1%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 7. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, District of Columbia

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Entire District				
CareFirst	Blue	$256	$229	-10.6%
Kaiser Permanente	Provider	$242	$243	0.7%
Aetna	National	$306	N/A	N/A
Percentage Change in Lowest-Premium Option				**-5.2%**
Average Change in District [1]				**-4.9%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Colorado

Colorado is one of the four study states where several insurers had very large premium increases in 2016 (Table 5). The state average change in insurer premiums was 12.6 percent across the three rating regions studied (Denver; Grand Junction; and Colorado Springs). The state average change in lowest-premium option was 33.8 percent. These changes are relatively consistent in all three rating regions and are largely attributable to the exit from these markets of the 2015 lowest-cost insurer, Colorado Health Op. Colorado Health Op reduced premiums dramatically between 2014 and 2015 and became the lowest-cost insurer in these areas. Presumably, high claims costs in 2015 forced them to exit the market. Plus, many of the remaining insurers had large increases in 2016.

In the Denver region, Colorado Health Op had an extremely low premium in 2015. The two next lowest-cost insurers in 2015, Kaiser Permanente and Humana, increased their premiums significantly in 2016 (17.8 and 13.7 percent, respectively), but nonetheless are the lowest-cost insurers in 2016 given Colorado Health OP's exit from the market. As a result, the change in the region's lowest-premium option was 34.6 percent this year. In Grand Junction, the Rocky Mountain Health Plan, headquartered in that city, was by far the lowest-cost insurer in 2015. Rocky Mountain's 27.0 percent premium increase in 2016 still allows the insurer to remain the lowest-priced offeror. HMO Colorado, a product of Anthem is very similar in price in 2016.

In Colorado Springs as well, Colorado Health Op had by far the lowest premium in 2015. Colorado Choice Health Plan became the lowest-premium insurer in 2016 following the co-op's exit, followed closely by Kaiser Permanente and Humana. While the region's lowest-premium option increased by 32.2 percent, this can be explained by the exit of Colorado Health Op, which appears to have set its premiums unrealistically low in 2015. The Rocky Mountain Health Plan's lowest-cost silver premium increased tremendously in Colorado Springs as it did in the other study regions, and Humana increased its lowest-cost silver plan premium by 15 percent.

Connecticut

Connecticut has fairly high premiums by national standards but, in general, insurers increased premiums there very little in 2016 (Table 6). The state average increase in insurer premiums across our three selected rating regions (Bridgeport/Stamford, Hartford and New Haven) was 2.1 percent. The state average change in lowest-premium option was only 0.5 percent. Each rating region average change in insurer premiums was small (2.7 percent in Bridgeport, Stamford; 1.8 percent in Hartford, and 1.9 percent in New Haven). The change in each of the region's lowest-premium options was small or negative.

HealthyCT Inc., a co-op, was the 2015 lowest-priced insurer in Bridgeport/Stamford and in New Haven and was quite competitive in Hartford. In 2016, the insurer increased its lowest-priced silver plan premiums approximately 8 percent in each rating region, by far the largest relative increase among the insurers in these regions. ConnectiCare Benefits Inc., a local commercial insurer, decreased its premiums modestly in 2016, becoming the lowest-cost insurer in the Bridgeport/Stamford and New Haven regions and keeping it the lowest-cost insurer in Hartford. Anthem Blue Cross Blue Shield is price-competitive in Hartford and New Haven, but is the highest-priced insurer in Bridgeport/Stamford. United HealthCare participates in each of these three regions, but is most price-competitive in New Haven.

Washington, D.C.

In the District of Columbia premiums are low by national standards, and the District's average insurer premium fell by 4.9 percent in 2016 (Table 7). The District's lowest-premium option fell by 5.2 percent. In 2015, Kaiser Permanente offered the lowest-premium silver plan and had a very small increase in 2016. But CareFirst BlueCross Blue Shield decreased the premium for its lowest-cost silver plan by 10.6 percent and became the lowest-cost plan in 2016. Aetna, the highest-priced insurer in 2015 and one which had a low market share in the area, left the D.C. marketplace in 2016.

Florida

In Florida we examined five rating regions (Miami, Orlando, Jacksonville, Ft. Lauderdale, and Tampa) (Table 8). In 2016, there was virtually no change in state average insurer premiums, an increase of only 0.1 percent. The state average change in the lowest-premium option was likewise extremely small, a decrease of 0.4 percent. However, there was significant variation across rating regions and insurers.

In Miami, the lowest- cost insurers in 2015 were Ambetter and Molina, both national Medicaid chains. In 2016 Ambetter reduced its premiums slightly, by 4.4 percent, while Molina kept its premium constant, allowing Ambetter to hold the most price-competitive position this year. Florida's Blue HMO reduced the premium of its lowest-cost silver offering in Miami by almost 29 percent, making it much more price-competitive than in 2015. It followed a similar strategy throughout the regions studied. In Ft Lauderdale, Coventry offered the lowest-cost silver plan in 2015, and despite a 10 percent premium increase, remains the most competitive in that region in 2016. However, in 2016, it faces stronger competition from Ambetter, Florida Blue Cross HMO, and Molina.

In Orlando, the Florida Blue Cross HMO is now the lowest-premium option, replacing Humana. Neither of the Medicaid plans, Ambetter nor Molina, is currently participating in the Orlando marketplace region. The change in the Orlando region's lowest-premium option was 4.9 percent in 2016. In Tampa, the change in the region's lowest-premium option was a decline of 10.2 percent, the result of Ambetter's entry into this region. The rating region average change in insurer premium was a modest 3.4 percent. In Jacksonville, there was also a decline in the rating region's lowest-premium option due to the entrance into that market of Ambetter, with the premium of the lowest-cost option falling by 3.0 percent.

Indiana

In the three Indiana rating regions we studied (Indianapolis, Gary, and selected rural counties), marketplace competition was intense between Anthem (a Blue Cross Blue Shield plan) and three Medicaid insurers: Caresource, Ambetter, MDwise in both 2015 and 2016 (Table 9). That competition was enhanced in 2016 by the entry of IU Health Plan (a partnership with the Indiana University School of Medicine) into two of these markets and that insurer's large premium decrease in Indianapolis. The state had a large, 10.7 percent, decrease in average premiums in 2016. The state average change in lowest-premium option was a substantial decrease of -12.5 percent. As shown in Table 1, Indiana premiums were above the national average in 2015.

In Indianapolis, CareSource and Ambetter were the lowest-cost insurers in 2015. In 2016, Anthem decreased its lowest-cost silver plan premium by 21.9 percent to become the lowest-cost insurer. Six of the seven insurers offering marketplace coverage in Indianapolis in 2016 reduced their premiums this year, with the only one not reducing premiums (All Savers) increasing its lowest silver premium by 1.2 percent, offering consumers many lower cost alternatives. Assurant, the highest-priced insurer in the area in 2015, left the market in 2016 (likewise for Gary and

Table 8. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Florida

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 43: Miami				
Ambetter	Medicaid	$274	$262	-4.4%
Coventry	National	$309	$301	-2.6%
Florida Blue (BCBS of Florida)	Blue	$362	$347	-4.1%
Florida Blue HMO	Blue	$430	$307	-28.6%
Humana	National	$301	$362	20.3%
Molina	Medicaid	$274	$274	0.0%
UnitedHealthcare	National	N/A	$366	N/A
Cigna	National	$419	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-4.4%**
Rating Area Average - Change in Insurer Premium [1]				**-3.2%**
Rating Area 48: Orlando				
Florida Blue (BCBS of Florida)	Blue	$312	$312	0.0%
Florida Blue HMO	Blue	$374	$302	-19.3%
Humana	National	$288	$336	16.7%
Cigna	National	$374	N/A	N/A
UnitedHealthcare	National	$298	$355	19.1%
Percentage Change in Region's Lowest-Premium Option				**4.9%**
Rating Area Average - Change in Insurer Premium [1]				**4.1%**

Rating Area 15: Jacksonville				
Ambetter	Medicaid	N/A	$263	N/A
Florida Blue (BCBS of Florida)	Blue	$291	$286	-1.7%
Florida Blue HMO	Blue	$340	$290	-14.7%
UnitedHealthcare	National	$280	$336	20.0%
Coventry	National	$271	$292	7.7%
Percentage Change in Region's Lowest-Premium Option				**-3.0%**
Rating Area Average - Change in Insurer Premium [1]				**2.8%**
Rating Area 6: Ft. Lauderdale				
Coventry	National	$241	$265	10.0%
Ambetter	Medicaid	$293	$277	-5.5%
Florida Blue (BCBS of Florida)	Blue	$363	$342	-5.8%
Florida Blue HMO	Blue	$388	$279	-28.1%
Molina	Medicaid	$287	$288	0.3%
Humana	National	$272	$299	9.9%
UnitedHealthcare	National	$308	$338	9.7%
Percentage Change in Region's Lowest-Premium Option				**10.0%**
Rating Area Average - Change in Insurer Premium [1]				**-1.3%**
Rating Area 28: Tampa				
Ambetter	Medicaid	N/A	$247	N/A
Florida Blue (BCBS of Florida)	Blue	$275	$275	0.0%
Florida Blue HMO	Blue	$345	$287	-16.8%
Humana	National	$275	$306	11.3%
UnitedHealthcare	National	$292	$348	19.2%
Cigna	National	$369	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-10.2%**
Rating Area Average - Change in Insurer Premium [1]				**3.4%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**-0.4%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**0.1%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 9. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Indiana

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 10: Indianapolis				
UnitedHealthcare	National	$386	$390	1.2%
Anthem	Blue	$351	$274	-21.9%
Caresource	Medicaid	$317	$304	-4.1%
Ambetter	Medicaid	$329	$298	-9.5%
IU Health Plan	Provider	$408	$308	-24.5%
Mdwise	Provider	$365	$286	-21.7%
PHP	Provider	$403	$386	-4.1%
Assurant	National	$525	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-13.7%**
Rating Area Average - Change in Insurer Premium [1]				**-12.1%**
Rating Area 1: Gary (Northwest Counties)				
UnitedHealthcare	National	$382	$348	-8.9%
Anthem	Blue	$321	$251	-21.6%
Caresource	Medicaid	$317	$282	-11.2%
Ambetter	Medicaid	$296	$286	-3.5%
IU Health Plan	Provider	N/A	$282	N/A
Mdwise	Medicaid	$339	$267	-21.0%
PHP	Provider	$385	$376	-2.3%
Assurant	National	$425	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-15.0%**
Rating Area Average - Change in Insurer Premium [1]				**-11.4%**
Rating Area 16: Selected Rural Counties				
UnitedHealthcare	National	$282	$285	1.3%
Anthem	Blue	$259	$206	-20.3%
Caresource	Medicaid	$217	$237	9.2%
Ambetter	Medicaid	$197	$186	-5.9%
IU Health Plan	Provider	N/A	$227	N/A
Mdwise	Medicaid	$293	$244	-16.8%
SIHO Insurance Services	Regional	$347	$338	-2.7%
Assurant	National	$401	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-5.9%**
Rating Area Average - Change in Insurer Premium [1]				**-5.9%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**-12.5%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**-10.7%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 10. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Iowa

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 6: Cedar Rapids				
UnitedHealthcare	National	N/A	$284	N/A
Coventry Healthcare	National	$234	$269	15.0%
Medica	Medicaid	N/A	$382	N/A
CoOportunity Health	Co-op	N/A	N/A	N/A
Gundersen	Medicaid	$370	$406	9.8%
Percentage Change in Region's Lowest-Premium Option				**15.0%**
Rating Area Average - Change in Insurer Premium [1]				**12.4%**
Rating Area 2: Des Moines				
UnitedHealthcare	National	N/A	$275	N/A
Coventry Healthcare	National	$195	$233	19.4%
Medica	Medicaid	N/A	$376	N/A
CoOportunity	Co-op	N/A	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**19.4%**
Rating Area Average - Change in Insurer Premium [1]				**19.4%**
Rating Area 3: Sioux City				
Coventry Healthcare	National	$247	$295	19.4%
UnitedHealthcare	National	N/A	$319	N/A
Medica	Medicaid	N/A	$375	N/A
Avera	Provider	$355	N/A	N/A
CoOportunity Health	Co-op	N/A	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**19.4%**
Rating Area Average - Change in Insurer Premium [1]				**19.4%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**17.2%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**15.9%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 11. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Maine

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Portland				
Maine Community Health Options (Co-op)	Co-op	$282	$284	0.7%
Anthem	Blue	$275	$288	4.8%
Harvard Pilgrim	Regional	$366	$287	-21.7%
Anthem MSP	Blue	$305	$301	-1.3%
Aetna	National	N/A	$279	N/A
Percentage Change in Region's Lowest-Premium Option				**1.5%**
Rating Area Average - Change in Insurer Premium [1]				**-4.4%**
Rating Area 3: Selected Rural Counties				
Maine Community Health Options (Co-op)	Co-op	$323	$326	0.9%
Anthem	Blue	$343	$334	-2.6%
Anthem MSP	Blue	$380	$350	-8.0%
Harvard Pilgrim	Regional	$404	$318	-21.3%
Aetna	National	N/A	$305	N/A
Percentage Change in Region's Lowest-Premium Option				**-5.6%**
Rating Area Average - Change in Insurer Premium [1]				**-7.8%**
Rating Area 2: Augusta				
Maine Community Health Options (Co-op)	Co-op	$306	$308	0.8%
Anthem	Blue	$319	$311	-2.6%
Anthem MSP	Blue	$354	$325	-8.2%
Harvard Pilgrim	Regional	$397	$312	-21.3%
Percentage Change in Region's Lowest-Premium Option				**0.8%**
Rating Area Average - Change in Insurer Premium [1]				**-7.9%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**-1.1%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**-6.3%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

the selected rural counties). The rating region average insurer premium fell by 12.1 percent and the change in Indianapolis' lowest-premium option fell by 13.7 percent.

In Gary, the competitive dynamics were similar, with Anthem decreasing its lowest-cost silver premium by 21.6 percent and overtaking CareSource and Ambetter to be the lowest-premium option in 2016. Every insurer participating in the region in 2016 reduced the premium for its lowest-cost silver plan, leading to a rating region average decrease in insurer premiums of 11.4 percent and a decrease of 15.0 percent in the region's lowest-premium option.

In a set of rural counties in the southeastern part of the state, Ambetter had the lowest silver premium in 2015 and remains the lowest-cost insurer in 2016 following a 5.9 percent premium reduction. Both Anthem and MDwise had large reductions in rates, but did not reduce premiums to the levels offered by Ambetter. All Savers participated in the region in both years, but has premiums well above those of the insurers mentioned above. IU Health Plan entered this region in 2016 with very competitive premiums.

Iowa

Iowa had very little insurer marketplace participation in 2015, with only one or two insurers per rating area, but those that did participate increased premiums significantly in 2016 (Table 10). The state's co-op left the marketplace entirely in early 2015. Iowa 2015 premiums were low, however, relative to the nation average. Two insurers, United Healthcare (a national insurer) and Medica (a Medicaid insurer), joined the state's marketplace in 2016. United Health Care and Medica entered the marketplaces in 2016 in all three regions, but with premiums well above Coventry.

In 2015 Coventry Healthcare, a large national insurer now part of Aetna, was the only insurer offering coverage statewide, including the three rating regions studied here, Cedar Rapids, Des Moines, and Sioux City. In Cedar Rapids, Gundersen, a Medicaid insurer, offered coverage as well, but at a much higher rate.

Coventry increased premiums for its lowest-cost silver plans by 15.0 percent in Cedar Rapids and 19.4 percent in Des Moines and Sioux City. Gunderson, the only 2015 competitor to Coventry in these regions remaining in the market in 2016 increased its lowest-cost premium by 9.8 percent. The premium increases for these two insurers averaged 15.9 percent across these three regions. The state average change in the lowest-premium option was 17.2 percent. Marketplace enrollment in Iowa was relatively low in 2015, reflecting the lack of insurance options as well as other issues.[13] Worth noting is that Wellmark, the state's largest nongroup insurer by far, has yet to participate in the state's marketplace. Wellmark announced that they will join the marketplace in 2017, once the so-called grandmothered plans (a market they dominate) expire; this is likely to change the competitive dynamics of the marketplace.[14]

Maine

The Maine state average change in insurer premiums across the three rating regions we studied (Portland, Augusta, and selected rural counties) decreased 6.3 percent in 2016 (Table 11). The state average change in the lowest-premium option was a modest decrease of 1.1 percent. The drop in average premiums was strongly affected by large reductions in premiums by Harvard Pilgrim, with over 21 percent reductions in each of these three rating regions.

In the Portland region, Anthem was the lowest-cost option in 2015, and increased its lowest-cost silver premium by 4.8 percent in 2016. Its multi-state plan was less competitively priced. Aetna entered the market in 2016 with the lowest premium, and as a result, the increase in the region's lowest-premium option was only 1.5 percent. In 2016, all of Portland's marketplace insurers have premiums close to one another in price, creating an intensely competitive environment.

In our selected rural region in Maine, the lowest-premium option in 2015 was the Maine Community Health Options, a co-op. Despite a very small 2016 increase in the premium of the lowest-premium silver plan offered by the co-op, Aetna entered this rating region with a lower premium as well, making it the lowest premium offered this year. Thus, the region's lowest-premium option fell by 5.6 percent. The rating region average insurer premium fell by 7.8 percent. In the Augusta market, the lowest-premium option in 2015 and 2016 was offered by Maine Community Health Options, but both Anthem and Harvard Pilgrim offer 2016 plans with only slightly higher premiums, resulting in another highly competitive Maine market.

Maryland

Maryland's state average change in insurer premiums was 8.0 percent in 2016 across the three rating regions we studied (Baltimore, DC suburbs, selected rural counties) (Table 12). The state's average change in the lowest-premium option was 6.8 percent. The three rating regions' average change in insurer premiums ranged between 7.3 percent and 10.1 percent. The driving force behind these above average rate increases were large premium hikes by CareFirst, the state's Blue Cross Blue Shield insurer, both in its Blue Choice product line and through its multi-state plan (MSP).

Table 12. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Maryland

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Baltimore				
BlueChoice	Blue	$244	$296	21.3%
CareFirst of Maryland (MSP)	Blue	$274	$353	29.0%
Evergreen Health	Co-op	$235	$252	7.3%
Kaiser Permanente	Provider	$226	$243	7.6%
All-Savers	National	$315	$311	-1.5%
Cigna	National	$340	$316	-7.1%
United Healthcare	National	$253	$249	-1.9%
Percentage Change in Region's Lowest-Premium Option				**7.6%**
Rating Area Average - Change in Insurer Premium [1]				**7.8%**
Rating Area 3: Washington, D.C. Suburbs				
BlueChoice	Blue	$227	$276	21.5%
CareFirst of Maryland (MSP)	Blue	$255	$329	29.2%
Evergreen Health	Co-op	$231	$255	10.1%
Kaiser Permanente	Provider	$226	$243	7.6%
All-Savers	National	$315	$311	-1.5%
Cigna	National	$345	$266	-22.9%
UnitedHealthcare	National	$259	$255	-1.3%
Percentage Change in Region's Lowest-Premium Option				**7.6%**
Rating Area Average - Change in Insurer Premium [1]				**7.3%**
Rating Area 2: Selected Rural Counties				
BlueChoice	Blue	$239	$290	21.4%
CareFirst of Maryland (MSP)	Blue	$268	$346	29.0%
Evergreen Health	Co-op	$237	$261	10.1%
Kaiser Permanente	Provider	N/A	$243	N/A
All-Savers	National	$315	$311	-1.5%
UnitedHealthcare	National	N/A	$261	N/A
Cigna	National	$345	$315	-8.7%
Percentage Change in Region's Lowest-Premium Option				**2.7%**
Rating Area Average - Change in Insurer Premium [1]				**10.1%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**6.8%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**8.0%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 13. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Michigan

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 2: North of Detroit				
Blue Care Network of Michigan	Blue	$244	$236	-3.3%
McLaren Health Plan, Inc.	Provider	$309	$324	4.9%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$301	$331	10.1%
Priority Health	Provider	$286	$246	-14.0%
Alliance Life and Health	Provider	N/A	$334	N/A
Health Alliance Plan	Provider	$264	$258	-2.3%
Humana Insurance Company	National	$221	$211	-4.4%
Molina	Medicaid	$252	$229	-8.8%
Total Health Care	Regional	$243	$250	2.8%
UnitedHealthcare	National	$248	$253	1.7%
Assurant	National	$347	N/A	N/A
Consumers Mutual Insurance of Michigan	Co-op	$348	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-4.4%**
Rating Area Average - Change in Insurer Premium [1]				**-1.5%**
Rating Area 1: Detroit				
Humana Insurance Company	National	$219	$209	-4.6%
Total Health Care USA, Inc.	Regional	$243	$250	2.8%
Blue Care Network of Michigan	Blue	$234	$236	0.6%
McLaren Health Plan, Inc.	Provider	$309	$324	4.9%
Health Alliance Plan (HAP)	Provider	$266	$260	-2.3%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$301	$332	10.2%
Priority Health	Provider	$285	$246	-13.8%
Molina	Medicaid	$252	$229	-8.8%
Alliance Health and Life	Provider	$338	$335	-0.9%
Consumers Mutual Insurance of Michigan	Co-op	$348	N/A	N/A
Assurant	National	$334	N/A	N/A
UnitedHealthcare	National	$230	$262	14.1%
Percentage Change in Region's Lowest-Premium Option				**-4.6%**
Rating Area Average - Change in Insurer Premium [1]				**0.2%**

Rating Area 12: Grand Rapids				
Blue Care Network of Michigan	Blue	$286	$226	-20.7%
McLaren Health Plan, Inc.	Provider	$274	$287	4.9%
Priority Health	Provider	$273	$235	-14.0%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$326	$378	15.9%
Consumers Mutual Insurance of Michigan	Co-op	$274	N/A	N/A
Humana Insurance Company	National	$232	$206	-10.9%
Assurant	National	$328	N/A	N/A
Physician's Health Plan	Provider	$356	$348	-2.3%
Percentage Change in Region's Lowest-Premium Option				**-10.9%**
Rating Area Average - Change in Insurer Premium [1]				**-4.5%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**-6.1%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**-1.7%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

In Baltimore, increases in the lowest-cost silver premiums offered through Blue Choice and the Carefirst MSP exceeded 20 percent. The lowest-cost option in Baltimore was Kaiser Permanente in both 2015 and 2016, despite a 7.6 percent increase. Kaiser has strong competition in 2016 from both Evergreen Health (the state's co-op) and United Healthcare. CareFirst, which had been the lowest-cost plan in Baltimore in 2014 (data not shown), has premiums in 2016 which are well above all the other marketplace insurers' lowest-premium options. Similar market relationships and premium changes occurred in the DC suburbs, with large increases for Blue Cross plans and Kaiser and Evergreen being the low-cost insurers. Cigna became increasingly competitive in this region in 2016.

In the rural counties in the southern part of Maryland as well, the Carefirst Blue Choice and MSP options increased their premiums by over 20 percent. While Evergreen Health had been the lowest-cost plan in this rating region in 2015, Kaiser Permanente entered in 2016 and captured the lowest-silver premium position. Kaiser's lowest-cost premium is, however, followed closely by Evergreen Health and United Healthcare. Because of the entrance of Kaiser Permanente, the change in the region's lowest-premium option was only 2.7 percent in this rural area.

Michigan

Michigan has a highly competitive market with eight or more insurers in each of the three rating regions we examined (North of Detroit, Detroit, and Grand Rapids) (Table 13). The state average change in insurer premiums in 2016 was a decrease of 1.7 percent. But because of premium reductions by Humana, the lowest-cost insurer in 2015, the state average change in the lowest-premium option fell by 6.1 percent.

In suburbs north of Detroit (the largest rating area by population), Humana was the lowest-cost insurer in both 2015 and 2016, and reduced its lowest-cost silver option premium by 4.4 percent this year. Humana has strong competition from Molina - a national Medicaid plan, Priority Health - a provider sponsored insurer, and the Blue Care Network of Michigan - a Blue Cross HMO. Each has premiums close to, but greater than, Humana's. Total Health Care, United Health Care, and Health Alliance Plan are not far behind them. The rating region average change in insurer premium was a 1.5 percent decrease in 2016, but the rating region's lowest-premium option (offered by Humana) decreased by 4.4 percent.

In Detroit, there was strong competition among the same four lowest-cost insurers as in the north suburbs. Humana remained the lowest-cost insurer in both 2015 and 2016, with a 4.6 percent reduction in the premium of its lowest-cost silver plan in 2016. The Blue Care Network of Michigan, Priority Health, and Molina all had silver plan premiums close to, but above that of Humana. In this region, average insurer premiums stayed about constant, but the lowest-premium option costs 4.6 percent less in 2016 than in 2015. In Grand Rapids, Humana remained the lowest-cost plan in 2016, with a 10.9 percent reduction in its lowest-cost silver plan premium. The Blue Care Network of Michigan and Priority Health both significantly

Table 14. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Minnesota

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 8: Minneapolis, St. Paul, Bloomington				
HealthPartners	Regional	$181	$235	29.8%
BCBS Minnesota	Blue	$201	$321	59.8%
Ucare	Medicaid	$183	$228	24.4%
Medica	Medicaid	$222	$254	14.2%
BCBS Minnesota (MSP)	Blue	$249	$361	45.1%
Blue Plus	Blue	$205	$300	46.4%
Percentage Change in Region's Lowest-Premium Option				**25.5%**
Rating Area Average - Change in Insurer Premium [1]				**36.6%**
Rating Area 1: Rochester				
Medica	Medicaid	$282	$329	16.8%
BCBS Minnesota	Blue	$283	$445	57.5%
BCBS Minnesota (MSP)	Blue	$351	$502	42.9%
Blue Plus	Blue	N/A	$422	N/A
Percentage Change in Region's Lowest-Premium Option				**16.8%**
Rating Area Average - Change in Insurer Premium [1]				**39.1%**
Rating Area 7: Selected Rural Counties				
HealthPartners	Regional	$207	$260	25.9%
Ucare	Medicaid	$189	$234	23.9%
BCBS Minnesota	Blue	$222	$358	60.9%
Medica	Medicaid	$236	$243	2.8%
Blue Plus	Blue	$225	$286	27.4%
BCBS Minnesota (MSP)	Blue	$276	$403	46.1%
Percentage Change in Region's Lowest-Premium Option				**23.9%**
Rating Area Average - Change in Insurer Premium [1]				**31.1%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**24.4%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**36.3%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

Table 15. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Nevada

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Las Vegas				
Healthplan of Nevada [3]	National	$237	$256	8.2%
Anthem	Blue	$260	$268	2.8%
Prominence	Provider	N/A	$280	N/A
Anthem MSP	Blue	$288	$330	14.7%
Nevada Health Co-op	Co-op	$243	N/A	N/A
Assurant	National	$323	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**8.2%**
Rating Area Average - Change in Insurer Premium [1]				**8.6%**
Rating Area 3: Carson City				
Anthem	Blue	$342	$343	0.2%
Prominence	Provider	$385	$381	-1.0%
Anthem MSP	Blue	$378	$424	12.2%
Nevada Health Co-op	Co-op	$327	N/A	N/A
Assurant	National	$355	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**4.9%**
Rating Area Average - Change in Insurer Premium [1]				**3.8%**
Rating Area 2: Reno				
Healthplan of Nevada [3]	National	$308	$333	8.2%
Anthem	Blue	$321	$298	-7.3%
Prominence	Provider	$331	$327	-1.4%
Anthem MSP	Blue	$355	$380	7.1%
Nevada Health Co-op	Co-op	$355	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-3.1%**
Rating Area Average - Change in Insurer Premium [1]				**1.7%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**6.0%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**6.7%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.
3. Healthplan of Nevada is owned by UnitedHealthcare.

Table 16. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, New Hampshire

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Entire State				
Minuteman Health Inc.	Co-op	$238	$260	9.3%
Anthem	Blue	$284	$290	2.3%
Harvard Pilgrim Healthcare	Regional	$295	$289	-2.1%
Anthem MSP	Blue	$296	$290	-1.9%
Community Health Options	Co-op	$305	$356	16.5%
Assurant Health	National	$474	N/A	N/A
Percentage Change in Lowest-Cost Option [1]				**9.3%**
Average Change in State [1]				**4.8%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

reduced premiums in 2016 (20.7 and 14.0 percent, respectively), giving them relatively low premiums, but they remained above Humana's.

Minnesota

Minnesota had very low premiums in 2015, but experienced very large increases between 2015 and 2016 in the three regions studied (Minneapolis, St. Paul; Rochester; selected rural counties) (Table 14). The state average increase in insurer premiums across the three rating regions was 36.3 percent. The state average change in the lowest-premium option was 24.4 percent. The large increases in premiums were driven by substantial increases by several different insurers, but principally by Blue Cross Blue Shield. In 2014, PreferredOne offered the lowest-premium plans in these areas and appeared to receive a large share of high-risk enrollees that had previously been covered through the state's high-risk pool. In 2015, PreferredOne left the marketplace, and many of these costly enrollees shifted to Blue Cross Blue Shield. Blue Cross Blue Shield responded in 2016 with rate increases close to 60 percent, essentially ceding the market to others. The multistate plan offered by Blue Cross Blue Shield Minnesota had similarly large increases.

The lowest-cost plan in 2015 in the Minneapolis, St. Paul region was Health Partners, a local commercial insurer; Ucare, a local Medicaid insurer, was a closely priced competitor. In 2016 UCare became the lowest-cost plan, despite a premium increase of 24.4 percent in 2016 relative to 2015. In the Rochester region, a much higher-cost market than Minneapolis, Medica, a local Medicaid plan, remained the lowest-cost plan, despite a 16.8 percent increase. In 2015, BCBS Minnesota had been priced almost the same as Medica, but the extremely large 2016 BCBS premium increase created a large pricing wedge between them. Essentially, Medica is the lowest-cost plan because the only alternatives are Blue Cross Blue Shield plans. In our selected rural region, a set of counties north of Minneapolis, UCare offered the lowest-cost plan in 2015 and 2016, despite a 23.9 percent premium increase this year. Medica increased its premium price by only 2.8 percent in 2016, making it a close price competitor to UCare. Thus, Minnesota experienced a major shake-up in 2016 with Blue Cross Blue Shield pricing itself to the margins of the market. The result is that Medicaid plans in Minnesota provide the lowest-cost options in each market studied in the state.

Nevada

Nevada's average increase in insurer premiums across the Las Vegas, Carson City, and Reno rating regions was 6.7 percent in 2016 (Table 15). The state average change in lowest-premium option was 6.0 percent. In Las Vegas, the Health Plan of Nevada, a subsidiary of United Healthcare, offered the lowest-cost silver plans in both years, despite an 8.2 percent premium increase in 2016. Anthem increased its lowest-cost silver plan premium by only 2.8 percent, but still has somewhat higher premiums.

Table 17. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, New Mexico

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Albuquerque				
Christus Health Plan	Medicaid	$303	N/A	N/A
Molina	Medicaid	$186	$190	2.3%
New Mexico Health Connections	Co-op	$178	$186	4.5%
Blue Cross Blue Shield of New Mexico	Blue	$167	N/A	N/A
Presbyterian Health Plan	Provider	$227	$245	7.8%
Percentage Change in Region's Lowest-Premium Option				**11.2%**
Rating Area Average - Change in Insurer Premium [1]				**3.4%**
Rating Area 5: Selected Rural Areas				
Christus Health Plan	Medicaid	N/A	$201	N/A
Molina	Medicaid	$259	$252	-2.7%
New Mexico Health Connections	Co-op	$243	$245	1.0%
Presbyterian Health Plan	Provider	$292	$289	-0.8%
Blue Cross Blue Shield of New Mexico	Blue	$297	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-17.4%**
Rating Area Average - Change in Insurer Premium [1]				**-0.8%**
Rating Area 3: Las Cruces				
Christus Health Plan	Medicaid	N/A	$292	N/A
Molina	Medicaid	$210	$204	-2.7%
New Mexico Health Connections	Co-op	$213	$203	-4.6%
Presbyterian Health Plan	Provider	$257	$277	8.1%
Blue Cross Blue Shield of New Mexico	Blue	$218	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-3.2%**
Rating Area Average - Change in Insurer Premium [1]				**0.3%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**-3.1%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**1.2%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

The region lost two insurers from the marketplace this year, the Nevada Health Co-Op (which ceased operations for 2016) and Assurant, a national insurer, but gained Prominence, a provider-sponsored insurer.[15]

In Carson City, the Nevada Health Co-op offered the lowest-silver premium in 2015, but given its 2016 exit, the lowest-cost insurer in the region in 2016 is Anthem. The exit of the co-op resulted in only a 4.9 percent increase in the region's lowest-premium option since Anthem kept its premium virtually unchanged in 2016. Assurant left this market in 2016 as well. In Reno, the Health Plan of Nevada was the lowest-cost insurer in 2015, but increased its premiums by 8.2 percent in 2016, while Anthem reduced its by 7.3 percent, making it the lowest-cost insurer in the region.

Table 18. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, New York

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 4: New York City				
Metro Plus	Medicaid	$383	$422	10.3%
Health Republic Insurance	Co-op	$380	N/A	N/A
Oscar	Regional	$394	$430	9.0%
Emblem	Regional	$407	$463	13.7%
New York Fidelis	Medicaid	$384	$408	6.4%
Empire BCBS	Blue	$448	$513	14.5%
Northshore LIJ	Provider	$394	$368	-6.6%
Healthfirst	Medicaid	$387	$435	12.3%
Affinity	Medicaid	$372	$395	6.3%
United Healthcare of NY	National	$545	$667	22.4%
Wellcare HMO	Medicaid	$472	$486	3.0%
MVP Health	Regional	$417	$444	6.4%
Percentage Change in Region's Lowest-Premium Option				**-1.0%**
Rating Area Average - Change in Insurer Premium [1]				**8.9%**
Rating Area 8: Long Island				
Metro Plus	Medicaid	$383	N/A	N/A
Health Republic Insurance	Co-op	$380	N/A	N/A
Affinity	Medicaid	$372	$403	8.4%
Emblem HIP	Regional	$407	$527	29.4%
Empire HMO	Blue	$448	$472	5.3%
Fidelis	Medicaid	$384	$395	3.0%
Health First	Medicaid	$387	$435	12.3%
North Shore LIJ	Provider	$394	$385	-2.3%
Oscar	Regional	$394	$430	9.0%
United Healthcare of NY	National	$545	$667	22.4%
Percentage Change in Region's Lowest-Premium Option				**3.6%**
Rating Area Average - Change in Insurer Premium [1]				**10.9%**

Rating Area 2: Buffalo				
New York Fidelis	Medicaid	$337	$353	4.7%
Univera (An Excellus Company)	Blue	$474	$514	8.3%
Health Republic Insurance	Co-op	$342	$N/A	N/A
IHBC	Provider	$428	$374	-12.7%
MVP Health	Regional	$365	$389	6.5%
Health Now	Regional	N/A	$380	N/A
Blue Cross Blue Shield of Western NY	Blue	$342	$352	2.9%
Percentage Change in Region's Lowest-Premium Option				**4.3%**
Rating Area Average - Change in Insurer Premium [1]				**2.0%**
Rating Area 6: Syracuse				
CDPHP	Provider	N/A	$512	N/A
Emblem HIP	Regional	N/A	$556	N/A
Health Republic Insurance	Co-op	Missing	N/A	N/A
Excellus	Blue	$459	$501	9.2%
Fidelis (NY State Catholic HP)	Medicaid	$361	$378	4.7%
Health Now	Regional	N/A	$514	N/A
MVP HP	Regional	$459	$489	6.4%
Percentage Change in Region's Lowest-Premium Option				**4.7%**
Rating Area Average - Change in Insurer Premium [1]				**6.8%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**0.8%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**8.4%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

New Hampshire

New Hampshire's state average increase in insurer premiums was 4.8 percent in 2016, and the state average change in lowest-premium option increased by 9.3 percent (Table 16). New Hampshire had only one insurer selling coverage in the marketplace in 2014—Anthem Blue Cross Blue Shield—and there was considerable controversy over its limited provider network.[16] In 2015, two co-ops, Minuteman Health Inc. and Community Health Options, entered the market, as did Harvard Pilgrim. Minuteman Health plan offered the lowest-cost silver option in 2015 and remains the lowest-cost option in 2016, despite a 9.3 percent premium increase. Anthem Blue Cross Blue Shield and Harvard Pilgrim remained somewhat competitive, though their 2016 premiums are more than 10 percent above those of Minuteman.

New Mexico

Premiums are, on average, extremely low in New Mexico by national standards (Table 17). The biggest change to the New Mexico marketplace in 2016 is the withdrawal from participation by Blue Cross Blue Shield of New Mexico. Although it had reasonably close price competitors in New Mexico Health Connections, a co-op, and Molina, a national Medicaid plan, Blue Cross Blue Shield was the lowest-cost insurer in Albuquerque in 2015. In 2016, the former two insurers will offer the lowest-cost silver plans in Albuquerque. Although these two insurers increased premiums modestly this year, the exit of Blue Cross Blue Shield in this market means that the cost of the region's lowest-premium option increased by 11.2 percent, although premiums are still low by national standards. For those insurers remaining in the Albuquerque market, the average insurer premium increased only 3.4 percent.

In the selected rural areas in 2015, the state's co-op offered the lowest-premium silver option. Despite a small 1.0 percent premium increase, the co-op's low-cost position was overtaken in 2016 by Christus Health Plan, a local Medicaid plan, which newly entered the market in 2016 with a much lower premium than any of those offered in 2015. Because of the entrance of Christus in the rural counties, the region's lowest-premium option fell by 17.4 percent.

In Las Cruces, as in Albuquerque, the 2016 lowest-cost plans are offered by Molina and New Mexico Health Connections. Both reduced premiums in 2016 leading to almost identical premiums. As a result, the cost of the region's lowest-premium option fell by 3.2 percent, and there was almost no change in the average insurer premium. Thus, these New Mexico markets adjusted to the exit of Blue Cross Blue Shield without large premium increases due to the low premiums of Molina Health Care and New Mexico Health Connections.

New York

New York's average insurer premium increased 8.4 percent in 2016 across the New York City, Long Island, Buffalo, and Syracuse rating regions (Table 18). However, the state average increase in the lowest-premium option was only 0.8 percent. The discrepancy is primarily due to large 2016 premium increases among insurers that were already more expensive in 2015.

In New York City the lowest-cost silver plan in 2015 was offered by Affinity, a Medicaid plan, with close competition by Health Republic (a co-op), Metroplus, and Fidelis (the latter two both Medicaid insurers). In 2016, Northshore LIJ, a provider sponsored insurer, offers the lowest silver premium, $368, a reduction of 6.6 percent from its 2015 premium. As a result the premium for the rating region's lowest-premium option declined 1.0 percent. Northshore LIJ's closest competitors in 2016 are Affinity and Fidelis. The larger commercial insurers, such as Emblem, Empire Blue Cross Blue Shield, and United HealthCare have higher premiums and experienced significantly larger increases. Health Republic closed its doors in New York in late 2015 after experiencing large financial losses.

On Long Island, the lowest-cost insurer in 2015 was Affinity, followed closely by Health Republic, Metro Plus, Fidelis, and Health First. In 2016, two of these insurers, Health Republic and Metro Plus, left the marketplace. Northshore LIJ, not far behind the five most competitive insurers in 2015, lowered its premium in 2016 by 2.3 percent, taking the lowest-cost insurer position this year. Fidelis and Affinity remain competitive in 2016, however, with modestly higher premiums than Northshore LIJ. The result of these changes is that the rating region's average increase in insurer premium was 10.9 percent, but the region's lowest-premium option increased by only 3.6 percent. On Long Island, as in New York City, Emblem, Empire, and United HealthCare continue to have substantially higher premiums and relatively large rate increases.

Table 19. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Oregon

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Portland				
Moda Health	Regional	$213	$274	28.4%
Providence Health Plan	Provider	$196	$226	15.2%
LifeWise Health Plan of Oregon	Blue	$227	$315	38.9%
PacificSource Health Plans	Regional	$272	$363	33.5%
Kaiser Permanente	Provider	$245	$237	-3.3%
Zoom Health Plan	Regional	N/A	$233	N/A
Oregon's Health Co-op	Co-op	$231	$234	1.2%
Health Republic Insurance	Co-op	$249	N/A	N/A
BridgeSpan	Blue	$238	$274	14.8%
Percentage Change in Region's Lowest-Premium Option				**15.2%**
Rating Area Average - Change in Insurer Premium [1]				**18.0%**

Rating Area 6: Selected Rural Counties				
Moda Health	Regional	$207	$301	45.2%
Health Republic Insurance	Co-op	$272	N/A	N/A
LifeWise Health Plan of Oregon	Blue	$232	$323	39.4%
Kaiser Permanente	Provider	N/A	$237	N/A
Providence Health Plan	Provider	N/A	$260	N/A
PacificSource Health Plans	Regional	$302	$385	27.3%
Oregon's Health Co-op	Co-op	$302	$267	-11.3%
BridgeSpan	Blue	$300	$352	17.3%
Percentage Change in Region's Lowest-Premium Option				**14.3%**
Rating Area Average - Change in Insurer Premium [1]				**23.6%**
Rating Area 3: Salem				
Moda Health	Regional	$221	$278	25.9%
Health Republic Insurance	Co-op	$276	N/A	N/A
PacificSource Health Plans	Regional	$272	$374	37.5%
LifeWise Health Plan of Oregon	Blue	$232	$323	39.5%
Kaiser Permanente	Provider	$245	$237	-3.3%
Providence Health Plan	Provider	$202	$231	14.0%
Oregon's Health Co-op	Co-op	$261	$234	-10.2%
ATRIO Health Plans	Regional	$246	$278	13.0%
BridgeSpan	Blue	$266	$312	17.3%
Percentage Change in Region's Lowest-Premium Option				**14.0%**
Rating Area Average - Change in Insurer Premium [1]				**16.7%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**14.9%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**18.7%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

In Buffalo, in both 2015 and 2016, Fidelis and Blue Cross Blue Shield of Western New York have been tight competitors, increasing premiums quite modestly in 2016. As a result, the region's lowest-premium option increased by only 4.3 percent. In Syracuse, a higher-cost market than the other three, Fidelis was and remains the lowest-cost insurer; the premiums for their lowest-cost plan increased by 4.7 percent.

Oregon

Oregon had very low premiums, on average, in 2015, but experienced large increases in 2016 (Table 19). The state average increase in insurer premiums across the three rating regions studied (Portland; Selected rural counties; and Salem) was 18.7 percent. The state average increase in the lowest-premium option was 14.9 percent. Several important insurers including Moda Health, LifeWise Health Plan of Oregon (a Blue Cross insurer), PacificSource, and BridgeSpan Health Plan, (another Blue Cross Plan), had very large increases. Only Oregon's Health CO-OP and Kaiser Permanente either decreased premiums or increased them only slightly in these rating areas. Health Republic, a co-op, left the Oregon marketplace at the end of 2015. A regional insurer, Zoom Health Plan, entered the Portland marketplace region in 2016, while Kaiser Permanente and Providence Health Plan joined the rural region studied.

Providence Health Plan, a provider-sponsored insurer, remained the lowest-cost insurer in the Portland region despite a 15.2 percent increase in premiums. Three other insurers in this region have 2016 premiums which are close to those of Providence e.g. Kaiser Permanente, Zoom Health Plan (a 2016 entrant), and the co-op, but the others had large premium increases this year. The Salem market changed similarly, with several of the same insurers having very large increases: Moda Health, PacificSource, LifeWise Health Plan, and BridgeSpan. Kaiser Permanente and the co-op reduced premiums. The Providence Health Plan was the lowest-cost option in both 2015 and 2016, followed closely by Kaiser in 2016. In our selected rural areas, Moda Health was the lowest-cost insurer in 2015, but increased the premium of its lowest-cost silver plan by 45.2 percent in 2016. Kaiser Permanente and Providence entered this rating region's market in 2016 with competitive premiums, becoming the lowest-cost insurers. On balance, rate increases in Oregon were quite large in 2016, but this in part reflects very low premiums by national standards in 2015 and disguises small increases and decreases by two competitors.

Pennsylvania

The state average increase in insurer premiums in Pennsylvania was 7.3 percent across the four rating regions studied – Philadelphia, Pittsburgh, Lancaster, and Wilkes Barre/Scranton (Table 20). The state average change in lowest-premium option was 9.6 percent. 2016 brought large premium increases in all but the Philadelphia market, but these increases seem in part to be related to quite low premiums in 2015.

In Philadelphia, the lowest-cost insurer in 2015 was United HealthCare, followed by Aetna and Keystone Health Plan, a Blue Cross insurer. In 2016, Keystone and United have nearly identical premiums, followed closely by Aetna. Each insurer in this market either increased premiums modestly or decreased them, thus the rating region average increase in insurer premium was only 0.3 percent. The increase in the rating region's lowest-premium option was 3.4 percent.

In Pittsburgh, premiums were considerably lower than in Philadelphia in 2015. The lowest premiums in 2015 were offered

Table 20. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Pennsylvania

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 8: Philadelphia				
QCC Life Insurance (MSP) [3]	Blue	$373	$389	4.5%
Aetna [4]	National	$287	$285	-0.7%
Keystone Health Plan [5]	Blue	$294	$276	-6.1%
UnitedHealthcare	National	$267	$276	3.5%
Assurant	National	$410	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**3.4%**
Rating Area Average - Change in Insurer Premium [1]				**0.3%**
Rating Area 4: Pittsburgh				
HHIC West (MSP)	Blue	$271	$333	22.9%
Highmark	Blue	$179	$211	17.3%
UPMC	Provider	$170	$187	9.9%
Aetna [4]	National	$269	$267	-0.9%
UnitedHealthcare	National	$204	$206	0.7%
Assurant	National	$306	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**9.9%**
Rating Area Average - Change in Insurer Premium [1]				**12.7%**

Rating Area 7: Reading/Lancaster				
Capital Advantage Assurance Co [6]	Blue	$374	$339	-9.1%
Geisinger Health Plan	Provider	$289	$369	28.0%
HHIC Central (MSP)	Blue	$291	$363	25.0%
Highmark	Blue	$225	$302	34.5%
Aetna [4]	National	$317	$319	0.5%
Keystone Health Plan [5]	Blue	$271	$253	-6.5%
Assurant	National	$350	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**12.7%**
Rating Area Average - Change in Insurer Premium [1]				**9.3%**
Rating Area 3: Scranton/Wilkes Barre				
First Priority Life Insurance [7]	Blue	$224	$288	28.7%
Geisinger Health Plan	Provider	$237	$281	18.6%
Aetna [4]	National	$325	$339	4.1%
Assurant	National	$393	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**25.9%**
Rating Area Average - Change in Insurer Premium [1]				**17.1%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**9.6%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**7.3%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.
3. QCC life insurance is a subsidiary of Independence Blue Cross.
4. Aetna did not participate last year, but Health America Pennsylvania, a subsidiary of Aetna/Coventry did.
5. Keystone is owned by Independence Blue Cross.
6. Capital Advantage is a product line of Capital Blue Cross.
7. First Priority is a product line of Blue Cross of Northeastern PA.

Table 21. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Rhode Island

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Entire State				
Blue Cross Blue Shield of Rhode Island	Blue	$302	$259	-14.3%
Neighborhood Health Plan	Provider	$244	$259	6.0%
UnitedHealthcare	National	$284	$273	-4.0%
Percentage Change in Lowest-Cost Option				**6.0%**
Average Change in State [1]				**-4.1%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

by the University of Pittsburgh Medical Center (UPMC), a provider-sponsored insurer, and Highmark, a Blue Cross insurer. In 2016, UPMC's lowest-cost silver plan premium increased by 9.9 percent and remained the lowest-cost silver plan in the market. Highmark and United HealthCare continue to have reasonably competitive offerings as well, even with Highmark increasing its lowest-price silver premium by over 17 percent.

In the Reading/Lancaster region, the lowest-cost insurer switched from Highmark in 2015 to Keystone in 2016, both Blues insurers; the resulting increase in the region's lowest-premium option was 12.7 percent. The Geisinger Health Plan, the HHIC Central MSP plan, and Highmark all increased their premiums by relatively large amounts (25 percent or more). In the Scranton/Wilkes Barre region, Geisinger became the lowest-cost insurer in 2016 despite an 18.6 percent premium increase. The increase in the lowest-premium option there was 25.9 percent, owing to a 28.7 percent premium increase by First Priority Life Insurance, a Blue Cross Plan, and seemingly reflecting a catch-up from very low 2015 premiums in the region.

Rhode Island

By New England standards, premiums are relatively low in Rhode Island, a state with a single premium rating region (Table 21). The state average premium decreased by -4.1 percent in 2016; however, the average change in the lowest-premium option was 6.0 percent. In 2015, the lowest-cost insurer was the Neighborhood Health Plan, with Blue Cross Blue Shield of Rhode Island and United Healthcare premiums being substantially higher. In 2016, Blue Cross Blue Shield of Rhode Island and Neighborhood Health Plan offer identical premiums with the former having reduced its 2015 premiums by 14.3 percent, and the latter increasing its by 6.0 percent. United Healthcare also reduced premiums this year and is now competitive with the other two.

Virginia

Virginia has fairly competitive markets in each of the rating regions we examined: the Washington, D.C. suburbs, Virginia Beach/Norfolk, and Richmond (Table 22). The state average increase in insurer premiums was 5.2 percent in 2016. The state average increase in the lowest-premium option was 4.6 percent.

In the Washington, D.C. suburbs, there is strong competition between Anthem HealthKeepers, a Blue Cross HMO insurer; Innovation Health Insurance Company, a provider-sponsored insurer organized by the INOVA hospital system; Kaiser Permanente; and United HealthCare, a new entrant to the region in 2016. Kaiser Permanente had the lowest silver premium in 2015, but Innovation's premium was close to it. In 2016, Innovation reduced its premium by 4.1 percent and became the lowest-priced insurer in 2016, despite only a modest premium increase for Kaiser. Close 2016 competitors to Innovation in this region are Kaiser Permanente, United HealthCare, and Anthem Health Keepers. The region's lowest-premium option fell by 0.9 percent in 2016.

In Virginia Beach/Norfolk as well, the lowest-cost insurer in 2015 was Kaiser Permanente, but here followed closely by Optima Health, a provider sponsored plan that is part of the Sentara Health System, and Anthem HealthKeepers. Kaiser Permanente dropped out of the Virginia Beach/Norfolk market in 2016, however, leaving HealthKeepers and Optima Health as the lowest-cost insurers in 2016. Due to the exit of Kaiser Permanente, the region's lowest-premium option increased in price by 10.2 percent.

In the 2015 Richmond market, the lowest-cost plan was offered by CoventryOne, followed by Anthem HealthKeepers and Kaiser Permanente. CoventryOne, now part of Aetna, remains the lowest-cost insurer in the region in 2016, despite increasing its premiums by 9.2 percent. CoventryOne's 2016 premiums are followed closely by those of Anthem Health Keepers, Kaiser Permanente, and United HealthCare.

Washington

Washington also has a highly competitive market with many insurers and relatively low premiums. The state average increase in insurer premiums across the three rating regions studied (Seattle; selected rural counties; and Spokane) was -0.8 percent in 2016 (Table 23). The state average lowest-premium option decreased by 4.4 percent. Competition in the Washington nongroup insurance market is increasingly driven by Medicaid plans.

In Seattle, the lowest-cost plan in 2015 was offered by Coordinated Care, a subsidiary of Centene, a national Medicaid chain. In 2016, Coordinated Care reduced its lowest-cost silver plan premium by 4.5 percent, keeping it the lowest-cost insurer. Group Health, a major HMO in the state of Washington, reduced its premium by 14.3 percent and Molina Health Care, another large national Medicaid chain, reduced its premium by 15.3 percent; both remained slightly more expensive than Coordinated Care. Because of aggressive pricing by these insurers, the rating region's lowest-premium option decreased 4.5 percent, and the region's average insurer premium fell 2.0 percent from the previous year.

In 14 rural counties in the state, Coordinated Care offered the lowest-premium option in 2015 and did so again in 2016 following a 4.1 percent price decrease. Molina reduced its lowest-cost silver premium by 19.1 percent and is now a much

Table 22. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Virginia

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 10: Washington D.C. Suburbs				
Anthem (MSP)	Blue	$309	$323	4.4%
Anthem HealthKeepers	Blue	$292	$303	3.8%
CareFirst Blue Choice, Inc.	Blue	$323	$356	10.1%
CareFirst (MSP)	Blue	N/A	$413	N/A
Innovation Health Insurance Company	Provider	$282	$270	-4.1%
Kaiser Permanente	Provider	$273	$284	3.9%
UnitedHealthcare	National	N/A	$288	N/A
Optima Health	Provider	$355	$389	9.4%
Percentage Change in Region's Lowest-Premium Option				**-0.9%**
Rating Area Average - Change in Insurer Premium [1]				**4.6%**
Rating Area 9: Virginia Beach, Norfolk				
Aetna	National	$305	$333	9.3%
Anthem (MSP)	Blue	$304	$321	5.4%
Anthem HealthKeepers	Blue	$287	$301	4.8%
Optima Health	Provider	$281	$308	9.4%
Kaiser Permanente	Provider	$273	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**10.2%**
Rating Area Average - Change in Insurer Premium [1]				**7.2%**
Rating Area 7: Richmond				
Aetna	National	$312	$335	7.4%
Anthem (MSP)	Blue	$280	$295	5.4%
Anthem HealthKeepers	Blue	$264	$276	4.7%
CoventryOne	National	$241	$264	9.2%
Kaiser Permanente	Provider	$273	$284	3.9%
Optima Health	Provider	$372	$382	2.5%
UnitedHealthcare	National	N/A	$280	N/A
Piedmont Community Health Care	Provider	$324	$305	-5.6%
Percentage Change in Region's Lowest-Premium Option				**9.2%**
Rating Area Average - Change in Insurer Premium [1]				**3.9%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**4.6%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**5.2%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

closer competitor for Coordinated Care. In contrast, Community Health Plans and BridgeSpan increased their premiums significantly in 2016.

In Spokane, Coordinated Care offered the lowest-cost option in 2015 and again in 2016 after a 4.3 percent reduction in premiums. Molina decreased its Spokane premium significantly (by 17.0 percent), just as it did in the other two regions in Washington, bringing its 2016 premium only slightly above that of Coordinated Care. Thus in Washington, premiums remain low, on average, due to aggressive pricing by the national Medicaid insurers. The Blues insurers- Premera, LifeWise, Regence and BridgeSpan, have premiums that are substantially above the two Medicaid insurers, as well as above Group Health. United HealthCare entered these Washington markets, but not with premiums that are competitive with Coordinated Care and Molina.

Table 23. Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016, Washington

Insurer Name	Insurer Type	2015 Lowest- Cost Silver Plan Premium	2016 Lowest-Cost Silver Plan Premium	Percentage Change 2015-2016
Rating Area 1: Seattle/Bellevue				
Coordinated Care	Medicaid	$235	$224	-4.5%
Group Health	Regional	$281	$241	-14.3%
Premera	Blue	$291	$315	8.3%
LifeWise	Blue	$291	$298	2.5%
BridgeSpan	Blue	$254	$282	11.1%
Molina HealthCare	Medicaid	$277	$234	-15.3%
Community Health Plans	Regional	$343	N/A	N/A
Moda	Regional	$284	N/A	N/A
Regence	Blue	N/A	$279	N/A
UnitedHealthcare	National	N/A	$302	N/A
Percentage Change in Region's Lowest-Premium Option				**-4.5%**
Rating Area Average - Change in Insurer Premium [1]				**-2.0%**
Rating Area 5: Selected Rural Counties				
Coordinated Care	Medicaid	$251	$240	-4.1%
Group Health	Regional	$282	$266	-5.7%
Premera	Blue	$291	$315	8.3%
LifeWise	Blue	$291	$298	2.5%
Community Health Plans	Regional	$360	$401	11.4%
BridgeSpan	Blue	$263	$301	14.2%
Molina	Medicaid	$304	$246	-19.1%
Moda	Regional	$284	N/A	N/A
Health Alliance	Regional	N/A	$329	N/A
UnitedHealthcare	National	N/A	$306	N/A
Percentage Change in Region's Lowest-Premium Option				**-4.1%**
Rating Area Average - Change in Insurer Premium [1]				**1.1%**

Rating Area 4: Spokane				
Coordinated Care	Medicaid	$219	$209	-4.3%
Premera	Blue	$267	$290	8.3%
LifeWise	Blue	$267	$274	2.5%
Group Health	Regional	$269	$257	-4.1%
BridgeSpan	Blue	$255	$277	8.6%
Community Health Plans	Regional	$332	$363	9.4%
Molina	Medicaid	$265	$220	-17.0%
UnitedHealthcare	National	N/A	$270	N/A
Moda	Regional	$284	N/A	N/A
Percentage Change in Region's Lowest-Premium Option				**-4.3%**
Rating Area Average - Change in Insurer Premium [1]				**0.5%**
State Average Change in Lowest-Premium Option (Select Rating Areas)[1]				**-4.4%**
State Average Change in Insurer Premiums (Select Rating Areas)[1]				**-0.8%**

1. Average across selected rating areas is weighted by population in the rating regions studied.
2. N/A stands for not applicable, as the insurer did offer marketplace coverage in one year in that rating region but not in the other.

CONCLUSION

Early this summer, forecasts of marketplace premium hikes of 30 percent or more caused widespread alarm. In setting 2016 premiums, insurers had actual 2014 marketplace enrollee claims experience on which to draw, and many believed that premiums would grow substantially as a result. It turns out that these concerns were exaggerated.

In this paper we reviewed premium changes for the lowest-cost silver premium offered by each insurer participating in the ACA marketplaces in 20 states and the District of Columbia. We included states of varying size and with considerable geographic diversity. We include at least three rating regions in each state, except for those states with a single statewide rating region.

We find that between 2015 and 2016, the average percentage change in lowest-cost silver premiums offered across all insurers studied in 63 rating regions is 5.6 percent. The lowest-premium silver plan available in each of these rating regions increased an average of 4.3 percent over the same period. This compares to our findings in a similar paper done last year, where we estimated the average change in the lowest-cost silver premium available in each rating region of the country to be 2.9 percent. Thus premium growth in the nation's most competitive plans appears to have increased somewhat, but by far less than many of the dire projections reported in the media.

As in 2015, however, there is significant variation across states and within states across rating regions. In the 20 states plus the District of Columbia, we find that premiums for the lowest-cost silver plans available in the marketplace fell in seven states (including DC), increased by less than 5 percent in five states, increased by between 5 and 10 percent in five states, and increased by double digits in four states. Among rating regions, 23 regions had reductions in the lowest-cost silver plan premium, 14 had increases of 5 percent or less, 10 had increases of between 5 and 10, percent, and 16 had double digit increases. In 35 of the 63 regions, individuals would have to change insurers to remain enrolled in the lowest-premium plan available.

Large premium increases in the lowest-cost silver plans were heavily concentrated in four states (Colorado, Iowa, Minnesota, and Oregon); each of these faced exceptional circumstances. In each, the 2015 lowest-cost silver plan premiums were below the national average. In Colorado, Colorado Health Op, a co-op that had offered the lowest-cost silver premium in 2015 but suffered significant financial losses, was shut down by the Colorado Division of Insurance. While there were significant increases in premiums by several of the insurers in Colorado, it was the exit of the co-op that led to the very large increase in the lowest-cost option available. In Iowa, 2015 silver premiums

were also low by national standards. The markets in the three Iowa regions we examined were dominated by a single insurer until 2016, following the liquidation of the state's co-op in 2015 by the state department of insurance.[17] The state's largest nongroup insurer has yet to participate in the marketplace, although it will participate in 2017 once the grandmothered plans expire. In Minnesota, the 2015 lowest-cost insurer, Blue Cross Blue Shield of Minnesota, increased its premiums considerably in 2016. Presumably this is a result of the 2015 marketplace exit of PreferredOne, a popular 2014 insurer that had suffered large losses after enrolling many Minnesotans previously enrolled in the state's high-risk pool. Without Preferred One, many of these high-cost enrollees joined Blue Cross Blue Shield, causing it financial problems and resulting in large 2016 rate increases. Finally, in Oregon there was a large increase in premiums by the lowest-cost plan in 2015. Oregon premiums were extremely low by national standards during the first two years of the coverage reforms, thus a significant increase is not terribly surprising.

In general, marketplaces are remaining extremely competitive. The incentive to offer the lowest-cost silver plan is strong, due to premium tax credits being tied to the second-lowest-cost silver premium in each rating region. As a result, insurers tend to price aggressively. But the types of insurers that drive premiums down varies by state. Blue Cross plans, including Anthem, have been aggressive in pricing in the District of Columbia, Indiana, Nevada, Pennsylvania, Rhode Island, Virginia, and Florida. The Blue Cross insurers studied have frequently offered a more limited network plan with lower premiums. But in some states, presumably because of a desire to avoid the losses incurred in 2015, Blues plans in Arkansas, Maryland, and Minnesota had extremely large premium increases and were no longer among the lowest-cost silver offerings. In New Mexico, the Blue Cross plan simply exited the market. In several other states (e.g. Washington, New York, Colorado, and Oregon), Blue Cross Blue Shield premiums were well above the lowest-cost competitors.

Medicaid plans became increasingly price competitive in many markets over the initial years of reform. Molina, a national Medicaid chain, priced aggressively in parts of California, Michigan, Washington, and Florida. Ambetter, a product of Centene Corporation, is a strong competitor in Indiana and Florida. Coordinated Care, also a product of Centene, offers the lowest-premium silver plan in Washington. A number of local plans led by Affinity and Fidelis are the lowest-cost silver plans in New York City, and Fidelis provides one of the lowest-cost silver plans throughout New York. Local plans, UCare and Medica, offer the lowest-cost silver plans in Minnesota, following the large premium increase by Blue Cross Blue Shield in 2016. Neighborhood Health Plan is one of the two lowest-cost plans in Rhode Island (offering the same premium as Blue Cross Blue Shield of Rhode Island).

Provider-sponsored plans are also highly competitive in some markets. The Innovation Health Insurance Plan, a product of the INOVA Hospital System, offers the lowest-premium silver plan in Northern Virginia. Optima Health Plan, a product of the Sentara Hospital System, provides the lowest-cost silver plan in the Norfolk region. The Providence Health System in Oregon is among the lowest-cost offerings throughout the state of Oregon. Priority Health offers one of the more competitive plans in Michigan. NorthShore LIJ's plans are among the lowest premiums in New York City and Long Island. Kaiser Permanente is among the lowest-cost insurers in California, Maryland, Oregon, Colorado, the District of Columbia and some markets in Virginia.

National plans entered more markets and became more competitive in 2016. Aetna now offers the lowest-premium plans in two markets in Maine. Coventry, a subsidiary of Aetna, is very competitive in Richmond, Virginia and dominates the Iowa marketplace. Humana offers one of the lowest-cost plans in Michigan and Colorado. United Healthcare is competitive in some markets in Pennsylvania, Maryland, and Rhode Island.

Co-Ops also played an important role in some states, although they are failing at a high rate. While co-ops failed in Oregon, New York and Colorado, they remain very competitive. In New Hampshire, New Mexico, and Maryland. While one co-op in Oregon failed, the other remained very competitive.

We also found that the insurer offering the lowest-premium plan frequently changes from year to year. And while this fluctuation may well decrease as markets reach their equilibrium level of enrollment over the next few years, at least for now, consistently taking advantage of the lowest premiums available requires many consumers to shop carefully and switch plans.

ENDNOTES

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10. To the extent that individuals enrolling in the first years of the new nongroup plans, which do not price discriminate based on health status, were those most in need of coverage and expecting higher need for medical services, those enrolling in later years (sometimes as an action to avoiding the higher individual mandate penalties) may be in better health than the earlier nongroup insurance enrollees.
11. In some instances, publicly available filings do not include complete rate tables; however, the premium rates can be calculated from the consumer adjusted index rate and applying the provided rate factors (geographic rating area, age rating factor, and tobacco usage factor).
12. In Medicaid expansion states, the lower income limit is 138 percent of the FPL.
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John Holahan is an Institute Fellow, Linda Blumberg is a Senior Fellow, and Erik Wengle and Patricia Solleveld are research assistants, all with the Urban Institute's Health Policy Center. The authors are grateful to Kevin Lucia for comments and suggestions and for research assistance from Emily Hayes.

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State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF

November 2015

Medicaid and the Indian Health Service: States to Receive Additional Federal Funds

Prepared by ***Deborah Bachrach*** *and* ***Julian Polaris,*** *Manatt Health Solutions*

Introduction

States with a significant American Indian and Alaskan Native (AI/AN) population will want to pay special attention to plans recently announced by the Centers for Medicare & Medicaid Services (CMS) to increase the range of Medicaid services furnished by Indian Health Services (IHS) eligible for 100 percent federal match. Where Medicaid-eligible AI/ANs receive services through an IHS facility, the federal matching rate is 100 percent and the state pays no share of the cost. Accordingly, as discussed below, CMS' proposal will effectively reduce states' cost for Medicaid expansion and buffer the impending decrease in the federal matching rate for newly eligible adults after 2016.

This report is the fifth in a series prepared by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* exploring the fiscal implications of Medicaid expansion. The first two reports explored state budget savings and revenue gains associated with expansion;[1] the third reviewed the impact on uncompensated care spending and related state budget implications;[2] and the fourth considered the ways in which Medicaid expansion may reduce states' criminal justice costs. This paper examines proposed rules that offer states additional federal funding for Medicaid services to American Indians and Alaskan Natives.

Federal funding in the Medicaid program

Under the Affordable Care Act (ACA), states that determine to expand their Medicaid programs to all adults with incomes below 138 percent of the federal poverty level receive 100 percent matching funds (FMAP) through 2016 for these newly eligible adults. In 2017, the matching rate decreases to 95 percent, decreasing further over time and leveling off at 90 percent in 2020 and thereafter.

However, for American Indians and Alaskan Natives within the newly eligible group,[3] the federal government covers 100 percent of the costs for certain Medicaid services received through the Indian Health Service.[4] Eligible IHS facilities include those operated directly by the IHS as well as those operated by an Indian Tribe or Tribal Organization.

ABOUT STATE NETWORK

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org.*

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For more information, please contact Deborah Bachrach at *DBachrach@manatt.com* or 212.790.4594.

Notably, the full federal match rate applies to IHS services for both the expansion and pre-expansion Medicaid populations and does not decrease over time. Thus, the proposal to expand the AI/AN services for which states may claim 100 percent federal funding will provide an economic benefit to states with respect to both newly eligible adults as well as previously eligible populations.

Proposed changes: federal government to fully fund additional services for American Indians and Alaskan Natives

Under current rules, the 100 percent federal match rate only applies to "facility services," meaning the set of services that are (or could be) furnished *directly* by an IHS facility. CMS issued a Request for Comment[5] in October 2015 stating that the agency is "strongly considering" significant changes to the funding rules that would further shift IHS-related Medicaid costs from states to the federal government.

Under the proposed rule, the 100 percent federal match rate would apply to *any service* that an IHS facility is authorized to provide under the state Medicaid plan. This definition includes several non-facility services that were not previously eligible, most notably transportation services. Emergency and non-emergency transportation is vital in ensuring access to needed services,[6] particularly in the remote areas where many American Indians and Alaskan Natives live.

The services eligible for the 100 percent federal match can be offered by the facility itself, by its employees, or by a contractual agent, as long as the Medicaid beneficiary is served as a patient of the IHS facility.[7] Urban Indian Health Programs may participate as contractual agents of an IHS facility, even though they are not directly eligible for the full match for their direct services.

As a result of these changes, IHS facilities may contract with third parties to provide services that are covered by the state plan but are not offered by the IHS facility. Examples include personal care, home health, and certain waiver services. Where the services provided are not within the facility's IHS benefit, the services will be paid at state plan rates rather than at the IHS facility rate, but in either case the state will receive 100 percent federal match.

Finally, noting that the current CMS policy was designed for Medicaid fee-for-service, CMS proposes to permit states to claim 100 percent federal match for the portion of the capitation payment representing services provided to AI/ANs through an IHS facility.

Conclusion

As a result of the proposed federal rule, states will be able to maintain or increase Medicaid services to American Indians and Alaskan Natives at no additional cost. States that expand their Medicaid programs will enjoy full federal matching for this subset of beneficiaries, even as the federal match declines for the general population starting in 2016. By funding the full cost of IHS services, the federal government supports two vulnerable populations at once: states can better meet the needs of American Indians and Alaskan Natives, while also relying on federal support to expand their Medicaid programs for the benefit of all their low-income residents.

STATES WITH LARGE AMERICAN INDIAN AND ALASKAN NATIVE POPULATIONS WILL REAP THE LARGEST BENEFIT

The increased federal funding is particularly helpful in states with a large number of Medicaid-eligible American Indian and Alaskan Native (AI/AN) people. The table below lists the 15 states where the nonelderly population (ages 0 to 64) has the highest proportion of AI/AN individuals. Under Medicaid expansion, nonelderly people are eligible if their income falls below 138 percent of the federal poverty level.

State	% AI/AN
Alaska	14.6%
New Mexico	10.1%
South Dakota	9.1%
Oklahoma	7.3%
Montana	6.9%
North Dakota	5.3%
Arizona	4.6%
Wyoming	2.5%
Washington	1.5%
Oregon	1.4%
Idaho	1.3%
North Carolina	1.2%
Utah	1.1%
Minnesota	1.1%
Nevada	1.1%

(States highlighted in red have not yet expanded their Medicaid programs)

End notes

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[3] Indian Health Service eligibility also includes other groups, such as Indians of Canadian or Mexican origin, as well as non-Indians with certain Indian familial relationships. For full details, see "Indian Health Manual," Section 2-1.2, (Washington, D.C.: Indian Health Service), accessed October 27, 2015, http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p2c1#2-1.2.

[4] 42 U.S.C. § 1396d(b).

[5] CMS & CMCS, *Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment* (Washington, D.C.: U.S. Department of Health & Human Services, 2015), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf.

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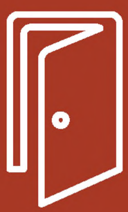
[7] CMS & CMCS, *Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment* (Washington, D.C.: U.S. Department of Health & Human Services, 2015), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf. The Request for Comment specifies that "[t]he IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual."

AIMING HIGHER

Results from a Scorecard on State Health System Performance

2015 Edition



Douglas McCarthy, David C. Radley, and Susan L. Hayes

December 2015

OVERVIEW

ON MOST OF THE 42 INDICATORS, MORE STATES IMPROVED THAN WORSENED.

The fourth Commonwealth Fund *Scorecard on State Health System Performance* tells a story that is both familiar and new. Echoing the past three state scorecards, the 2015 edition finds extensive variation among states in people's ability to access care when they need it, the quality of care they receive, and their likelihood of living a long and healthy life. However, this scorecard—the first to measure the effects of the Affordable Care Act's 2014 coverage expansions—also finds broad-based improvements. On most of the 42 indicators, more states improved than worsened.

By tracking performance measures across states, this scorecard can help policymakers, health system leaders, and the public identify opportunities and set goals for improvement. The 50 states and the District of Columbia are measured and ranked on 42 indicators grouped into five dimensions: access and affordability, prevention and treatment, avoidable hospital use and cost, healthy lives, and equity. Individual indicators measure things like rates of children or adults who are uninsured, hospital patients who get information about how to handle their recovery at home, hospital admissions for children with asthma, and breast and colorectal cancer deaths, among many others.

ACCESS AND AFFORDABILITY

PREVENTION AND TREATMENT

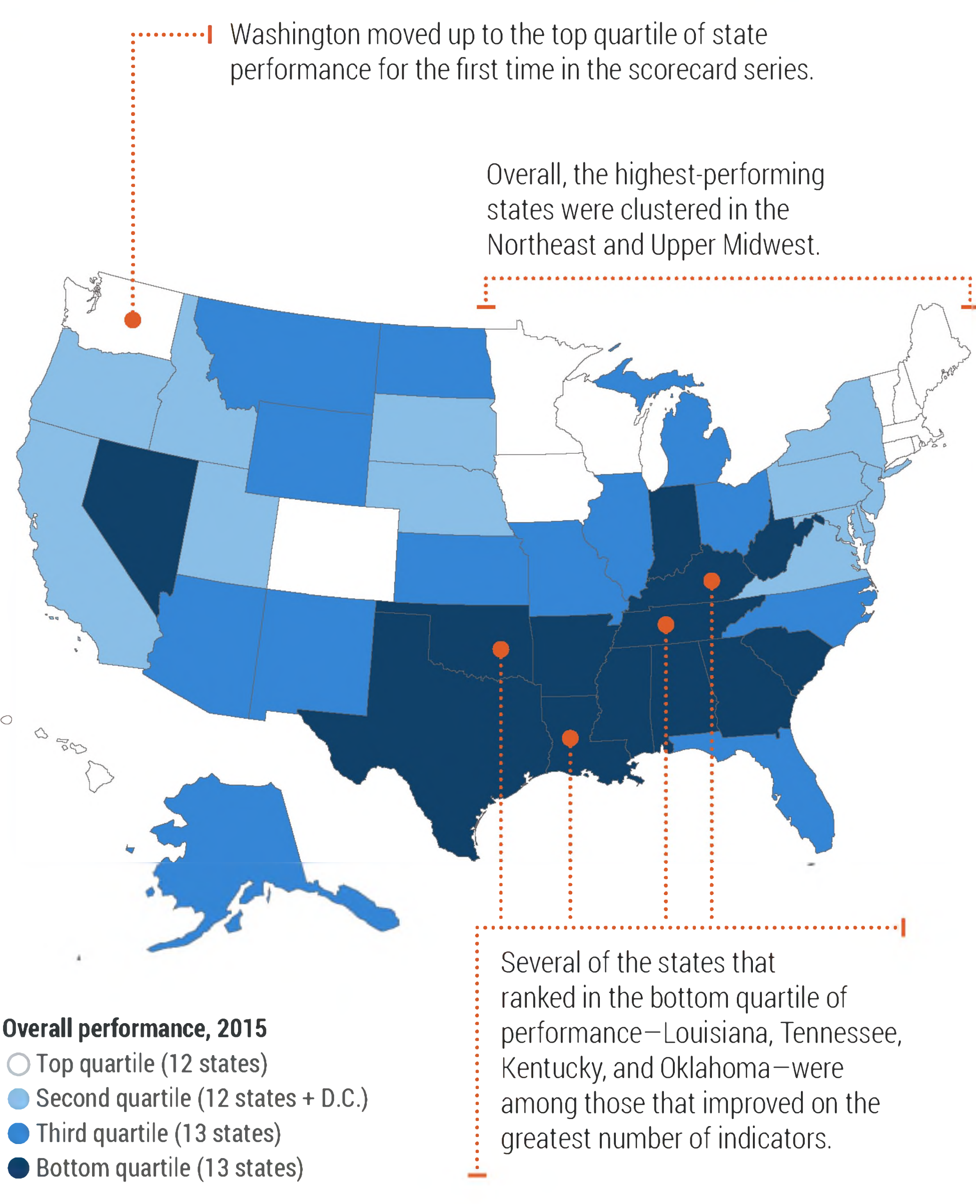
AVOIDABLE HOSPITAL USE AND COST

HEALTHY LIVES

EQUITY

HIGHLIGHTS FROM THE SCORECARD

The top-ranked states are Minnesota, Vermont, Hawaii, Massachusetts, Connecticut, New Hampshire, and Rhode Island. These states were also leaders in the 2014 scorecard.



IMPROVEMENTS IN ACCESS FROM 2013 TO 2014

The percentage of uninsured working-age adults declined in nearly every state and by 3 points or more in

39 STATES

The percentage of uninsured children 18 years and younger declined by 2 points or more in

16 STATES

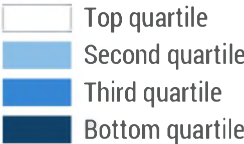
The percentage of adults who went without care because of costs in the past year declined by 2 points or more in

21 STATES

- There are wide variations in performance, with up to an **eightfold difference** between top- and bottom-ranked states.
- National attention may be encouraging better quality of care in hospitals and home health care settings and to more appropriate medication use in nursing homes and doctor's offices. However, declining rates of preventive care in several states signal the need for **greater attention to prevention**.
- **Reductions in hospital readmissions accelerated in 2012**, when the federal government began financially penalizing hospitals with high rates of readmissions. Rates of potentially preventable admissions to the hospital continued to fall in several states.
- In recent years, health care spending growth moderated for Medicare beneficiaries across states, while **premiums for employer-sponsored health plans continued to rise**.

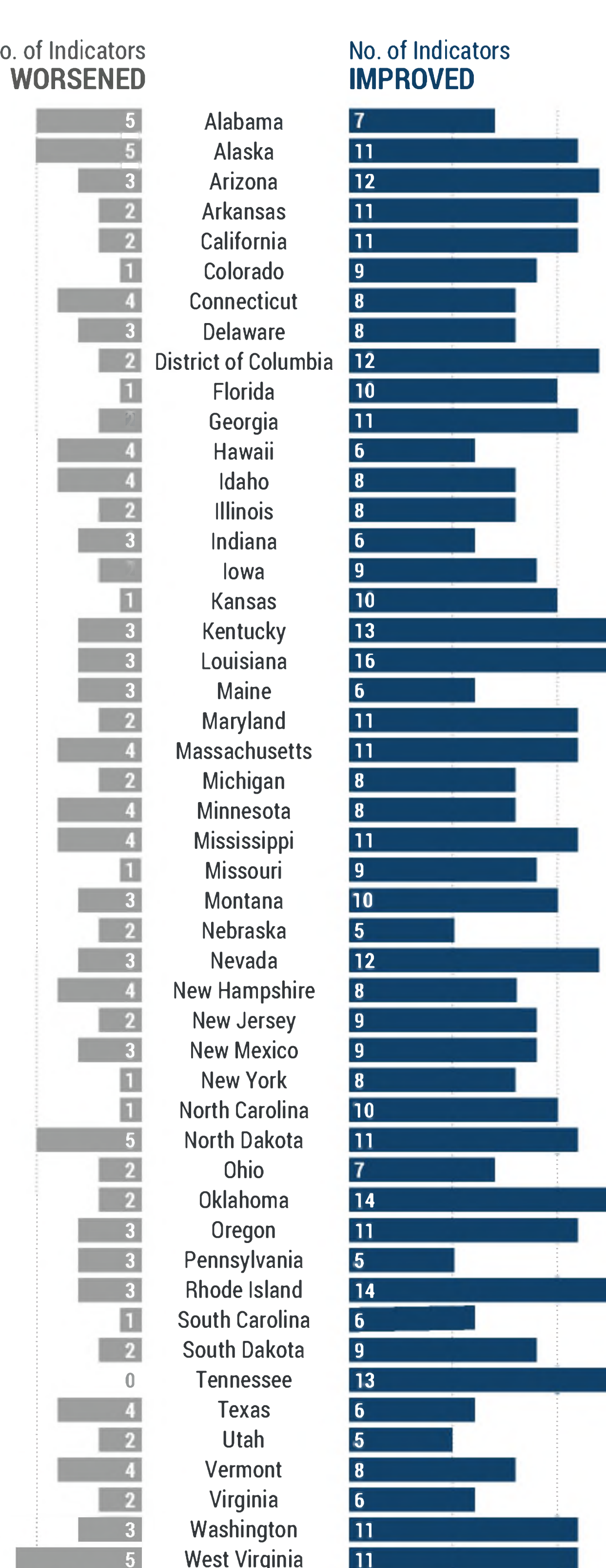
OVERALL RANKINGS ACROSS DIMENSIONS OF PERFORMANCE

Overall performance, 2015



Rank	State	Access & Affordability	Prevention & Treatment	Avoidable Hospital Use & Cost	Healthy Lives	Equity
1	Minnesota	Top	Top	Top	Top	Top
1	Vermont	Top	Top	Second	Top	Top
3	Hawaii	Top	Second	Top	Top	Top
4	Massachusetts	Top	Top	Third	Top	Top
5	Connecticut	Top	Top	Third	Top	Top
5	New Hampshire	Top	Top	Second	Top	Top
5	Rhode Island	Top	Top	Second	Top	Top
8	Colorado	Third	Top	Top	Top	Top
9	Iowa	Top	Top	Second	Second	Second
10	Washington	Second	Third	Top	Top	Top
11	Maine	Second	Top	Second	Third	Second
11	Wisconsin	Second	Top	Second	Second	Third
13	Nebraska	Second	Second	Second	Second	Second
13	New York	Second	Third	Third	Second	Top
15	Delaware	Top	Top	Second	Third	Second
15	Oregon	Third	Third	Top	Second	Top
15	South Dakota	Second	Second	Top	Third	Second
18	Maryland	Top	Second	Bottom	Second	Second
18	Utah	Third	Third	Top	Top	Second
20	District of Columbia	Top	Second	Bottom	Second	Top
20	New Jersey	Second	Second	Third	Top	Second
20	Pennsylvania	Top	Top	Third	Third	Second
23	California	Third	Third	Second	Top	Second
23	Virginia	Second	Second	Third	Second	Second
25	Idaho	Bottom	Third	Top	Second	Second
26	Illinois	Second	Second	Bottom	Second	Second
26	North Dakota	Second	Second	Second	Third	Third
28	Kansas	Second	Second	Third	Third	Third
28	Montana	Bottom	Third	Top	Second	Third
28	Wyoming	Third	Third	Second	Second	Third
31	Michigan	Second	Second	Third	Third	Third
32	Alaska	Bottom	Third	Top	Third	Third
33	Arizona	Bottom	Bottom	Top	Third	Second
33	New Mexico	Bottom	Bottom	Top	Third	Second
33	Ohio	Second	Second	Third	Bottom	Bottom
36	Missouri	Third	Second	Third	Bottom	Third
37	Florida	Bottom	Third	Third	Second	Third
37	North Carolina	Third	Third	Third	Third	Bottom
39	West Virginia	Third	Second	Bottom	Bottom	Third
40	Kentucky	Third	Second	Bottom	Bottom	Bottom
40	South Carolina	Bottom	Third	Second	Bottom	Bottom
40	Texas	Bottom	Bottom	Third	Second	Third
43	Indiana	Third	Third	Third	Bottom	Bottom
43	Nevada	Bottom	Bottom	Second	Third	Bottom
43	Tennessee	Third	Third	Bottom	Bottom	Bottom
46	Georgia	Bottom	Bottom	Third	Bottom	Bottom
47	Alabama	Third	Third	Bottom	Bottom	Bottom
48	Louisiana	Third	Bottom	Bottom	Bottom	Bottom
49	Arkansas	Bottom	Bottom	Third	Bottom	Bottom
50	Oklahoma	Bottom	Bottom	Bottom	Bottom	Bottom
51	Mississippi	Bottom	Bottom	Bottom	Bottom	Bottom

NUMBER OF INDICATORS IMPROVED OR WORSENED
BY STATE



Notes: Based on trends for 36 of 42 total indicators; trend data are not available for all indicators. Ambulatory care–sensitive conditions among Medicare beneficiaries from two age groups are considered a single indicator in tallies of improvement. Improvement or worsening refers to a change between the baseline and current time periods of at least 0.5 standard deviations larger than the difference in rates across all states over the two years being compared.

ABOUT THE SCORECARD SERIES

This 2015 edition of the Scorecard on State Health System Performance is the fourth in an ongoing series. Previous state scorecards were published in 2007, 2009, and 2014. The 2014 scorecard assessed changes from 2007 to 2012, which included the 2007–2009 recession but stopped short of major coverage expansions under the Affordable Care Act (ACA).

The 2015 edition measures changes in performance during 2013 and 2014 to assess the effects of the ACA's 2014 health insurance expansions, as well as early effects of health care delivery and payment reforms like accountable care organizations and financial incentives to reduce hospital readmissions. The effects of the ACA are not yet fully reflected in the 2015 scorecard results. It may take many years to see the resulting changes.

Annual updates in this series will document the trajectory of states' performance as changes shaped by public policy and the private market continue to unfold.

See Methods, page 19, for a complete description of scorecard methods and indicators. See appendices for state-specific rates for each indicator. Also see a companion brief, *The Changing Landscape of Health Care Coverage and Access: Comparing States' Progress in the ACA's First Year*.

2015 SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE

ACCESS AND AFFORDABILITY

Being able to get—and afford—health care when you need it are fundamental elements of a well-functioning health care system. One key measure of access to care is rates of insurance: do people have health insurance coverage that makes it possible for them to seek medical care when they are sick and get the preventive services they need to stay healthy? Health insurance also protects individuals and their families from burdensome costs in the case of an accident or illness. In 2014, the Affordable Care Act expanded access for many millions of Americans by creating health insurance marketplaces that offer coverage—with subsidies for those eligible—and providing federal funding to states to expand Medicaid eligibility for low-income residents.

THE GREATEST IMPROVEMENT:

Between 2013 and 2014, the uninsured rates for adults ages 19–64 fell by 3 percentage points or more in

39 STATES

Across the country, the uninsured rates among working-age adults ranged from 5% in Massachusetts to 26% in Texas.

5% MASSACHUSETTS

26% TEXAS

California, Florida, Montana, Oklahoma, Oregon, and Rhode Island

IMPROVED ON THE GREATEST NUMBER OF INDICATORS

KEY FINDINGS

- The number of uninsured children fell by 2 percentage points or more in **16 states**.

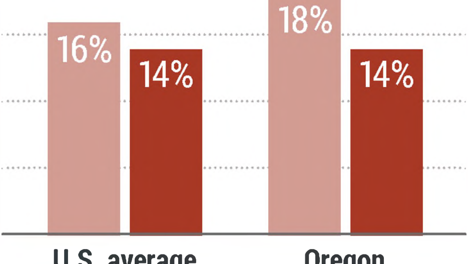
Children ages 0–18 who were uninsured across all states

2013	2014
8%	6%

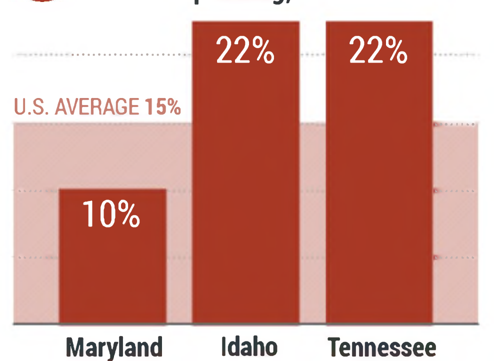
- The number of adults who said they went without care because of costs fell by 2 percentage points or more in **21 states**. In Oregon, the rate fell the most—from 18 percent to 14 percent of adults.

Adults who went without care because of cost in the past year

2013 2014



- The percentage of adults under age 65 who had high out-of-pocket spending relative to their income ranged from **10 percent** in Maryland to **22 percent** in Idaho and Tennessee.



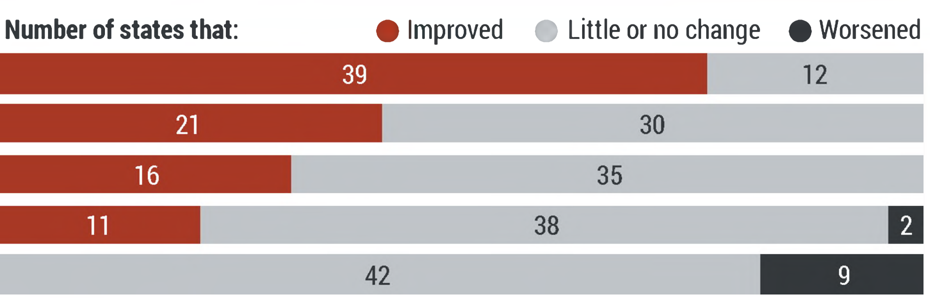
[a] Defined as out-of-pocket medical expenses equaling 10 percent or more of annual household income, or 5 percent or more of income if low income (below 200% of the federal poverty level). To ensure adequate sample size, state-level estimates are an average of rates found in 2013 and 2014.

- Ten states—Alaska, Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, South Carolina, and Texas—had rates of uninsured adults in 2014 that were **20 percent or higher**. Of these, only Nevada and New Mexico expanded their Medicaid programs as of January 2014 (Alaska did in 2015).

2015 RANKING

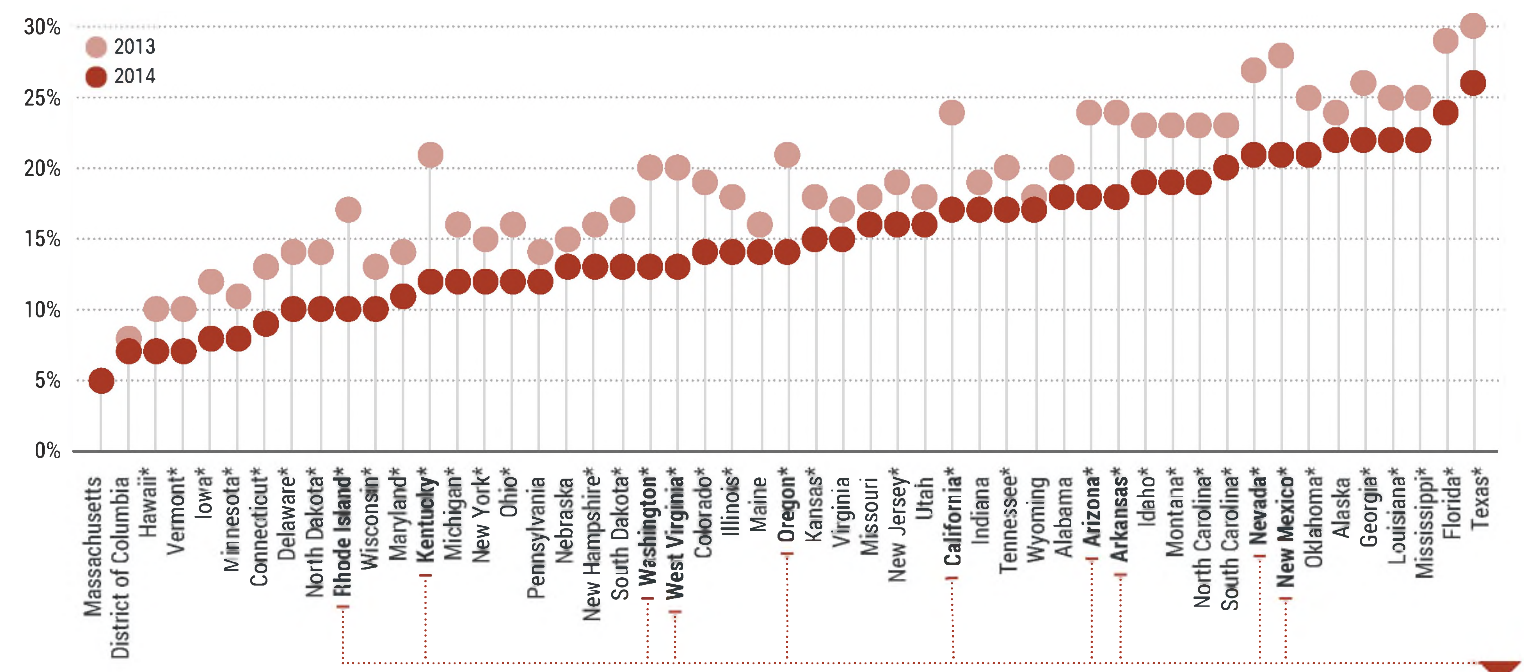
Rank	State
1	Massachusetts
2	Vermont
3	Minnesota
4	Rhode Island
5	Connecticut
5	Maryland
7	District of Columbia
7	Iowa
9	Delaware
9	New Hampshire
11	Hawaii
12	Pennsylvania
13	Wisconsin
14	New York
15	Michigan
16	Maine
16	Ohio
16	Washington
19	Illinois
19	Virginia
21	New Jersey
22	South Dakota
23	Kansas
23	Nebraska
25	North Dakota
26	Colorado
26	West Virginia
28	Kentucky
28	Oregon
30	California
30	North Carolina
32	Alabama
33	Missouri
34	Indiana
34	Tennessee
36	Utah
36	Wyoming
38	Louisiana
39	Montana
40	Florida
41	Georgia
41	South Carolina
43	Arizona
44	Alaska
44	Arkansas
46	Idaho
46	New Mexico
48	Mississippi
48	Oklahoma
50	Nevada
51	Texas

CHANGE IN STATE HEALTH SYSTEM PERFORMANCE BY INDICATOR



Notes: This exhibit measures indicator change over the two most recent years of data available. See Appendix A1 for baseline and current data years for each indicator. Trend data are not available for all indicators. Improvement or worsening refers to a change between the baseline and current time periods of at least 0.5 standard deviations. The "little or no change" category includes the number of states with changes of less than 0.5 standard deviations, as well as states with no change or without sufficient data to assess change over time. Adult uninsured rates declined in all states and D.C. from 2013 to 2014 except for Massachusetts where the rate did not change; in the remaining 11 states, the decline was less than 0.5 standard deviations. High out-of-pocket spending indicator is not included because data are not comparable to prior years.

Ten states had declines of 6 to 9 percentage points in uninsured rates for working-age adults



Note: States are arranged in rank order based on their current data year (2014) value.
* Denotes states with at least -.5 standard deviation change (3 percentage points) between 2013 and 2014.
Data: 2013 and 2014 American Community Survey (ACS), Public Use Microdata Sample (PUMS).

FUTURE IMPLICATIONS

If all states performed as well as the top-performing state:

More than
24 million

additional adults and children would gain health insurance.

Nearly
12 million

fewer people would be burdened by high medical spending relative to income.

Nearly
17 million

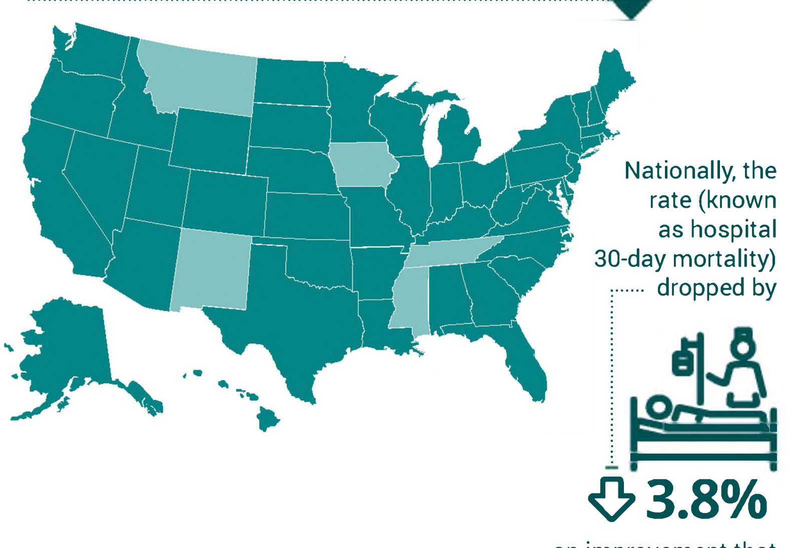
fewer adults would forgo needed care because of cost.

PREVENTION AND TREATMENT

Patients and their families have the right to expect care that is effective, coordinated among their different physicians and other providers, and respectful of their values and preferences. The Prevention and Treatment dimension assesses these factors by measuring the quality of care provided in hospitals, nursing homes, doctors' offices, and patients' homes.

THE GREATEST IMPROVEMENT: IN 45 STATES

patients who were hospitalized for heart attack, heart failure, or pneumonia were substantially less likely to die within 30 days of their hospital stay, compared with the previous three-year measurement period.



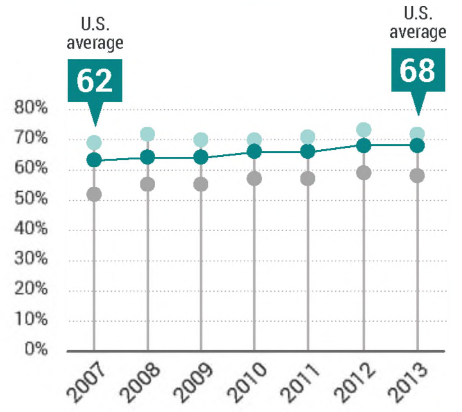
KEY FINDINGS

Patients' hospital experiences have improved steadily in recent years

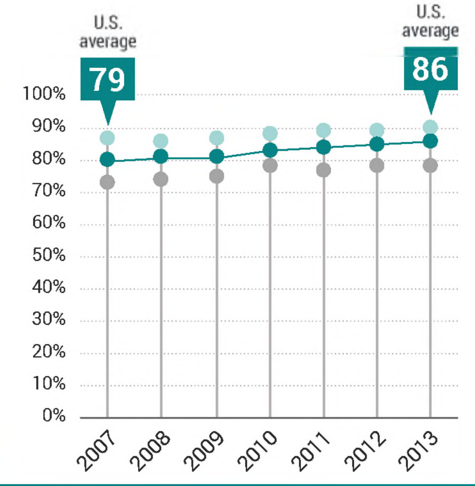
- Although changes in hospital quality may be modest from year to year, all states improved between 2007 and 2013 on two indicators of patient-reported care experiences in the hospital. These measures have received heightened attention through public reporting of hospital performance and, for measures of patient education, as part of national efforts to reduce hospital readmissions.

Percent of hospitalized patients who reported hospital staff always managed pain well, responded when needed help to get to bathroom or pressed call button, and explained medicines and side effects

Best-performing state (highest rate)
U.S. average
Worst-performing state (lowest rate)



Percent of hospitalized patients given information about what to do during their recovery at home

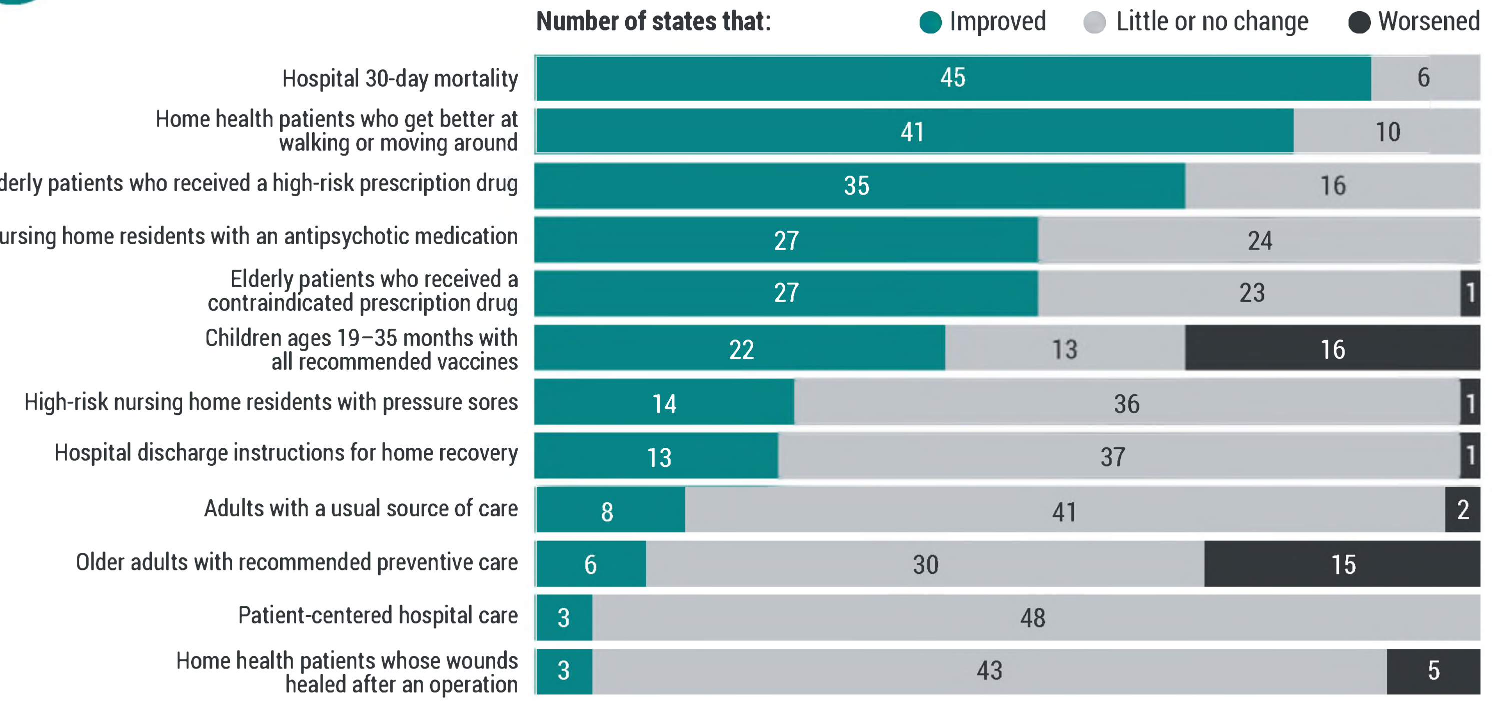


Data: CMS Hospital Compare.

2015 RANKING

Rank	State
1	Maine
2	Massachusetts
3	Rhode Island
4	New Hampshire
4	Vermont
4	Wisconsin
7	Pennsylvania
8	Minnesota
9	Colorado
9	Connecticut
9	Delaware
9	Iowa
13	Nebraska
14	Maryland
14	South Dakota
16	Kansas
16	Michigan
18	Hawaii
19	North Dakota
20	Kentucky
21	District of Columbia
21	Illinois
21	Missouri
21	New Jersey
21	Ohio
21	Virginia
21	West Virginia
28	New York
28	South Carolina
28	Utah
31	Idaho
31	Montana
31	North Carolina
34	Indiana
34	Wyoming
36	Oregon
37	Alabama
37	Alaska
37	California
37	Florida
37	Tennessee
37	Washington
43	Louisiana
44	Oklahoma
45	Georgia
45	New Mexico
47	Arizona
47	Arkansas
47	Mississippi
50	Texas
51	Nevada

CHANGE IN STATE HEALTH SYSTEM PERFORMANCE BY INDICATOR



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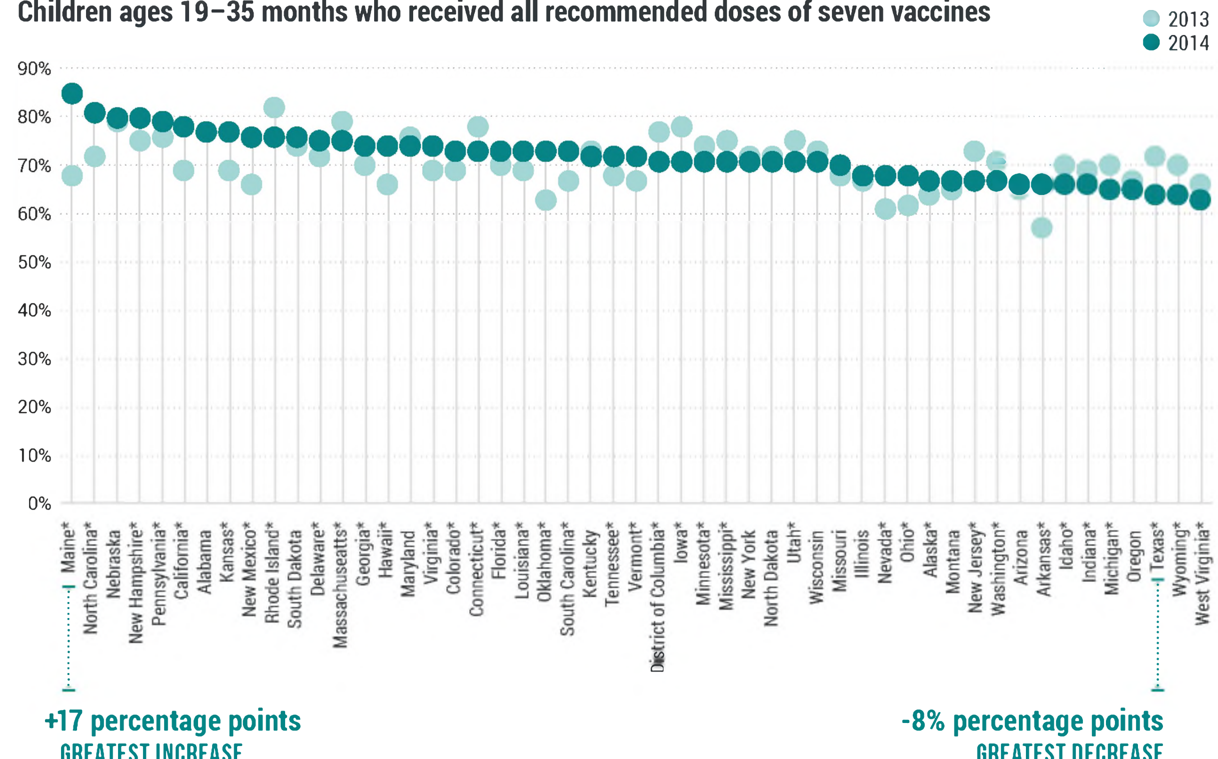
VACCINATIONS IN CHILDREN

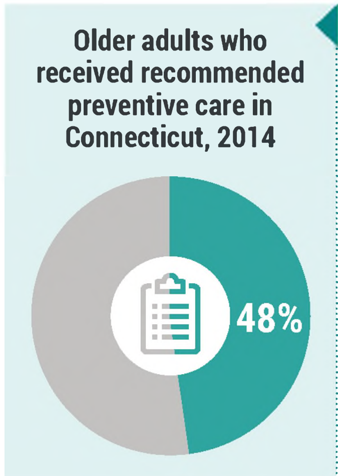
- High rates of vaccinations protect the population from communicable diseases. Among children ages 19 to 35 months, the percentage receiving all seven recommended vaccines on time increased by 3 points or more in **22 states** from 2013 to 2014 while decreasing by a similar magnitude in 15 states and D.C. Nationally, more than **1 of 4 young children** were not up-to-date on all recommended vaccines in 2014, a rate little-changed from 2013.



Notes: States are arranged in rank order based on their current data year (2014) value. *Denotes states with at least -.5 standard deviation change (3 percentage points) between 2013 and 2014. Recommended vaccines are the 4:3:1:3:3:1:4 series, which includes ≥4 doses of DTaP/DT/DTP, ≥3 doses of poliovirus vaccine, ≥1 doses of measles-containing vaccine, full series of Hib (3 or 4 doses, depending on product type), ≥3 doses of HepB, ≥1 dose of varicella vaccine, and ≥4 doses of PCV.
Data: 2013 and 2014 National Immunization Surveys.

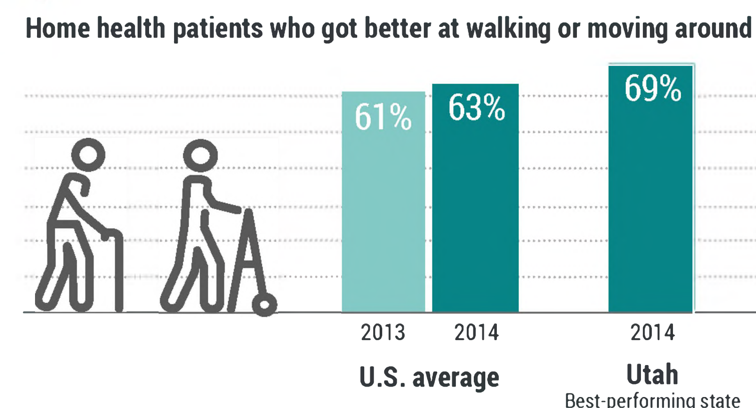
OLDER ADULTS

Among adults 50 and older, the share who reported receiving all appropriate preventive care services—like cancer screenings and flu shots—declined by 2 percentage points or more in **15 states** between 2012 and 2014.

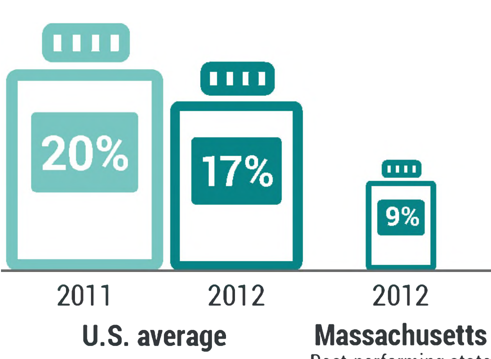


Even in Connecticut, the best-performing state, **less than half** of older adults received all the recommended services in the appropriate time frame.[1] Although the ACA requires most insurance plans to cover certain preventive services with no cost-wsharing, other factors—like patient awareness and physicians' recommendations—can be factors in whether adults receive services.[2]

When adults receive home health care, it is critical that they receive help in regaining functional abilities, like walking.[3] In 41 states, there were gains of at least 2 percentage points between 2013 and 2014 in the share of home health patients who got better at walking or moving around.



Elderly patients who received a high-risk prescription drug



In **35 states**, there was a reduction of at least 3 percentage points between 2011 and 2012 in the share of elderly Medicare beneficiaries who received a high-risk prescription medication that should be avoided for elderly people. This improvement may reflect actions taken by the Food and Drug Administration that led to a high-risk drug being removed from the market, as well as providers' increased awareness of drug safety concerns and the increased use of electronic prescribing tools that alert providers when unsafe drugs are ordered.[4]

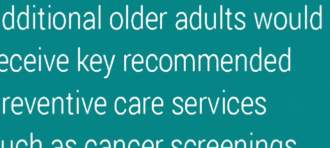
In **27 states**, there was a promising reduction of at least 2 percentage points in the use of antipsychotic drugs in nursing homes, where they are sometimes inappropriately prescribed to chemically restrain residents with cognitive impairments or difficult behaviors.[5]

WHAT IS AN UNSAFE DRUG?

Certain medications that are commonly taken by younger patients without incident can put those age 65 and older at increased risk for experiencing severe side effects and complications such as confusion, sedation, immobility, falls, and fractures. The National Committee for Quality Assurance has identified more than 100 high-risk medications that should be avoided in the elderly, ranging from antianxiety drugs and antihistamines to narcotics and muscle relaxants. Safer alternatives may be available, but these potentially harmful medications are still frequently prescribed to the elderly.

FUTURE IMPLICATIONS

If all states performed as well as the top-performing state:



More than **8 million** additional older adults would receive key recommended preventive care services such as cancer screenings and flu shots.

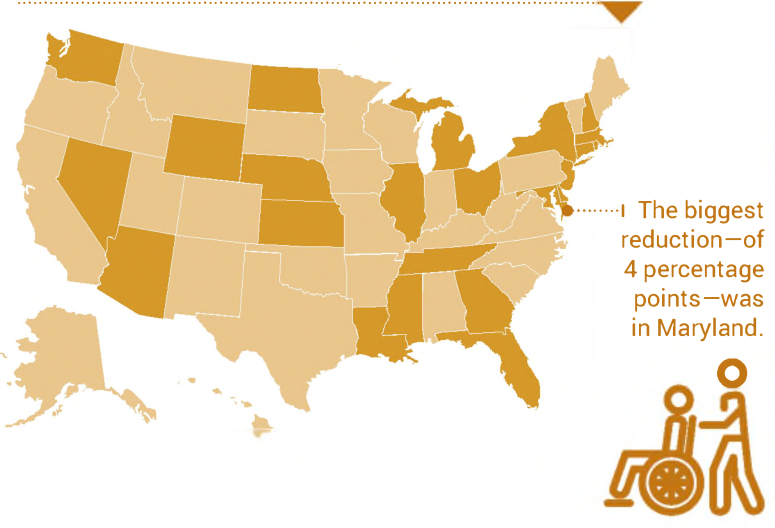
2015 SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE

AVOIDABLE HOSPITAL USE AND COSTS OF CARE

Inefficient or wasteful health care, along with high costs, are among the chief problems burdening our health care system. To measure inefficiency, this scorecard dimension focuses on rates of potentially avoidable and expensive hospital care. It also looks at two cost measures: the average cost of an individual employer-based health insurance premium and average annual spending per Medicare beneficiary. Many studies have found that higher spending is not systemically associated with better outcomes. The Affordable Care Act encourages changes to the way we deliver and pay for care and encourages new models, like accountable care organizations and bundled payment arrangements.

THE GREATEST IMPROVEMENT: IN 23 STATES

there were reductions of 2 percentage points or more between 2010 and 2012 in rates of hospital readmissions among Medicare beneficiaries receiving postacute care in nursing homes.



Louisiana, Massachusetts, and Tennessee

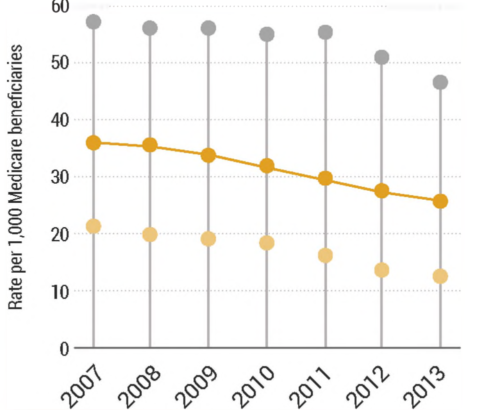
IMPROVED ON THE GREATEST NUMBER OF INDICATORS

5 OF 9

KEY FINDINGS

Hospitalizations for ambulatory–care sensitive conditions

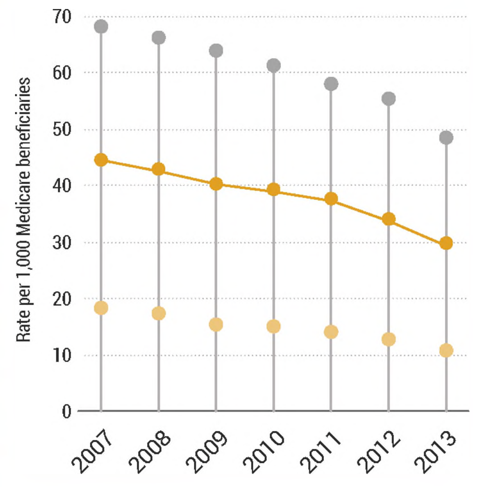
- Among Medicare beneficiaries ages 65 to 74, hospital admissions for ambulatory care–sensitive conditions—that is, conditions that can be managed outside the hospital, like hypertension—fell **2 percent** from 2007 to 2008 and then an average **6 percent** annually between 2008 and 2013.



- The worst-performing states improved the most for this indicator in 2013. The rate fell **16 percent** in Oklahoma and **14 percent** in West Virginia; rates varied about threefold across states.

30-day hospital readmissions

- The hospital readmission rate for Medicare beneficiaries fell by **10.5 percent** in 2012 and **10.8 percent** in 2013, after declining an average **3.8 percent** annually between 2007 and 2011. In October 2012, the Medicare program began financially penalizing hospitals with high rates of readmissions, motivating hospitals to reduce readmissions to avoid these penalties.[6]



Data: Ambulatory-care sensitive hospitalizations & 30-day readmissions: Medicare claims via Feb. 2015 CMS Geographic Variation Public Use File.

2015 RANKING

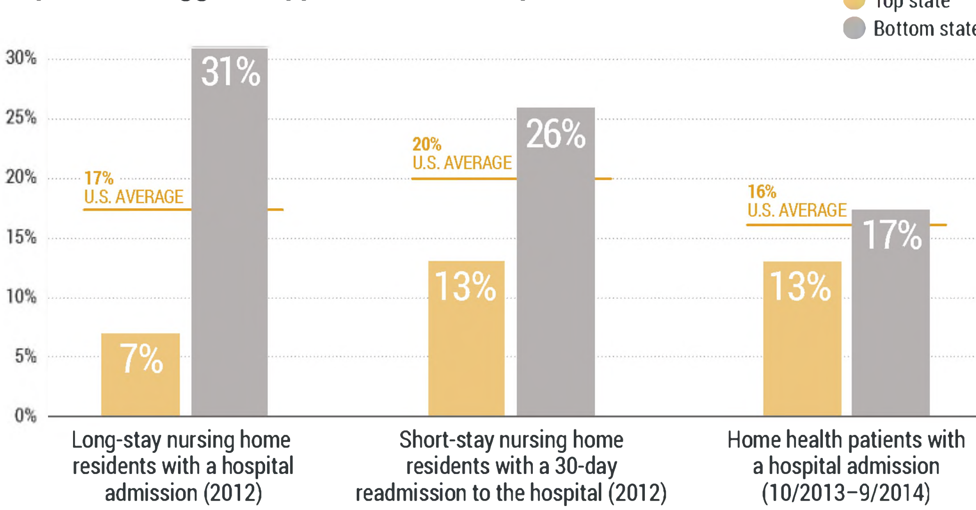
Rank	State
1	Hawaii
2	Oregon
3	Idaho
4	Washington
5	Colorado
5	Montana
5	Utah
8	Minnesota
8	South Dakota
10	Alaska
10	Arizona
10	New Mexico
13	Vermont
14	California
14	Nebraska
14	Wisconsin
14	Wyoming
18	Iowa
18	Nevada
18	New Hampshire
21	Maine
22	North Dakota
22	Rhode Island
24	Delaware
24	South Carolina
26	New York
26	North Carolina
28	Connecticut
28	Georgia
28	Virginia
31	Kansas
31	Massachusetts
33	Florida
33	Pennsylvania
33	Texas
36	Indiana
36	New Jersey
38	Arkansas
38	Michigan
38	Missouri
38	Ohio
42	Maryland
42	Tennessee
44	Illinois
45	District of Columbia
46	Alabama
46	Oklahoma
48	West Virginia
49	Kentucky
50	Louisiana
51	Mississippi

AVOIDABLE HOSPITAL USE

Long-term care for elderly Americans is often funded by state Medicaid programs, while their hospital stays and postacute care are paid for by Medicare. Postacute care in either patients' homes or institutions, like skilled nursing facilities, is the greatest source of Medicare spending variation.[7] Hospital admissions or readmissions from these settings can often be avoided with good transitional care and proactive patient monitoring and intervention.[8]

- There was considerable variation among states in hospital admission and readmission rates among nursing home residents and home health patients.

Wide state variation on indicators of potentially avoidable hospital use suggests opportunities for improvement



Data: Nursing home admissions/readmissions: V. Mor, Brown University, analysis of 2012 Medicare enrollment data, Medicare Provider and Analysis Review (MedPAR), and Minimum Data Set (MDS) data; Home health admissions: authors' analysis of CMS Medicare claims data from CMS Home Health Compare.

States with the highest hospital readmission rates in 2012 tended to have the largest reductions in 2013

2012
2013

Rate of 30-day hospital readmissions per 1,000 Medicare beneficiaries

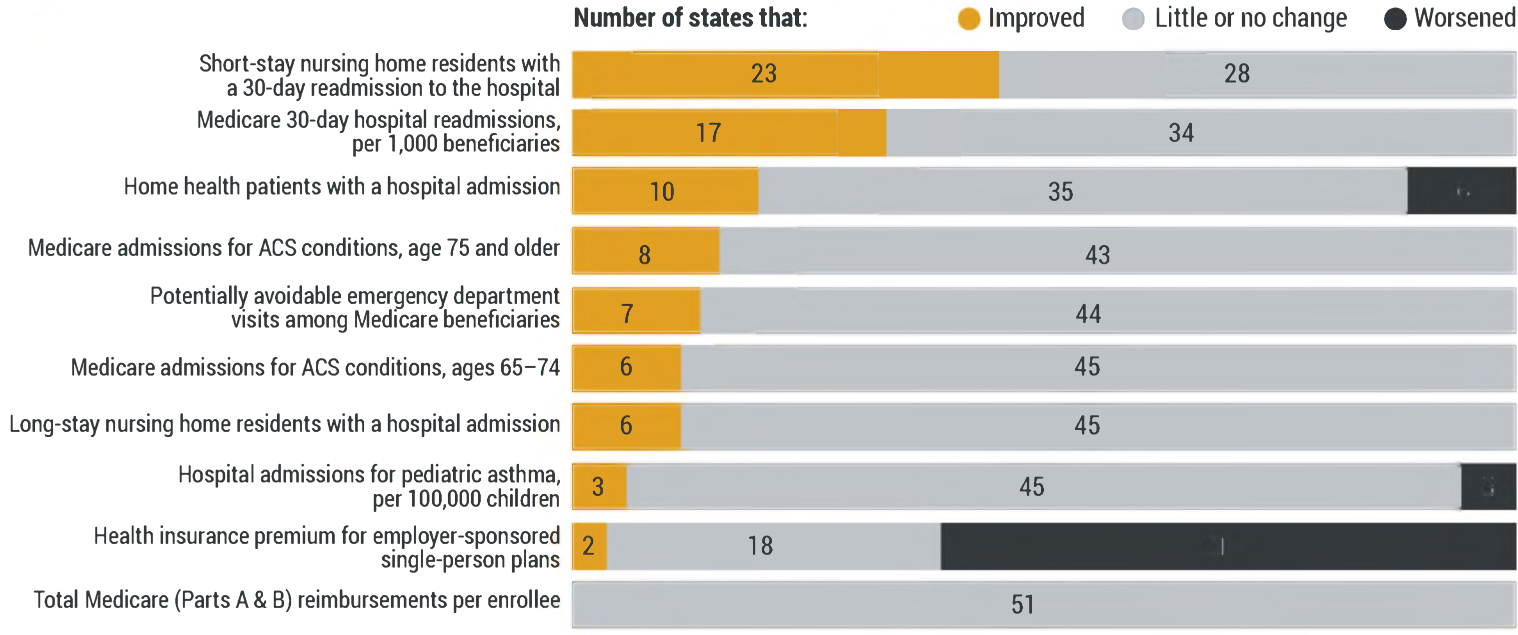
U.S. average, 2012: 34

U.S. average, 2013: 30

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

Notes: States are arranged in order (lowest to highest) of their readmission rate in 2012.
*Denotes states with at least -.5 standard deviation change (5 readmissions per 1,000) between 2012 and 2013.
Data: Medicare claims via Feb. 2015 CMS Geographic Variation Public Use File.

CHANGE IN STATE HEALTH SYSTEM PERFORMANCE BY INDICATOR



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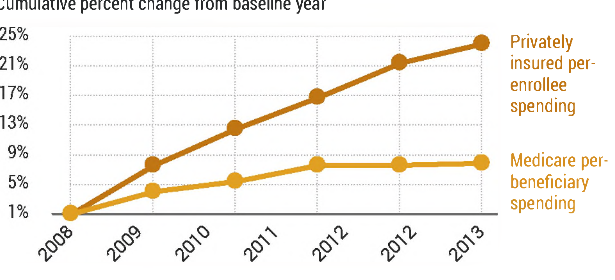
COST OF CARE

- National per-beneficiary Medicare spending grew by **7.8 percent** between 2008 and 2013, representing average annual growth of **1.9 percent**. In contrast, among people with private health insurance, spending grew more rapidly during the same period: by 23.9 percent, or average annual growth of 5.5 percent.[9]
- Per-person Medicare spending growth between 2008 and 2013 was 8 percent or less in **31 states** and higher than 15 percent in only North Dakota and South Dakota.
- Average health insurance premiums for employer-sponsored individual plans increased in **every state** between 2008 and 2013, with growth ranging from 16 percent in Arkansas to 39 percent in South Dakota, North Dakota, Ohio, and Alaska.

Trend in national health expenditures

Cumulative percent change from baseline year



Data: CMS Office of the Actuary, National Health Expenditure Historical Tables, 2013; Table 21.

State change: Medicare spending and employer-sponsored health insurance premiums

Number of states and D.C. with

- Less than or equal to 8% growth, 2008–2013
- 9% to 14% growth, 2008–2013
- 15% to 29% growth, 2008–2013
- 30% or higher growth, 2008–2013

Medicare spending per beneficiary

Less than or equal to 8%	9% to 14%	15% to 29%	30% or higher
31	18	2	

Single-person employer-sponsored insurance premium

Less than or equal to 8%	9% to 14%	15% to 29%	30% or higher
		34	17

Notes: State change reflects 2008 to 2013; 2014 data on ESI premiums used in Scorecard rankings are excluded for comparability to Medicare data. Medicare spending estimates exclude prescription drug costs and reflect only the age 65+ Medicare fee-for-service population. For measuring trend, Medicare spending and insurance premiums are unadjusted.
Data: Medicare spending: Medicare claims via Feb. 2015 CMS Geographic Variation Public Use File; Insurance premiums: 2008–2013 Medical Expenditure Panel Survey.

FUTURE IMPLICATIONS

If all states performed as well as the top-performing state:

Medicare beneficiaries would have over

1.4 million

fewer emergency room visits for care that could be provided outside the emergency room.

Children between 2 and 17 would endure about

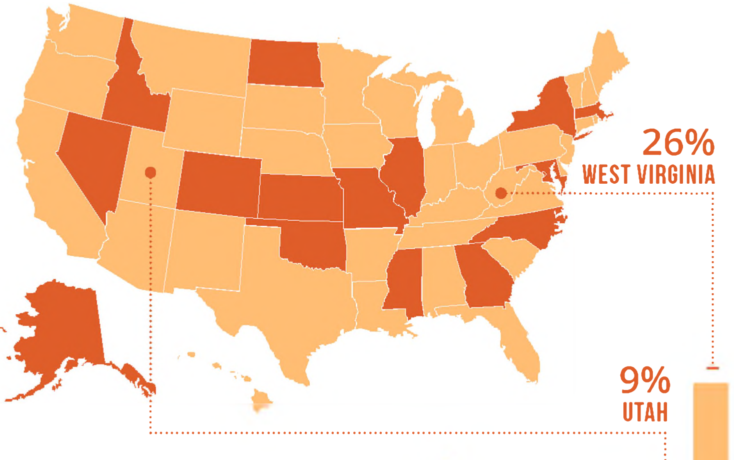
85,000

fewer asthma-related hospital admissions.

HEALTHY LIVES

Having insurance and getting care are not the only factors that contribute to a healthy population. This dimension includes measures that affect people's ability to lead long and healthy lives—like rates of smoking, premature death, and obesity.

THE GREATEST IMPROVEMENT: Reducing the number of adults who smoke.



15 STATES + D.C.

SAW THEIR SMOKING RATES DROP BY 2 TO 3 PERCENTAGE POINTS BETWEEN 2013 AND 2014.

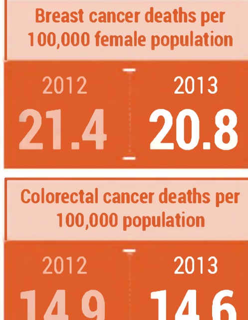
Across the country, the smoking rate among adults ranged from 9% in Utah to 26% in West Virginia.

D.C.

IMPROVED ON THE GREATEST NUMBER OF INDICATORS

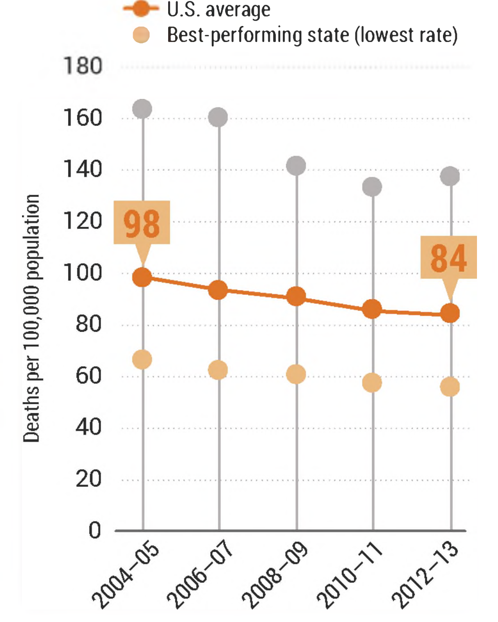
KEY FINDINGS

- Deaths from breast cancer fell in **13 states**, while deaths from colorectal cancer dropped in **10 states**, between 2012 and 2013.



Mortality Amenable to Health Care

- This measure refers to premature deaths (from certain diseases like diabetes or hypertension) that could have been prevented with effective and timely health care. Although there was little change in this measure during the time period measured by the 2015 scorecard, looking at a longer trend shows that the rate of these premature deaths fell 14 percent during the past decade—from 98 deaths per 100,000 people in 2004–05 to 84 in 2012–13.



Note: Age-standardized deaths before age 75 from select causes.
Data: 2004–2013 National Vital Statistics System (NVSS) Mortality All-County Micro Data Files.

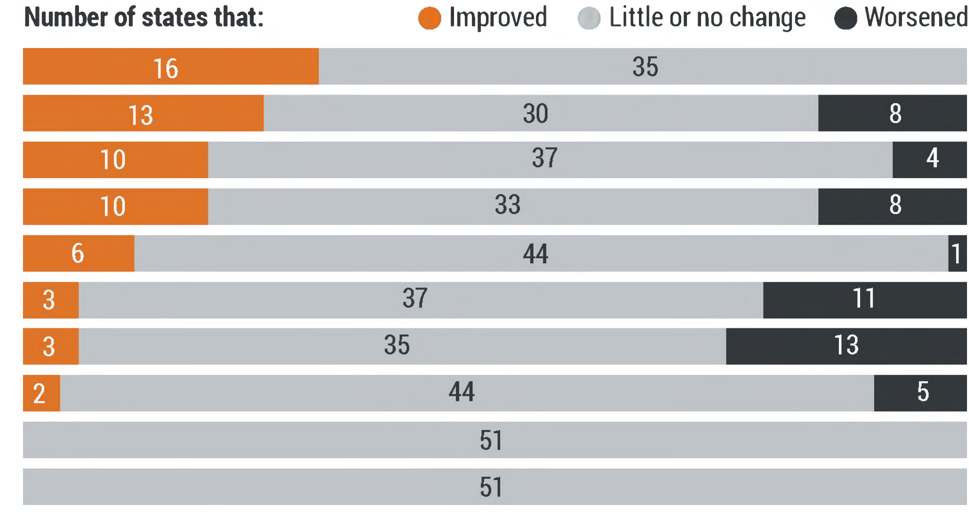
– The largest reductions occurred in states that had the highest rates to start with—for example, since 2004–05, premature deaths dropped **19 percent** in Nevada, from 114 to 92 per 100,000 people.

2015 RANKING

Rank	State
1	Minnesota
2	Colorado
2	Connecticut
4	Massachusetts
4	Utah
6	Hawaii
7	California
7	New Hampshire
9	Vermont
10	Rhode Island
10	Washington
12	New Jersey
13	New York
14	Nebraska
14	Oregon
16	Iowa
17	Idaho
18	Wisconsin
18	Wyoming
20	Maryland
20	Virginia
22	District of Columbia
22	Florida
22	Illinois
22	Montana
22	Texas
27	Kansas
27	North Dakota
29	Arizona
29	Maine
29	South Dakota
32	Alaska
33	Delaware
34	New Mexico
34	Pennsylvania
36	Nevada
36	North Carolina
38	Michigan
39	Georgia
40	Missouri
41	Ohio
42	Indiana
43	South Carolina
44	Kentucky
44	Tennessee
46	Alabama
46	Oklahoma
48	Louisiana
49	Arkansas
50	West Virginia
51	Mississippi

CHANGE IN STATE HEALTH SYSTEM PERFORMANCE BY INDICATOR

Adults who smoke
Breast cancer deaths per 100,000 female population
Colorectal cancer deaths per 100,000 population
Infant mortality, deaths per 1,000 live births
Adults who have lost six or more teeth
Adults who are obese
Adults with poor health-related quality of life
Suicide deaths per 100,000 population
Mortality amenable to health care
Years of potential life lost before age 75



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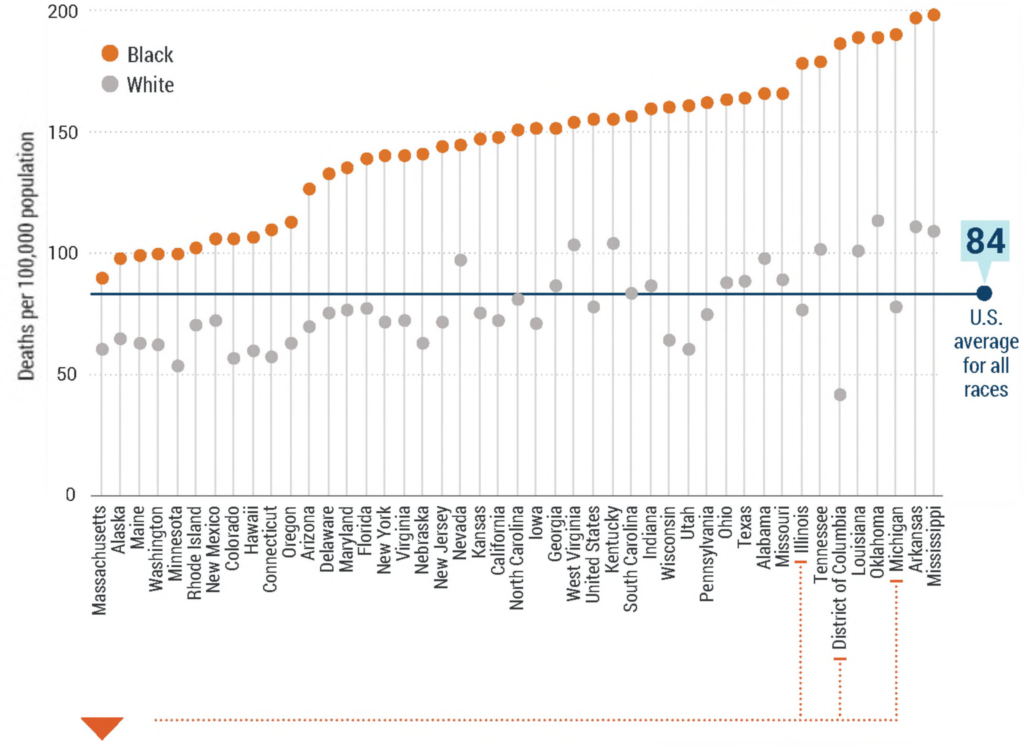
DISPARITY FINDING

- African Americans are more likely than whites to die early from a treatable condition in every state (where data are available).



The greatest disparities in rates between white and black deaths were in D.C. (186 vs. 41 per 100,000), Illinois (178 vs. 76), and Michigan (190 vs. 77).

Notes: Data for black race are not available for Idaho, Montana, New Hampshire, North Dakota, South Dakota, Vermont, or Wyoming. States are arranged in rank order based on black mortality.

Data: 2012 and 2013 National Vital Statistics System (NVSS) Mortality All-County Micro Data Files.

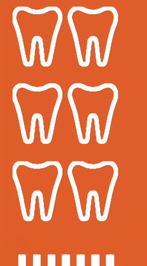
FUTURE IMPLICATIONS

If all states performed as well as the top-performing state:

There would be approximately

84,000

fewer premature deaths before age 75 for conditions that can be **detected early and effectively treated with good follow-up care.**



There would be nearly

8 million

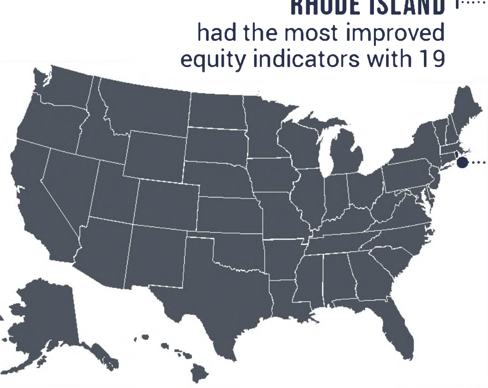
fewer adults (ages 18 to 64) who would lose six or more teeth to decay, infection, or gum disease.

EQUITY

When health care is inequitable, there are disparities in access and availability of care (e.g., the number of people who have insurance or who visit a dentist regularly) and health status (e.g., the number of people who are obese or smokers) between various groups based on different factors, like their income level. Across the nation, health care equity remains an unfulfilled goal. However, the health insurance expansions of the Affordable Care Act offer the opportunity to close these gaps. The Equity dimension looks at two vulnerable populations—low-income people and those who belong to racial and ethnic minorities. States' performance is based on gaps in equity—that is, the difference between the state's vulnerable population and the U.S. average for any given indicator. Improvement is defined as a decline in the states' vulnerable group rate and a narrowing in the performance gap between the vulnerable group and the U.S. average.

KEY FINDINGS

- Every state improved on **at least five** equity indicators.



- For most equity indicators, however, there were states for which **the gap widened**, meaning performance worsened for the most vulnerable group and the gap grew between that group and the U.S. average.

INCOME DISPARITIES

THE GREATEST IMPROVEMENT:

Widespread reductions in the percentage of low-income elderly adults who received a high-risk prescription medication

IN 37 STATES,

the percentage of low-income elderly adults receiving a high-risk prescription medication declined and the equity gap narrowed.

Rhode Island
IMPROVED ON THE GREATEST NUMBER OF INDICATORS

12 OF 15

- For the equity gaps based on income, **more states improved** than worsened. At least half the states improved on six indicators: rates of nonelderly uninsured, elderly patients who received a high-risk prescription medication, three measures of avoidable hospital use among Medicare beneficiaries who also receive Medicaid, and nonelderly adults who have lost six or more teeth due to gum disease. The majority of states worsened on only one indicator: **rates of obesity among adults**.

RACIAL/ETHNIC DISPARITIES

THE GREATEST IMPROVEMENT:

Premature death rates among states' racial and ethnic minority populations declined in most states

IN 34 STATES,

death rates from conditions amenable to health care interventions declined and the equity gap narrowed.

- For the equity gaps based on race or ethnicity, **more states worsened than improved**. At least half the states improved on three indicators: rates of nonelderly uninsured, mortality amenable to health care, and infant mortality, but at least half worsened on six others.

Arizona, Illinois, North Carolina, New York, Oklahoma, California, and Florida
IMPROVED ON THE GREATEST NUMBER OF INDICATORS

8 OF 13

2015 RANKING

Rank	State
1	Hawaii
2	Massachusetts
3	Connecticut
3	Vermont
5	New Hampshire
5	New York
7	Rhode Island
8	Washington
9	District of Columbia
9	Minnesota
11	Colorado
11	Oregon
13	Maryland
14	Delaware
15	Iowa
15	Maine
17	New Jersey
17	South Dakota
19	Pennsylvania
20	Nebraska
20	New Mexico
22	California
22	Idaho
24	Arizona
24	Illinois
24	Utah
24	Virginia
28	Missouri
29	Alaska
29	Wisconsin
31	Florida
31	Michigan
31	Texas
31	West Virginia
35	Wyoming
36	Kansas
36	Montana
36	North Dakota
39	Nevada
39	Tennessee
41	Ohio
42	Alabama
43	North Carolina
44	Louisiana
45	Georgia
45	Kentucky
47	Indiana
48	South Carolina
49	Mississippi
49	Oklahoma
51	Arkansas

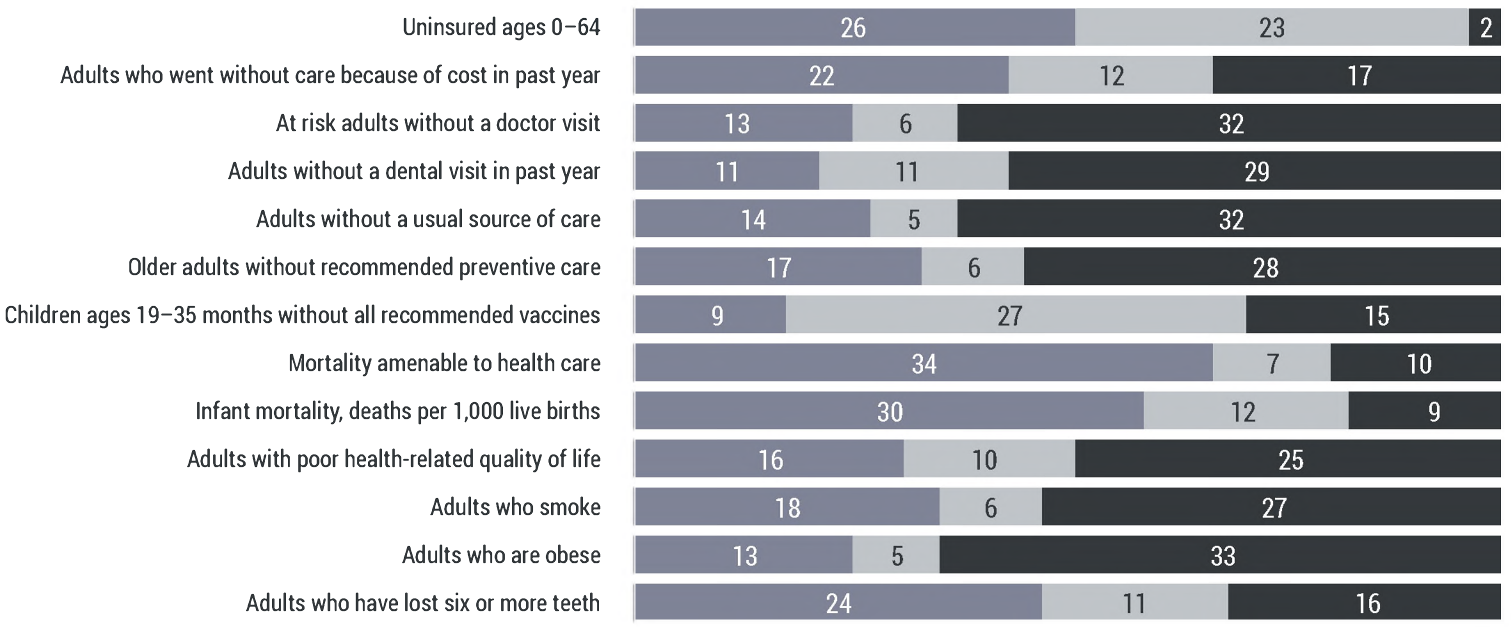
CHANGE IN STATE HEALTH SYSTEM PERFORMANCE BY INDICATOR

Income

Number of states where equity: Improved / No change / Worsened

Indicator	Improved	No change	Worsened
Uninsured ages 0–64	28	23	
Adults who went without care because of cost in past year	19	25	7
At-risk adults without a doctor visit	11	21	19
Adults without a dental visit in past year	16	12	23
Adults without a usual source of care	16	12	23
Older adults without recommended preventive care	18	19	14
Children ages 19–35 months without all recommended vaccines	21	13	17
Elderly patients who received a high-risk prescription drug	37	14	
Medicare admissions for ambulatory care–sensitive conditions	34	15	2
Medicare 30-day hospital readmissions, per 1,000 beneficiaries	35	12	4
Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	27	14	10
Adults with poor health-related quality of life	17	15	19
Adults who smoke	12	17	22
Adults who are obese	14	7	30
Adults who have lost six or more teeth	25	8	18

Race/Ethnicity



Notes: This exhibit measures indicator change over the two most recent years of data available. See Appendix A1 for baseline and current data years for each indicator. Trend data are not available for all indicators. Improvement indicates that the equity gap between states' vulnerable population and the U.S. average narrowed and that the rate among the states' vulnerable population improved. Worsening indicates that the equity gap between states' vulnerable population and the U.S. average widened and that the rate among the states' vulnerable population got worse. The "no change" category includes the number of states where the vulnerable group rate remained the same or changed but without a narrowing or widening in the gap with the U.S. average rate. It also includes the number of states without sufficient data for the vulnerable population to assess change over time.

LOOKING TOWARD THE FUTURE

Gains reported by the scorecard likely reflect the influence of public policy—most noticeably, the role of the Affordable Care Act in expanding health insurance coverage—as well as public and private initiatives at the national, state, and community levels. States have many opportunities to widen these gains in various ways—purchasing health care for low-income Medicaid populations and state employees, establishing rules that guide health care and insurance markets, setting strategy for health information technology and exchange, supporting public health, and acting as conveners and collaborators in improvement with other health care stakeholders.

It will be important to continue tracking health system performance as health reforms are implemented, paying close attention to states that are expanding Medicaid and participating in other reforms. In addition, states can help to ensure that proven practices are fully adopted. For example, the stagnation and decline in rates of adult preventive care suggests an opportunity to implement evidence-based clinical and community-based interventions recommended by the U.S. Preventive Services Task Force.[10]

The scorecard's findings remind us that where you live matters. The sobering truth is that residents of certain states realize greater benefits from their health care systems than do those in other states. It doesn't have to be this way. By acknowledging that access to care is the foundation of a high-performing health system and by focusing on the needs of low-income and other vulnerable populations, all states can safeguard and promote the health of their residents. All states can strive through policy and leadership to enhance patient care experiences, improve health outcomes, and lower health care spending.[11]

Only by aiming high can the U.S. reach its potential as a nation where geography is not destiny, and where everyone, everywhere, has the opportunity to live a long and healthy life.

ACCESS AND AFFORDABILITY

PREVENTION AND TREATMENT

AVOIDABLE HOSPITAL USE AND COST

HEALTHY LIVES

EQUITY

METHODS

The Commonwealth Fund's *Scorecard on State Health System Performance, 2015 Edition*, evaluates 42 key indicators grouped into five dimensions (Appendix Exhibit A1):

Access and Affordability (six indicators): includes rates of insurance coverage for children and adults, as well as individuals' out-of-pocket expenses for medical care and cost-related barriers to receiving care.

Prevention and Treatment (16 indicators): includes measures of receiving preventive care and the quality of care in ambulatory, hospital, and long-term care and postacute settings.

Potentially Avoidable Hospital Use and Cost (nine indicators): includes indicators of hospital use that might have been reduced with timely and effective care management and follow-up care, as well as estimates of per-person spending among Medicare beneficiaries and the cost of employer-sponsored insurance. One indicator, hospital admissions for ambulatory care–sensitive conditions, reported separately for two distinct age groups.

Healthy Lives (11 indicators): includes indicators that measure premature death and health risk behaviors.

Equity: The scorecard evaluates differences in performance on 33 equity indicators associated with patients' income level (18 indicators) or race or ethnicity (15 indicators) that span the other four dimensions of performance. The data available for some equity indicators, such as childhood vaccinations, may represent a different time point from that used in the corresponding main scorecard indicator. For each state, health system performance on each equity indicator as it pertains to low-income populations (under 200% of the federal poverty level) and racial or ethnic minority groups (black or other race or Hispanic ethnicity) is compared with the national average. The resulting difference in performance is the "equity gap," which forms the basis of our state rankings for this dimension. To support more comprehensive assessment of disparities, the 2015 scorecard expanded the number of indicators evaluated in the equity dimension; hence, the 2015 equity rankings are not strictly comparable to earlier scorecards.

The following principles guided the development of the scorecard:

Performance Metrics. The 42 performance metrics selected for this report span the health care system, representing important dimensions of care. Where possible, indicators align with those used in previous state scorecards. Since earlier versions of the scorecard, several indicators have been dropped either because all states improved to the point where no meaningful variations existed (e.g., hospital quality process-of-care measures) or the data to construct the measures were no longer available. Several new indicators were added to the scorecard series starting in 2014, including measures of premature death, out-of-pocket spending on medical care relative to income, and potentially avoidable emergency department use.

Measuring Change over Time. We were able to construct a time series for 36 of 42 indicators. Four scorecard indicators derived from the National Survey of Children's Health could not be updated because the survey is conducted only every four years; a fifth indicator (Medicare beneficiaries' ratings of provider communication) did not have a comparable baseline data point in the time period measured in this scorecard.

There were generally one to two years between indicators' baseline and current year data observation, though the starting and ending points depended on data availability. We chose this short time horizon so as to capture the immediate effects of changes relative to the policy and delivery system environment, such as recent coverage expansions under the Affordable Care Act, and other reforms as they are or may be enacted and implemented in the future.

We considered a change in an indicator's value between the historical and current year data points to be meaningful if it was at least one-half (0.5) of a standard deviation larger than the indictor's combined distribution over the two time points—a common approach in social science research.

To assess change over time in the Equity dimension, we count how often the equity gap (described above) narrowed across indicators for each state during the time period measured by this scorecard. Within the race/ethnicity Equity subdimension, we evaluate trend data for an indicator only when there was comparable historical data on the racial/ethnic group with the largest equity gap in the most current assessment period. We consider improvement to have occurred in an equity indicator only if the equity gap narrowed and health care for the states' most-vulnerable group improved.

Data Sources. Indicators draw from publicly available data sources, including government-sponsored surveys, registries, publicly reported quality indicators, vital statistics, mortality data, and administrative databases. The most current data available were used in this report whenever possible. Appendix Exhibits A1 and H1 provides detail on the data sources and time frames.

Scoring and Ranking Methodology. The scoring method follows previous state scorecards. States are first ranked from best to worst on each of the 42 performance indicators. We averaged rankings for indicators within each dimension to determine a state's dimension rank and then averaged dimension rankings to determine overall ranking. This approach gives each dimension equal weight, and within dimensions it weights indicators equally. As in previous scorecards, if historical data were not available for a particular indicator in the baseline period, the most current year of data available was used as a substitute ensuring that ranks in each time period were based on the same number of indicators and as similar as possible.

NOTES

1. The scorecard measures the percent of adults age 50 and older who have received all of the following: sigmoidoscopy or colonoscopy in the past 10 years or a fecal occult blood test in the past two years; a mammogram in the past two years (women only); a Pap smear in the past three years (women only); and a flu shot in the past year and a pneumonia vaccine ever (age 65 and older only).

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APPENDIX EXHIBIT A1. STATE SCORECARD DATA YEARS AND DATABASES

	Indicator	Past year	Current year	Database
	Access and Affordability			
1	Adults ages 19–64 uninsured	2013	2014	ACS PUMS
2	Children ages 0–18 uninsured	2013	2014	ACS PUMS
3	Adults who went without care because of cost in past year	2013	2014	BRFSS
4	Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	—[a]	2013–14	CPS ASEC
5	At-risk adults without a routine doctor visit in past two years	2013	2014	BRFSS
6	Adults without a dental visit in past year	2012	2014	BRFSS
	Prevention and Treatment			
7	Adults with a usual source of care	2013	2014	BRFSS
8	Adults ages 50 and older who received recommended screening and preventive care	2012	2014	BRFSS
9	Children with a medical home	—[a]	2011/12	NSCH
10	Children with a medical and dental preventive care visit in the past year	—[a]	2011/12	NSCH
11	Children with emotional, behavioral, or developmental problems who received needed mental health care in the past year	—[a]	2011/12	NSCH
12	Children ages 19–35 months who received all recommended doses of seven key vaccines	2013	2014	NIS
13	Medicare beneficiaries who received at least one drug that should be avoided in the elderly	2011	2012	5% Medicare enrolled in Part D
14	Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure who received a prescription drug that is contraindicated for that condition	2011	2012	5% Medicare enrolled in Part D
15	Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them	—[a]	2013	CAHPS (via AHRQ National Healthcare Quality Report)
16	Risk-adjusted 30-day mortality among Medicare beneficiaries hospitalized for heart attack, heart failure, or pneumonia	07/2009–06/2012	07/2010–06/2013	CMS Hospital Compare
17	Hospitalized patients given information about what to do during their recovery at home	2012	2013	HCAHPS (via CMS Hospital Compare)
18	Hospitalized patients who reported hospital staff always managed pain well, responded when needed help to get to bathroom or pressed call button, and explained medicines and side effects	2012	2013	HCAHPS (via CMS Hospital Compare)
19	Home health patients who get better at walking or moving around	2013	2014	OASIS (via CMS Home Health Compare)
20	Home health patients whose wounds improved or healed after an operation	2013	2014	OASIS (via CMS Home Health Compare)
21	High-risk nursing home residents with pressure sores	2013	2014	MDS (via CMS Nursing Home Compare)
22	Long-stay nursing home residents with an antipsychotic medication	2013	2014	MDS (via CMS Nursing Home Compare)
	Avoidable Hospital Use and Cost			
23	Hospital admissions for pediatric asthma, per 100,000 children	2011	2012	HCUP (via AHRQ National Healthcare Quality Report)
24	Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, ages 65–74, and age 75 and older per 1,000 beneficiaries	2012	2013	CCW (via CMS Geographic Variation Public Use File)
25	Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	2013	CCW (via CMS Geographic Variation Public Use File)
26	Short-stay nursing home residents readmitted within 30 days of hospital discharge to nursing home	2010	2012	MedPAR, MDS
27	Long-stay nursing home residents hospitalized within a six-month period	2010	2012	MedPAR, MDS
28	Home health patients also enrolled in Medicare with a hospital admission	2013	10/2013–9/2014	OASIS (via CMS Home Health Compare)
29	Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2012	2013	5% Medicare SAF
30	Total single premium per enrolled employee at private-sector establishments that offer health insurance	2013	2014	MEPS
31	Total Medicare (Parts A & B) reimbursements per enrollee	2012	2013	CCW (via CMS Geographic Variation Public Use File)
	Healthy Lives			
32	Mortality amenable to health care, deaths per 100,000 population	2010–11	2012–13	CDC NVSS: Mortality Restricted Use File
33	Years of potential life lost before age 75	2012	2013	CDC NVSS: WISQARS
34	Breast cancer deaths per 100,000 female population	2012	2013	CDC NVSS: WONDER
35	Colorectal cancer deaths per 100,000 population	2012	2013	CDC NVSS: WONDER
36	Suicide deaths per 100,000 population	2012	2013	CDC NVSS: WONDER
37	Infant mortality, deaths per 1,000 live births	2012	2013	CDC NVSS: WONDER
38	Adults ages 18–64 who report fair/poor health or activity limitations because of physical, mental, or emotional problems	2013	2014	BRFSS
39	Adults who smoke	2013	2014	BRFSS
40	Adults ages 18–64 who are obese (BMI >= 30)	2013	2014	BRFSS
41	Children ages 10–17 who are overweight or obese (BMI >= 85th percentile)	—[a]	2011/12	NSCH
42	Percent of adults ages 18–64 who have lost six or more teeth because of tooth decay, infection, or gum disease	2012	2014	BRFSS

Note: (a) Previous data not available or its definition is not comparable over time.

APPENDIX EXHIBIT A2. LIST OF 42 INDICATORS IN THE STATE SCORECARD ON HEALTH SYSTEM PERFORMANCE

	Indicator	Data Years Represented		U.S. Average Rate		Range of State Performance		2015 Scorecard
		Baseline[a]	2015 Scorecard	Baseline[a]	2015 Scorecard	Baseline[a]	2015 Scorecard	Best State(s)[b]
	Access and Affordability							
1	Adults ages 19–64 uninsured	2013	2014	20	16 *	5–30	5–26	MA
2	Children ages 0–18 uninsured	2013	2014	8	6 *	2–14	2–12	MA
3	Adults who went without care because of cost in the past year	2013	2014	16	14 *	7–22	7–19	ND
4	Individuals with high out-of-pocket medical spending	—[c]	2013-14	—[c]	15	—[c]	10–22	MD
5	At-risk adults without a doctor visit	2013	2014	14	13	7–23	6–22	RI
6	Adults without a dental visit in past year	2012	2014	15	16	10–20	11–20	SD, VT
	Prevention and Treatment							
7	Adults with a usual source of care	2013	2014	76	77	65–88	65–89	MA
8	Older adults with recommended preventive care	2012	2014	42	40 *	34–52	32–48	CT
9	Children with a medical home	—[c]	2011/12	—[c]	54	—[c]	45–69	VT
10	Children with a medical and dental preventive care visit in the past year	—[c]	2011/12	—[c]	68	—[c]	56–81	VT
11	Children who received needed mental health care in the past year	—[c]	2011/12	—[c]	61	—[c]	40–86	ND
12	Children ages 19–35 months with all recommended vaccines	2013	2014	70	72	57–82	63–85	ME
13	Elderly patients who received a high-risk prescription drug	2011	2012	20	17 *	12–29	9–24	MA
14	Elderly patients who received a contraindicated prescription drug	2011	2012	23	21 *	14–29	13–28	ME, RI
15	Medicare patients experienced good communication with provider	—[c]	2013	—[c]	76	—[c]	72–80	LA
16	Hospital 30-day mortality	07/2009–06/2012	07/2010–06/2013	13.1	12.6 *	12.1–14.0	11.8–13.6	DE, MA
17	Hospital discharge instructions for home recovery	2012	2013	85	86	78–89	78–90	UT
18	Patient-centered hospital care	2012	2013	67	68	59–73	58–72	LA, ME, NE, SD
19	Home health patients who get better at walking or moving around	2013	2014	61	63*	49–66	51–69	UT
20	Home health patients whose wounds healed after an operation	2013	2014	89	89	80–93	74–95	RI
21	High-risk nursing home residents with pressure sores	2013	2014	6	6	3–9	3–8	HI, ID
22	Nursing home residents with an antipsychotic medication	2013	2014	21	19 *	9–27	9–25	AK
	Avoidable Hospital Use and Cost							
23	Hospital admissions for pediatric asthma, per 100,000 children	2011	2012	107	143 *	33–232	28–231	VT
24	Medicare admissions for ambulatory care–sensitive conditions, ages 65–74	2012	2013	29	27	13–51	13–46	HI
	Medicare admissions for ambulatory care–sensitive conditions, age 75 and older	2012	2013	70	66	41–100	36–95	HI
25	Medicare 30-day hospital readmissions, per 1,000 beneficiaries	2012	2013	34	30	12–55	10–48	HI
26	Short-stay nursing home residents with a 30-day readmission to the hospital	2010	2012	22	20 *	14–28	13–26	MT
27	Long-stay nursing home residents with a hospital admission	2010	2012	19	17	7–31	7–30	MN
28	Home health patients with a hospital admission	2013	10/2013-9/2014	16	16	14–18	13–17	AK
29	Potentially avoidable ED visits among Medicare beneficiaries, per 1,000 beneficiaries	2012	2013	188	181	131–248	127–251	HI
30	Health insurance premium for employer-sponsored single-person plans	2013	2014	$5,633	$5,859 *	$4,197–$7,334	$4,392–$7,592	CA
31	Total Medicare (Parts A & B) reimbursements per enrollee	2012	2013	$8,854	$8,801	$5,399–$10,868	$5,421–$10,697	HI
	Healthy Lives							
32	Mortality amenable to health care, deaths per 100,000 population	2010-11	2012-13	85	84	57–133	56–137	MN
33	Years of potential life lost before age 75	2012	2013	$6,412	$6,420	$4,892–$9,610	$4,963–$9,945	MN
34	Breast cancer deaths per 100,000 female population	2012	2013	21.4	20.8	15.7–31.1	15.5–29.8	HI
35	Colorectal cancer deaths per 100,000 population	2012	2013	14.9	14.6	10.7–19.4	10.9–19.8	UT
36	Suicide deaths per 100,000 population	2012	2013	12.6	12.6	5.7–29.6	5.8–23.7	DC
37	Infant mortality, deaths per 1,000 live births	2012	2013	6	6	4.2–8.9	4.2–9.6	MA
38	Adults ages 18–64 who report fair/poor health or activity limitations because of physical, mental, or emotional problems	2013	2014	26	27	20–34	19–34	DC
39	Adults who smoke	2013	2014	18	17	10–27	9–26	UT
40	Adults ages 18–64 who are obese (BMI >= 30)	2013	2014	29	29	22–37	21–38	CO, DC
41	Children ages 10–17 who are overweight or obese (BMI >= 85th percentile)	—[c]	2011/12	—[c]	31	—[c]	22–40	UT
42	Percent of adults ages 18–64 who have lost six or more teeth because of tooth decay, infection, or gum disease	2012	2014	10	10	6–23	6–22	UT

Notes: (a) The baseline period generally reflects the year prior to the time of observation for the latest year of data available. (b) Multiple states may be listed in the event of ties. (c) Previous data are not shown because of changes in the indicators' definitions or data were not available.
* Asterisks indicate change between baseline and current time periods of at least 0.5 standard deviations (see Scorecard Methodology).

APPENDIX EXHIBIT A3. NATIONAL CUMULATIVE IMPACT IF ALL STATES ACHIEVED TOP STATE RATE

Indicator	If all states improved their performance to the level of the best-performing state for this indicator, then:	
Insured Adults	**21,126,092**	more adults (ages 19–64) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.
Insured Children	**3,124,744**	more children (ages 0–18) would be covered by health insurance (public or private), and therefore would be more likely to receive health care when needed.
High Out-of-Pocket Medical Spending	**11,636,543**	fewer individuals would be burdened by high out-of-pocket spending on medical care.
Went Without Care Because of Cost	**16,957,363**	fewer adults (age 18 and older) would go without needed health care because of cost.
Adult Usual Source of Care	**29,069,764**	more adults (age 18 and older) would have a usual source of care to help ensure that care is coordinated and accessible when needed.
Older Adult Preventive Care	**8,691,519**	more adults (age 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, Pap smears, and flu shots at appropriate ages.
Children with a Medical Home	**11,087,987**	more children (ages 0–17) would have a medical home to help ensure that care is coordinated and accessible when needed.
Children with Preventive Medical and Dental Visits	**9,609,589**	more children (ages 0–17) would receive annual preventive medical and dental care visits each year.
Medicare Received a High-Risk Drug	**1,174,142**	fewer Medicare beneficiaries would receive an inappropriately prescribed medication.
Preventable Hospital Admissions Among Children	**85,008**	fewer children ages 2 to 17 would be hospitalized for asthma exacerbations.
Hospital Readmissions	**152,166**	fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older).
Potentially Avoidable Emergency Department Visits	**1,425,210**	fewer emergency department visits for nonemergent or primary care–treatable conditions would occur among Medicare beneficiaries.
Mortality Amenable to Health Care	**83,707**	fewer premature deaths (before age 75) might occur from causes that are potentially treatable or preventable with timely and appropriate health care.
Breast Cancer Deaths	**8,552**	fewer women would die from breast cancer.
Colon Cancer Deaths	**11,698**	fewer individuals would die from colon cancer.
Suicides	**21,499**	fewer individuals might take their own lives.
Infant Mortality	**7,078**	more infants might live to see their first birthday.
Adults Who Smoke	**19,379,843**	fewer adults would smoke, reducing their risk of lung and heart disease.
Adults Who Are Obese	**15,700,326**	fewer adults would be obese, with body weights that increase their risk for disease and long-term complications.
Children Who Are Overweight or Obese	**3,019,159**	fewer children (ages 10–17) would be overweight or obese, thus reducing the potential for poor health as they transition into adulthood.
Adults with Tooth Loss	**7,850,163**	fewer adults (ages 18–64) would have lost six or more teeth to decay, infection, or gum disease.

APPENDIX EXHIBIT B1. SUMMARY OF STATE RANKINGS IN CURRENT AND PREVIOUS SCORECARDS

State	2015 Scorecard Ranks						Overall Ranking in the Baseline Time Period[a]	2014 Scorecard Overall Rank[b]
	Overall Rank	Access Dimension	Prevention and Treatment Dimension	Avoidable Use and Cost Dimension	Healthy Lives Dimension	Equity Dimension		
Alabama	47	32	37	46	46	42	40	46
Alaska	32	44	37	10	32	29	33	31
Arizona	33	43	47	10	29	24	35	36
Arkansas	49	44	47	38	49	51	49	50
California	23	30	37	14	7	22	25	26
Colorado	8	26	9	5	2	11	11	12
Connecticut	5	5	9	28	2	3	6	6
Delaware	15	9	9	24	33	14	12	10
District of Columbia	20	7	21	45	22	9	23	21
Florida	37	40	37	33	22	31	38	41
Georgia	46	41	45	28	39	45	45	45
Hawaii	3	11	18	1	6	1	1	5
Idaho	25	46	31	3	17	22	22	31
Illinois	26	19	21	44	22	24	31	26
Indiana	43	34	34	36	42	47	40	43
Iowa	9	7	9	18	16	15	7	10
Kansas	28	23	16	31	27	36	26	23
Kentucky	40	28	20	49	44	45	46	42
Louisiana	48	38	43	50	48	44	48	48
Maine	11	16	1	21	29	15	8	7
Maryland	18	5	14	42	20	13	18	17
Massachusetts	4	1	2	31	4	2	4	2
Michigan	31	15	16	38	38	31	29	26
Minnesota	1	3	8	8	1	9	1	1
Mississippi	51	48	47	51	51	49	51	51
Missouri	36	33	21	38	40	28	37	34
Montana	28	39	31	5	22	36	29	29
Nebraska	13	23	13	14	14	20	14	17
Nevada	43	50	51	18	36	39	46	46
New Hampshire	5	9	4	18	7	5	5	2
New Jersey	20	21	21	36	12	17	21	15
New Mexico	33	46	45	10	34	20	34	36
New York	13	14	28	26	13	5	15	19
North Carolina	37	30	31	26	36	43	36	36
North Dakota	26	25	19	22	27	36	18	14
Ohio	33	16	21	38	41	41	31	31
Oklahoma	50	48	44	46	46	49	50	49
Oregon	15	28	36	2	14	11	24	24
Pennsylvania	20	12	7	33	34	19	15	22
Rhode Island	5	4	3	22	10	7	8	9
South Carolina	40	41	28	24	43	48	40	36
South Dakota	15	22	14	8	29	17	18	12
Tennessee	43	34	37	42	44	39	38	40
Texas	40	51	50	33	22	31	40	44
Utah	18	36	28	5	4	24	12	19
Vermont	1	2	4	13	9	3	1	2
Virginia	23	19	21	28	20	24	26	24
Washington	10	16	37	4	10	8	15	15
West Virginia	39	26	21	48	50	31	40	34
Wisconsin	11	13	4	14	18	29	8	7
Wyoming	28	36	34	14	18	35	26	29

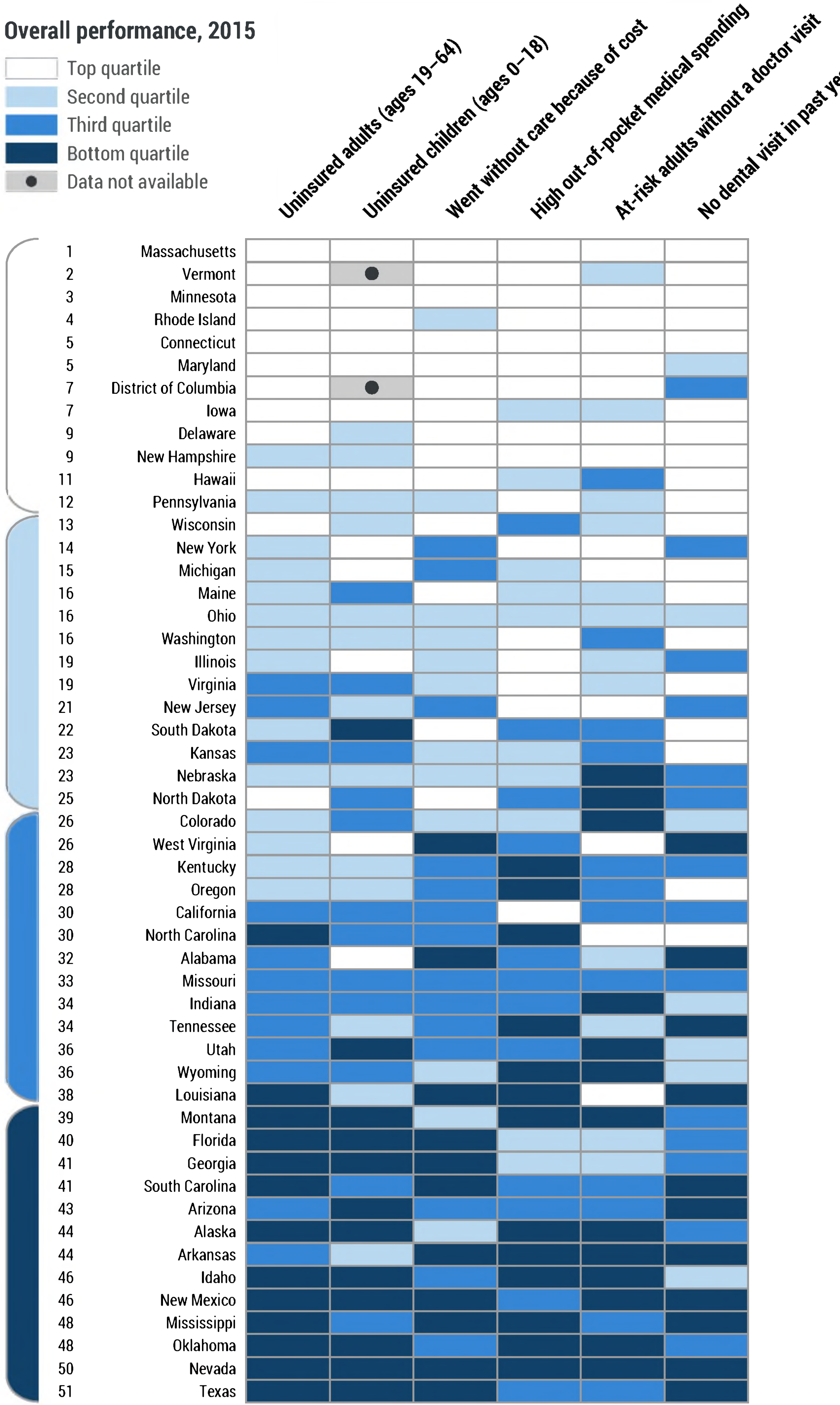
Notes: (a) The baseline period generally reflects the year prior to the time of observation for the latest year of data available. (b) The 2014 scorecard ranking is not based on the same set of indicators used to calculate the 2015 scorecard and 2015 scorecard baseline rankings. Rather, it represents the time period evaluated in the 2014 scorecard, generally encompassing the years 2010–2012. The 2015 scorecard added several variables to the equity dimension.

APPENDIX EXHIBIT B2. SUMMARY OF INDICATOR RANKINGS BY STATE

Overall Rank	State	No. of indicators scored (of 42)	Top 5 States	Top Quartile	2nd Quartile	3rd Quartile	Bottom Quartile	Bottom 5 States	No. of indicators with trend (of 36)	No. of indicators improved	No. of indicators worsened	Net change
47	Alabama	41	1	4	4	12	21	12	35	7	5	2
32	Alaska	39	6	9	11	5	14	9	34	11	5	6
33	Arizona	42	2	6	12	12	12	3	36	12	3	9
49	Arkansas	42	0	2	7	9	24	16	36	11	2	9
23	California	42	8	16	9	12	5	2	36	11	2	9
8	Colorado	42	14	19	16	5	2	0	36	9	1	8
5	Connecticut	42	10	24	9	7	2	1	36	8	4	4
15	Delaware	41	4	14	9	16	2	2	35	8	3	5
20	District of Columbia	38	10	15	5	9	9	8	32	12	2	10
37	Florida	42	2	4	16	11	11	7	36	10	1	9
46	Georgia	42	0	1	11	16	14	4	36	11	2	9
3	Hawaii	40	16	25	8	4	3	2	34	6	4	2
25	Idaho	41	7	16	10	2	13	4	35	8	4	4
26	Illinois	42	0	8	13	14	7	3	36	8	2	6
43	Indiana	42	0	0	10	22	10	0	36	6	3	3
9	Iowa	42	8	14	17	11	0	0	36	9	2	7
28	Kansas	42	1	5	18	18	1	1	36	10	1	9
40	Kentucky	42	1	3	9	12	18	11	36	13	3	10
48	Louisiana	42	2	4	5	6	27	21	36	16	3	13
11	Maine	42	8	20	12	7	3	0	36	6	3	3
18	Maryland	42	5	14	12	13	3	4	36	11	2	9
4	Massachusetts	42	22	26	7	6	3	1	36	11	4	7
31	Michigan	42	1	8	14	12	8	2	36	8	2	6
1	Minnesota	42	17	31	6	2	3	3	36	8	4	4
51	Mississippi	41	3	4	1	5	31	28	35	11	4	7
36	Missouri	42	0	3	10	24	5	1	36	9	1	8
28	Montana	42	4	12	12	9	9	1	36	10	3	7
13	Nebraska	42	7	15	17	7	3	1	36	5	2	3
43	Nevada	42	2	7	5	10	20	11	36	12	3	9
5	New Hampshire	41	10	20	17	2	2	0	35	8	4	4
20	New Jersey	42	6	16	9	6	11	7	36	9	2	7
33	New Mexico	41	2	7	10	9	15	4	35	9	3	6
13	New York	42	4	12	13	11	6	4	36	8	1	7
37	North Carolina	42	1	5	10	19	8	1	36	10	1	9
26	North Dakota	40	9	13	7	12	8	3	35	11	5	6
33	Ohio	42	0	1	18	13	10	1	36	7	2	5
50	Oklahoma	42	1	3	3	12	24	11	36	14	2	12
15	Oregon	42	8	15	15	6	6	3	36	11	3	8
20	Pennsylvania	41	4	11	14	13	3	1	35	5	3	2
5	Rhode Island	41	11	22	13	4	2	0	36	14	3	11
40	South Carolina	42	0	4	13	9	16	3	36	6	1	5
15	South Dakota	41	8	15	14	6	6	1	36	9	2	7
43	Tennessee	42	0	1	8	14	19	7	36	13	0	13
40	Texas	42	3	4	7	13	18	11	36	6	4	2
18	Utah	42	14	18	8	8	8	3	36	5	2	3
1	Vermont	41	17	23	12	5	1	1	35	8	4	4
23	Virginia	42	1	3	21	15	3	2	36	6	2	4
10	Washington	42	4	18	13	5	6	2	36	11	3	8
39	West Virginia	42	3	5	9	11	17	15	36	11	5	6
11	Wisconsin	42	9	15	17	10	0	0	36	5	3	2
28	Wyoming	41	4	13	11	7	10	6	35	10	7	3

Notes: Improvement or worsening refers to a change between the baseline and current time periods of at least 0.5 standard deviations. Ambulatory care–sensitive conditions among Medicare beneficiaries are counted as a single indicator in tallies of improvement.

APPENDIX EXHIBIT C1. ACCESS AND AFFORDABILITY: DIMENSION AND INDICATOR RANKING

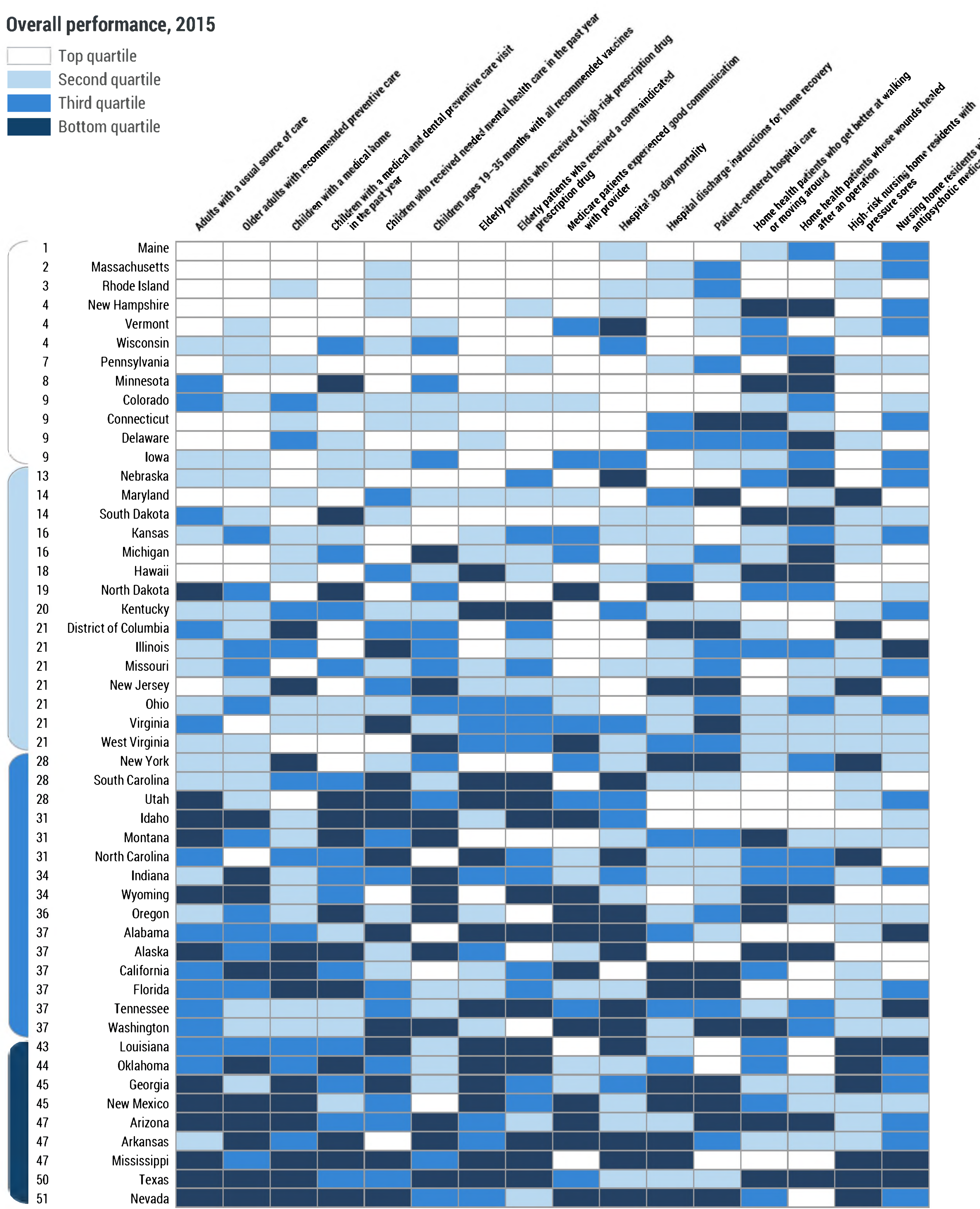


APPENDIX EXHIBIT C2. ACCESS AND AFFORDABILITY: DIMENSION RANKING AND INDICATOR RATES

	Adults ages 19–64 uninsured		Children ages 0–18 uninsured		Uninsured ages 0–64		Adults who went without care because of cost in the past year		Individuals with high out-of-pocket medical spending	At-risk adults without a doctor visit		Adults without a dental visit in past year	
	2013	2014	2013	2014	2013	2014	2013	2014	2013-14	2013	2014	2012	2014
United States	20%	16% *	8%	6% *	17%	13% *	16%	14% *	15%	14%	13%	15%	16%
Alabama	20	18	5	4	16	14 *	16	17	16	12	12	18	18
Alaska	24	22	12	12	20	19	14	12 *	18	23	22	14	16 *
Arizona	24	18 **	13	10 **	20	16 *	17	16	16	19	16 *	17	18
Arkansas	24	18 **	6	5	19	14 **	21	18 *	21	18	18	19	18
California	24	17 **	8	6 *	19	14 **	16	14 *	13	17	15 *	16	17
Colorado	19	14 *	9	6 **	16	12 *	15	13 *	15	18	17	16	15
Connecticut	13	9 *	4	4	11	8 *	12	11	13	10	11	11	12
Delaware	14	10 *	5	5	12	9 *	12	11	13	9	10	12	14 *
District of Columbia	8	7	--	--	7	6	11	11	11	9	8	16	16
Florida	29	24 *	12	10 *	24	20 *	21	18 *	15	14	12 *	18	17
Georgia	26	22 *	10	8 *	21	18 *	20	19	15	14	13	16	17
Hawaii	10	7 *	3	3	8	6 *	9	9	14	14	15	15	14
Idaho	23	19 *	9	8	19	15 *	16	16	22	21	20	13	15 *
Illinois	18	14 *	5	4	14	11 *	14	12 *	13	14	13	15	16
Indiana	19	17	9	7 *	16	14 *	16	15	16	17	17	15	15
Iowa	12	8 *	5	3 *	10	7 *	10	9	15	14	12 *	12	13
Kansas	18	15 *	7	6	14	12 *	14	13	15	14	15	13	13
Kentucky	21	12 **	6	5	17	10 **	19	16 *	18	15	15	16	16
Louisiana	25	22 *	6	5	19	17 *	20	17 *	19	10	10	20	20
Maine	16	14	5	6	13	12	10	11	15	12	12	13	13
Maryland	14	11 *	5	4	11	9 *	13	10 *	10	10	7 *	13	15 *
Massachusetts	5	5	2	2	4	4	9	8	11	7	7	11	12
Michigan	16	12 *	5	4	13	10 *	15	15	15	13	11 *	14	14
Minnesota	11	8 *	6	4 *	9	7 *	10	9	12	12	11	11	13 *
Mississippi	25	22 *	8	6 *	20	17 *	22	19 *	20	15	14	19	20
Missouri	18	16	7	7	15	13 *	16	14 *	17	16	15	15	16
Montana	23	19 *	11	9 *	20	16 *	14	12 *	19	19	17 *	17	16
Nebraska	15	13	6	5	12	11	13	12	15	18	17	15	16
Nevada	27	21 **	14	10 **	23	17 **	17	17	18	15	17 *	20	19
New Hampshire	16	13 *	4	5	13	11 *	12	11	12	11	11	10	12 *
New Jersey	19	16 *	6	5	15	13 *	15	14	13	10	9	15	16
New Mexico	28	21 **	9	8	22	17 **	18	17	16	17	18	18	18
New York	15	12 *	4	4	12	10 *	15	14	12	10	10	15	16
North Carolina	23	19 *	6	6	18	15 *	18	16 *	18	12	11	15	14
North Dakota	14	10 *	8	7	12	9 *	7	7	17	17	17	15	16
Ohio	16	12 *	5	5	13	10 *	15	13 *	15	13	12	14	15
Oklahoma	25	21 *	11	9 *	20	18 *	17	15 *	19	21	19 *	18	17
Oregon	21	14 **	7	5 *	17	12 **	18	14 **	20	20	16 **	15	14
Pennsylvania	14	12	5	5	11	10	12	12	12	12	12	13	14
Rhode Island	17	10 **	6	3 **	14	8 **	14	12 *	13	10	6 **	12	12
South Carolina	23	20 *	7	6	18	16 *	19	18	17	16	15	18	18
South Dakota	17	13 *	7	8	14	12 *	10	10	16	14	16 *	11	11
Tennessee	20	17 *	6	5	16	14 *	18	16 *	22	11	12	17	18
Texas	30	26 *	13	12	24	21 *	19	18	17	15	16	18	20 *
Utah	18	16	9	9	15	14	15	14	16	19	19	16	15
Vermont	10	7 *	--	--	8	5 *	9	9	12	11	12	11	11
Virginia	17	15	6	6	14	12 *	15	13 *	12	12	12	12	14 *
Washington	20	13 **	7	5 *	16	11 **	15	12 *	13	17	16	14	14
West Virginia	20	13 **	5	3 *	16	11 **	18	17	17	12	9 *	18	20 *
Wisconsin	13	10 *	5	5	10	9	12	11	16	13	12	12	12
Wyoming	18	17	7	7	15	14	14	12 *	18	21	21	15	15
Change		**39**		**16**		**42**		**21**			**13**		**9**
States Improved		39		16		42		21			11		0
States Worsened		0		0		0		0			2		9

Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more. -- Data not available.

APPENDIX EXHIBIT D1. PREVENTION AND TREATMENT: DIMENSION AND INDICATOR RANKING



APPENDIX EXHIBIT D2. PREVENTION AND TREATMENT: DIMENSION RANKING AND INDICATOR RATES

	Adults with a usual source of care		Older adults with recommended preventive care		Children with a medical home	Children with a medical and dental preventive care visit in the past year	Children who received needed mental health care in the past year	Children ages 19–35 months with all recommended vaccines		Elderly patients who received a high-risk prescription drug		Elderly patients who received a contraindicated prescription drug	
	2013	2014	2012	2014	2011/12	2011/12	2011/12	2013	2014	2011	2012	2011	2012
United States	**76%**	**77%**	**42%**	**40% ***	**54%**	**68%**	**61%**	**70%**	**72%**	**20%**	**17% ***	**23%**	**21% ***
Alabama	78	76	42	40 *	54	70	54	77	77	29	24 **	29	28
Alaska	67	66	39	38	52	59	63	64	67 *	19	17	21	17 **
Arizona	68	72 *	34	37 *	46	65	60	65	66	19	17	18	18
Arkansas	77	78	34	35	55	62	67	57	66 **	25	17 **	26	23 *
California	71	74 *	40	32 **	45	65	63	69	78 **	19	16 *	22	21
Colorado	76	76	44	42 *	55	70	65	69	73 *	19	16 *	19	18
Connecticut	85	84	47	48	58	79	65	78	73 **	14	13	17	15 *
Delaware	86	86	48	47	56	72	67	72	75 *	18	16	16	17
District of Columbia	76	75	44	43	50	77	59	77	71 **	17	13 *	19	20
Florida	73	76 *	39	38	50	60	58	70	73 *	19	16 *	22	21
Georgia	72	71	46	42 **	52	65	53	70	74 *	25	21 *	24	21 *
Hawaii	85	85	44	45	57	73	58	66	74 **	21	21	18	18
Idaho	72	71	35	33 *	57	59	56	70	66 *	22	16 **	24	22 *
Illinois	80	81	39	39	56	74	55	67	68	15	13	19	18
Indiana	80	80	37	36	58	69	58	69	66 *	20	17 *	22	21
Iowa	81	80	44	43	67	70	66	78	71 **	15	12 *	19	17 *
Kansas	78	80	43	39 **	59	70	72	69	77 **	20	15 **	22	20 *
Kentucky	78	79	40	44 **	56	68	66	73	72	26	23 *	27	24 *
Louisiana	74	74	40	40	56	67	40	69	73 *	28	24 *	26	23 *
Maine	87	88	47	46	63	73	78	68	85 **	13	12	14	13
Maryland	79	82 *	48	47	57	73	59	76	74	16	15	19	18
Massachusetts	88	89	52	47 **	63	79	65	79	75 *	12	9 *	16	15
Michigan	83	84	45	45	59	68	68	70	65 **	16	14	20	19
Minnesota	73	76 *	46	45	61	60	72	74	71 *	13	10 *	17	15 *
Mississippi	77	73 *	37	38	49	60	53	75	71 *	29	22 **	27	26
Missouri	79	79	42	38 **	62	65	63	68	70	20	16 *	23	21 *
Montana	70	71	35	38 *	58	61	60	65	67	17	13 *	22	17 **
Nebraska	79	80	39	41 *	61	70	71	79	80	18	13 **	21	21
Nevada	65	65	36	34 *	45	56	49	61	68 **	21	17 *	20	18 *
New Hampshire	88	85 *	48	46 *	67	79	66	75	80 **	14	13	20	19
New Jersey	81	82	41	42	53	76	58	73	67 **	15	15	20	18 *
New Mexico	69	69	36	37	48	70	58	66	76 **	22	18 *	23	21 *
New York	81	81	44	43	53	73	64	72	71	13	12	18	17
North Carolina	73	76 *	46	45	55	67	54	72	81 **	23	20 *	23	21 *
North Dakota	73	71	37	39 *	62	61	86	72	71	14	11 *	16	14 *
Ohio	81	80	41	39 *	57	71	66	62	68 **	19	17	22	20 *
Oklahoma	74	75	37	36	56	62	61	63	73 **	27	22 **	27	26
Oregon	74	77 *	39	39	57	63	66	67	65	19	16 *	19	17 *
Pennsylvania	86	85	44	42 *	59	73	69	76	79 *	15	13	19	18
Rhode Island	84	86	46	47	60	76	66	82	76 **	14	11 *	16	13 *
South Carolina	76	77	42	41	54	64	50	67	73 **	24	20 *	24	22 *
South Dakota	76	75	41	44 *	62	59	64	74	76	13	10 *	18	15 *
Tennessee	77	76	41	41	60	70	60	68	72 *	27	21 **	26	24 *
Texas	67	67	38	37	52	68	59	72	64 **	23	19 *	23	22
Utah	72	71	40	41	64	61	49	75	71 *	21	18 *	26	23 *
Vermont	87	87	47	44 *	69	81	78	67	72 **	12	11	17	14 *
Virginia	76	76	45	46	57	70	53	69	74 **	20	17 *	21	20
Washington	72	75 *	43	43	59	72	54	71	67 *	19	16 *	19	17 *
West Virginia	77	77	43	41 *	61	74	74	66	63 *	22	17 **	22	20 *
Wisconsin	81	81	43	43	66	68	65	73	71	13	11	16	15
Wyoming	69	69	36	34 *	59	65	67	70	64 **	17	13 *	18	22 **
Change		**10**		**21**					**38**		**35**		**28**
States Improved		8		6					22		35		27
States Worsened		2		15					16		0		1

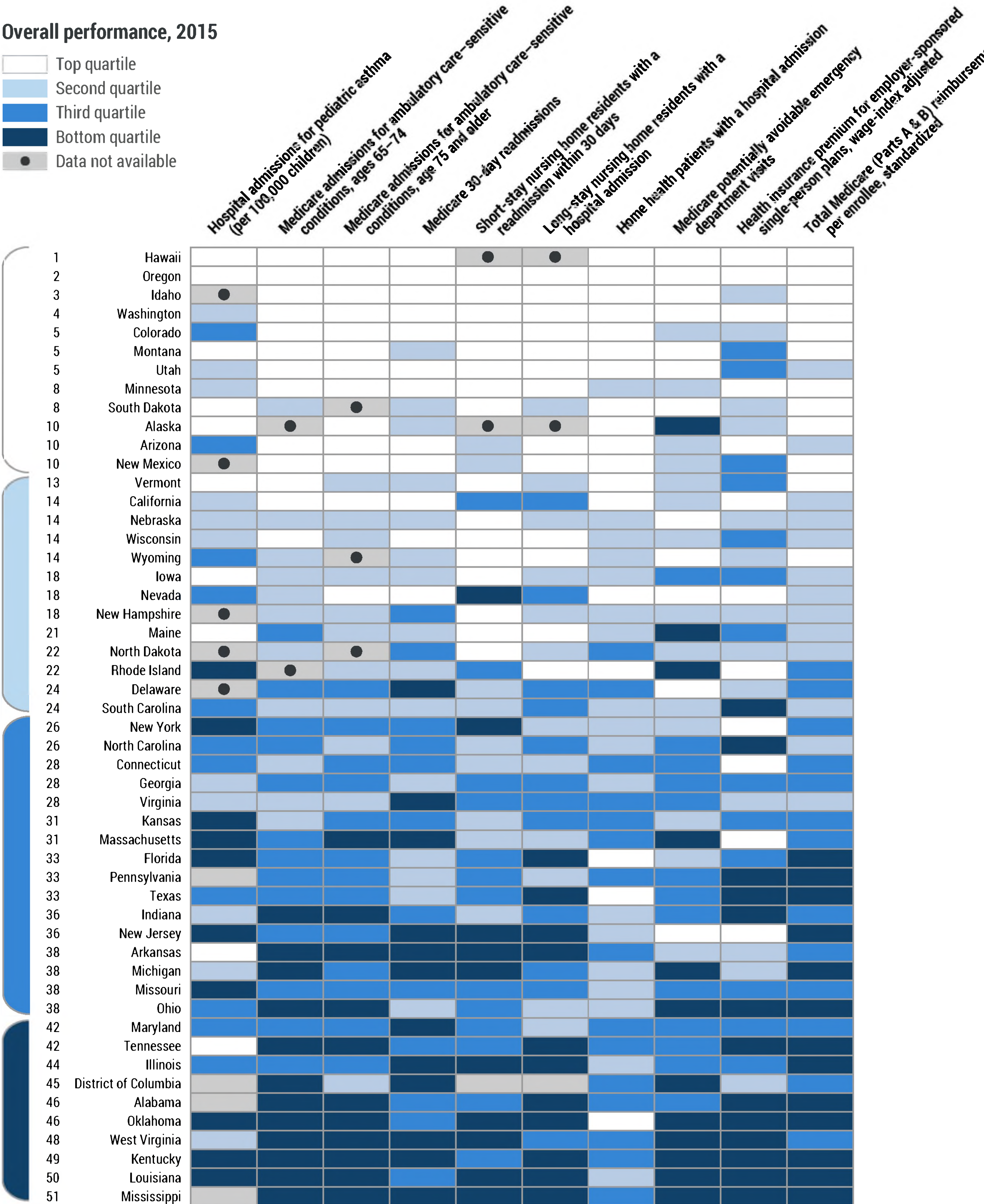
Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more.

APPENDIX EXHIBIT D2. PREVENTION AND TREATMENT: DIMENSION RANKING AND INDICATOR RATES (CONTINUED)

	Medicare patients experienced good communication with provider	Hospital 30-day mortality		Hospital discharge instructions for home recovery		Patient-centered hospital care		Home health patients who get better at walking or moving around		Home health patients whose wounds healed after an operation		High-risk nursing home residents with pressure sores		Nursing home residents with an antipsychotic medication	
	2013	07/09–06/12	07/10–06/13	2012	2013	2012	2013	2013	2014	2013	2014	2013	2014	2013	2014
United States	76%	13.1%	12.6% **	85%	86%	67%	68%	61%	63% *	89%	89%	6%	6%	21%	19% *
Alabama	74	13.4	13.1 *	83	85 *	69	69	65	68 *	91	91	5	5	23	22
Alaska	76	14.0	13.1 **	85	88 **	67	70 **	49	51 *	80	74 **	6	4 **	9	9
Arizona	74	13.3	12.5 **	84	86 *	66	66	58	60 *	86	87	6	5 *	21	19 *
Arkansas	72	13.9	13.6 *	82	83	67	68	61	64 *	90	90	6	6	24	19 **
California	74	12.8	12.4 *	82	84 *	63	64	59	61 *	91	92	6	6	16	14 *
Colorado	76	12.9	12.2 **	87	88	69	70	62	64 *	90	89	4	4	18	18
Connecticut	77	13.2	12.4 **	84	85	65	65	59	60	90	90	5	4 *	22	20 *
Delaware	79	12.4	11.8 **	84	85	67	67	58	61 *	82	83	5	5	17	15 *
District of Columbia	79	12.1	11.9	78	78	59	58	60	64 **	90	91	9	8 *	18	16 *
Florida	76	13.2	12.6 **	82	83	63	63	65	67 *	92	91	6	6	22	21
Georgia	76	13.2	12.9 *	83	84	66	66	61	64 *	90	90	7	7	22	20 *
Hawaii	77	13.0	12.7 *	82	85 **	68	69	55	59 **	83	82	3	3	12	10 *
Idaho	74	13.6	12.9 **	88	88	70	70	63	65 *	91	92	4	3 *	20	18 *
Illinois	77	12.7	12.4 *	85	86	66	67	61	62	88	88	7	6 *	23	22
Indiana	76	13.2	12.9 *	86	87	69	69	59	62 *	89	89	6	6	20	19
Iowa	75	13.0	12.9	86	88 *	69	69	62	64 *	88	88	4	4	19	19
Kansas	75	12.9	12.6 *	86	86	70	70	61	63 *	88	88	5	5	21	20
Kentucky	77	13.2	12.9 *	85	86	69	69	64	66 *	91	91	7	6 *	22	21
Louisiana	80	13.3	13.0 *	84	86 *	71	72	60	62 *	92	91	9	8 *	27	25 *
Maine	77	13.5	12.7 **	89	89	71	72	62	64 *	88	89	4	4	22	20 *
Maryland	76	12.7	12.0 **	84	85	62	61	63	65 *	89	90	7	7	17	16
Massachusetts	77	12.3	11.8 **	87	87	67	67	63	66 *	92	92	5	5	22	20 *
Michigan	75	12.8	12.4 *	87	87	69	68	61	64 *	87	87	6	6	15	14
Minnesota	78	12.7	12.3 *	87	88	70	71	57	59 *	85	84	4	4	16	14 *
Mississippi	78	13.2	13.1	81	83 *	69	70	64	66 *	92	92	7	7	24	23
Missouri	77	13.2	12.7 **	86	87	66	67	62	65 *	90	90	6	6	23	21 *
Montana	77	12.7	12.6	83	85 *	67	67	56	60 **	92	90 *	5	6 *	19	18
Nebraska	79	13.3	13.0 *	87	88	71	72	59	62 *	83	84	4	4	22	21
Nevada	73	13.5	13.2 *	83	84	61	64 **	60	62 *	91	91	7	7	22	21
New Hampshire	78	13.7	12.6 **	88	88	70	69	59	60	87	87	4	4	22	19 *
New Jersey	76	12.7	12.2 **	81	82	62	63	63	65 *	90	90	8	7 *	16	15
New Mexico	73	12.9	12.7	82	84 *	66	66	59	62 *	93	90 **	6	6	19	17 *
New York	75	13.0	12.5 **	82	84 *	62	63	59	63 **	89	89	8	8	19	18
North Carolina	76	13.3	13.0 *	86	87	68	69	61	62	90	89	7	7	16	15
North Dakota	73	12.8	12.2 **	86	82 **	65	70 **	56	61 **	87	89 *	4	4	18	18
Ohio	76	12.8	12.4 *	86	87	68	68	61	63 *	88	88	6	6	22	21
Oklahoma	76	13.1	12.7 *	83	85 *	69	70	60	62 *	91	91	8	8	22	21
Oregon	74	13.9	13.0 **	85	86	67	68	56	59 *	89	90	7	6 *	18	18
Pennsylvania	78	12.9	12.4 **	85	86	66	67	63	65 *	87	87	6	5 *	20	18 *
Rhode Island	77	13.3	12.7 **	85	86	66	67	63	65 *	93	95 *	6	5 *	18	16 *
South Carolina	77	13.4	13.0 *	85	86	69	69	64	65	92	91	6	6	17	16
South Dakota	77	13.0	12.5 **	86	87	73	72	58	60 *	88	85 **	5	5	18	18
Tennessee	75	13.2	13.0	84	85	68	68	63	64	90	89	5	5	25	23 *
Texas	75	13.1	12.5 **	84	86 *	69	69	56	57	88	87	7	7	27	25 *
Utah	75	13.5	12.9 **	89	90	69	70	66	69 *	92	91	5	5	23	21 *
Vermont	75	13.9	13.1 **	88	88	68	69	60	62 *	88	91 **	5	5	21	19 *
Virginia	75	13.3	12.9 *	85	86	65	66	63	64	90	90	6	6	21	18 *
Washington	74	14.0	13.4 **	86	87	66	66	56	58 *	88	88	6	6	20	18 *
West Virginia	73	13.1	12.6 **	84	85	66	67	63	64	91	90	7	6 *	19	17 *
Wisconsin	78	13.4	12.8 **	88	89	71	71	59	62 *	87	88	5	4 *	17	14 *
Wyoming	74	12.9	12.5 *	87	88	68	69	58	58	88	86 *	4	4	18	16 *
Change			**45**		**14**		**3**		**41**		**8**		**15**		**27**
States Improved			45		13		3		41		3		14		27
States Worsened			0		1		0		0		5		1		0

Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more.

APPENDIX EXHIBIT E1. AVOIDABLE HOSPITAL USE AND COST: DIMENSION AND INDICATOR RANKING



APPENDIX EXHIBIT E2. AVOIDABLE HOSPITAL USE AND COST: DIMENSION RANKING AND INDICATOR RATES

	Hospital admissions for pediatric asthma, per 100,000 children		Medicare admissions for ambulatory care–sensitive conditions, ages 65–74		Medicare admissions for ambulatory care–sensitive conditions, age 75 and older		Medicare 30-day hospital readmissions, per 1,000 beneficiaries		Medicare 30-day hospital readmissions as a percent of admissions(a)		Short-stay nursing home residents with a 30-day readmission to the hospital		Long-stay nursing home residents with a hospital admission		Home health patients with a hospital admission		Potentially avoidable ED visits among Medicare beneficiaries, per 1,000 beneficiaries	
	2011	2012	2012	2013	2012	2013	2012	2013	2012	2013	2010	2012	2010	2012	2013	10/13–9/14	2012	2013
United States	107	143 *	29	27	70	66	34	30	18	17	22%	20% *	19%	17%	16%	16%	188	181
Alabama	--	--	38	34 *	82	75 *	39	34 *	17	16	22	22	21	21	17	17	192	184
Alaska	46	62	--	--	52	49	29	26	14	14	--	--	--	--	14	13 **	205	203
Arizona	106	125	20	18	51	48	23	20	16	15	23	20 *	12	9 *	15	15	178	171
Arkansas	64	81	35	31 *	83	78	42	36 *	18	16	25	25	27	26	17	17	185	177
California	87	96	21	20	55	53	24	21	18	17	23	22	21	20	15	15	167	163
Colorado	143	129	16	15	50	45	19	16	14	13	17	16	12	10	14	14	173	164
Connecticut	144	136	26	24	75	70	39	34 *	18	17	22	20 *	19	16 *	16	17 **	189	189
Delaware	--	--	27	27	68	66	40	37	17	16	22	20 *	19	19	16	17 **	159	159
District of Columbia	--	--	37	36	74	65 *	55	48 *	21	20	--	--	--	--	18	17 **	248	251
Florida	145	143	28	27	68	66	34	30	18	18	24	22 *	25	23	15	15	179	176
Georgia	88	97	31	29	73	68	33	29	17	16	23	21 *	20	19	16	16	201	188 *
Hawaii	52	69	13	13	41	36	12	10	15	14	--	--	--	--	14	15 **	131	127
Idaho	--	--	17	16	45	42	17	16	13	13	14	14	12	11	14	14	162	159
Illinois	117	119	31	28	73	70	51	44 *	19	18	25	23 *	25	22 *	16	16	192	186
Indiana	105	102	35	32	77	73	40	34 *	17	16	21	20	20	19	16	16	200	192
Iowa	69	71	24	22	64	60	33	29	15	15	18	17	16	15	16	16	184	179
Kansas	144	160	27	25	71	66	37	33	16	15	21	19 *	20	20	17	17	173	169
Kentucky	167	152	51	46 *	100	95	50	42 *	19	19	23	22	24	24	18	17 **	219	219
Louisiana	232	203 *	44	41	97	88 *	40	35 *	18	18	28	26 *	31	30	16	16	236	219 *
Maine	72	76	26	26	65	61	31	28	16	15	18	17	14	12	16	16	233	217 *
Maryland	132	137	29	28	69	66	49	43 *	19	18	26	22 **	20	17 *	17	17	193	186
Massachusetts	182	141 *	30	28	80	76	41	36 *	18	17	22	19 *	17	14 *	16	17 **	209	197 *
Michigan	97	94	34	31	73	70	42	38	19	18	25	23 *	20	18	16	16	214	210
Minnesota	70	82	20	19	55	54	18	15	16	15	18	17	7	7	16	16	181	175
Mississippi	--	--	42	38 *	91	88	48	42 *	18	17	26	24 *	31	29	17	17	231	222
Missouri	150	161	31	30	73	69	37	33	17	17	22	22	21	20	16	16	197	190
Montana	65	77	21	19	--	55	25	24	14	14	14	13	12	12	15	15	158	159
Nebraska	58	82 *	24	23	63	59	33	29	15	14	18	16 *	17	16	16	16	153	149
Nevada	98	112	25	23	60	55	26	23	18	17	25	23 *	20	20	15	15	165	158
New Hampshire	--	--	23	23	64	62	34	32	16	16	18	16 *	13	14	17	16 **	192	175 *
New Jersey	149	163	27	26	73	69	47	41 *	19	18	27	24 *	26	21 *	16	16	170	160
New Mexico	--	--	23	21	59	52 *	22	19	15	15	19	18	15	13	15	15	170	170
New York	221	231	29	26	73	69	36	31 *	20	19	26	23 *	19	17	17	16 **	173	165
North Carolina	109	113	29	27	67	64	35	31	17	16	21	20	19	18	16	16	197	192
North Dakota	--	--	24	22	65	--	35	31	16	15	18	16 *	14	15	15	17 **	187	178
Ohio	143	128	38	35	82	76	34	30	18	18	23	21 *	17	15	16	16	219	214
Oklahoma	139	189 **	38	32 *	80	71 *	40	35 *	17	16	24	23	24	24	16	15 **	211	206
Oregon	40	41	17	17	48	46	15	14	14	14	17	17	10	8	14	15 **	162	155
Pennsylvania	187	--	31	28	74	70	31	27	18	17	22	21	17	16	17	17	187	181
Rhode Island	139	149	27	--	66	62	28	25	18	17	24	21 *	12	10	15	15	188	196
South Carolina	138	133	27	25	65	62	33	30	16	16	21	20	19	20	16	16	176	169
South Dakota	72	76	22	22	--	--	31	27	14	13	16	15	16	15	17	15 **	168	149 *
Tennessee	98	73 *	37	34	84	77 *	37	31 *	18	17	23	21 *	24	22	17	17	200	189 *
Texas	104	114	31	29	76	70	34	28 *	17	16	23	22	24	23	15	15	186	180
Utah	80	93	17	16	42	39	17	16	13	13	14	14	11	11	14	14	147	142
Vermont	33	28	--	20	65	61	31	27	16	15	16	16	13	15	16	15 **	187	178
Virginia	107	100	27	25	71	63 *	40	36	18	17	22	21	20	20	17	17	193	187
Washington	77	84	18	17	49	48	23	21	15	15	19	17 *	13	13	15	15	157	156
West Virginia	110	98	50	43 *	98	87 *	46	40 *	20	19	23	23	20	19	18	17 **	226	223
Wisconsin	78	86	22	21	60	57	26	23	16	15	17	17	13	12	16	16	182	176
Wyoming	92	123 *	--	23	--	--	32	28	15	14	17	15 *	14	13	17	16 **	169	160
Change		**6**		**6**		**8**		**17**				**23**		**6**		**16**		**7**
States Improved		3		6		8		17				23		6		10		7
States Worsened		3		0		0		0				0		0		6		0

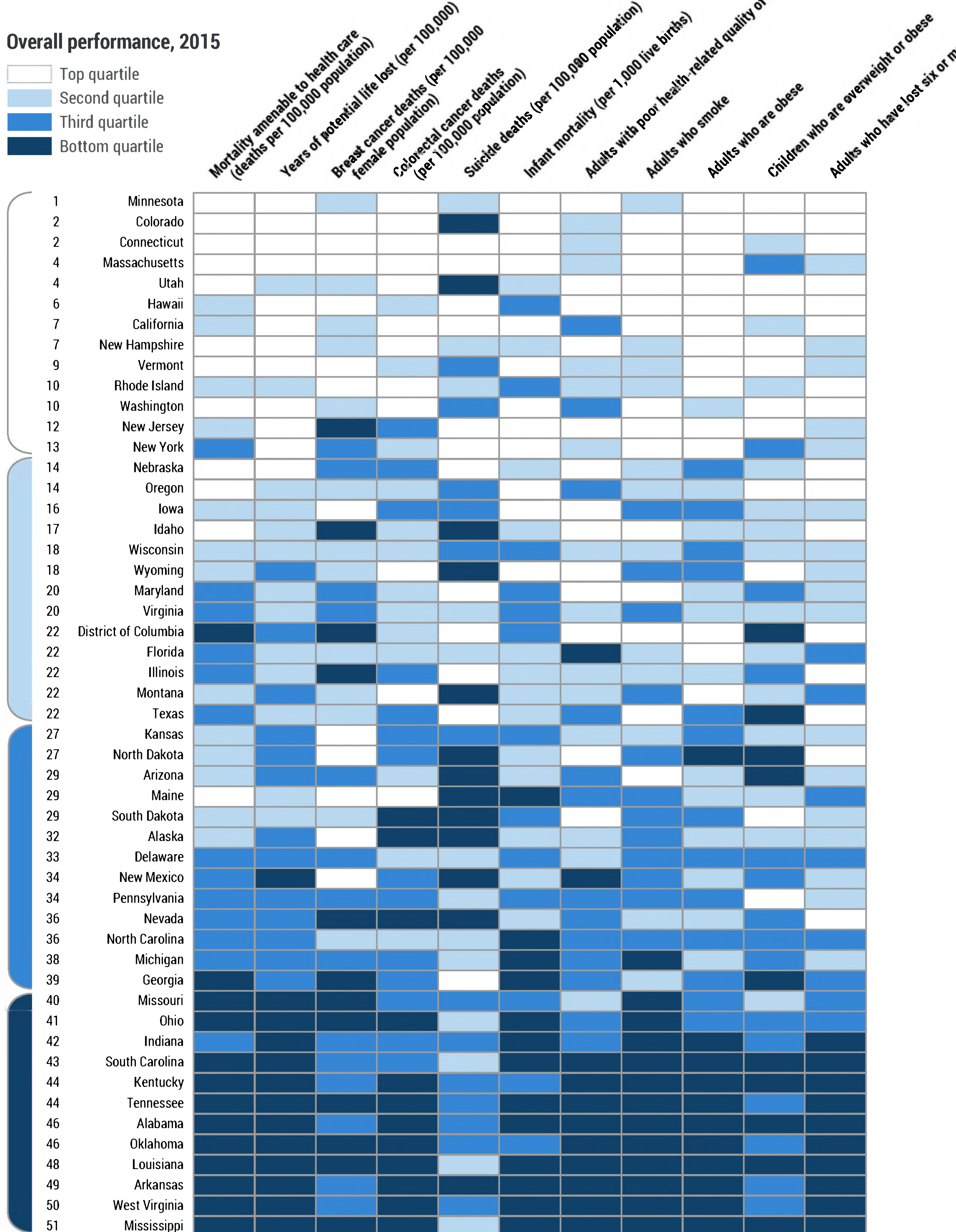
Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more. -- Data not available. (a) Not a scored indicator, included here for information only.

APPENDIX EXHIBIT E3. AVOIDABLE HOSPITAL USE AND COST: COST INDICATORS

	Total Medicare (Parts A & B) reimbursements per enrollee[a]					Health insurance premium for employer-sponsored single-person plans				
	Unadjusted		Adjusted[b]		Annual Growth Rate[c]	Unadjusted		Adjusted[b]		Annual Growth Rate[c d]
	2012	2013	2012	2013		2013	2014	2013	2014	
United States	$9,409	$9,289	$8,854	$8,801	-1.3%	$5,571	$5,832	$5,633	$5,859	4.7%
Alabama	8,686	8,469	9,344	9,250	-2.5%	5,204	5,526	6,450	6,849	6.2%
Alaska	7,675	7,827	5,399	5,621	2.0%	7,369	7,099	5,701	5,492	-3.7%
Arizona	8,588	8,459	7,998	7,943	-1.5%	5,343	5,356	5,014	5,026	0.2%
Arkansas	8,158	8,017	8,619	8,548	-1.7%	4,536	4,846	5,328	5,692	6.8%
California	10,244	10,167	8,310	8,285	-0.8%	5,581	5,841	4,197	4,392	4.7%
Colorado	7,884	7,684	7,460	7,344	-2.5%	5,668	5,848	5,550	5,726	3.2%
Connecticut	10,589	10,710	8,936	9,018	1.1%	6,002	6,223	4,820	4,997	3.7%
Delaware	9,339	9,342	8,514	8,554	0.0%	5,934	6,145	5,562	5,759	3.6%
District of Columbia	10,920	10,446	8,887	8,676	-4.3%	6,018	6,097	5,757	5,833	1.3%
Florida	10,693	10,536	10,597	10,402	-1.5%	5,383	5,767	5,766	6,177	7.1%
Georgia	8,664	8,511	8,743	8,693	-1.8%	5,374	5,570	5,917	6,133	3.6%
Hawaii	6,432	6,410	5,408	5,421	-0.3%	5,103	5,316	4,355	4,537	4.2%
Idaho	7,367	7,413	7,198	7,306	0.6%	5,019	4,978	5,557	5,511	-0.8%
Illinois	9,797	9,650	9,219	9,167	-1.5%	5,824	6,126	5,781	6,081	5.2%
Indiana	9,026	8,939	9,045	9,006	-1.0%	6,099	6,041	6,398	6,337	-1.0%
Iowa	7,696	7,694	7,496	7,564	0.0%	5,207	5,557	5,641	6,020	6.7%
Kansas	8,478	8,401	8,586	8,563	-0.9%	5,432	5,365	6,130	6,055	-1.2%
Kentucky	8,971	8,913	9,167	9,161	-0.6%	5,257	5,914	6,080	6,840	12.5%
Louisiana	10,334	10,076	10,868	10,697	-2.5%	5,300	5,700	6,345	6,824	7.5%
Maine	8,015	8,049	7,606	7,653	0.4%	5,865	5,903	5,992	6,031	0.6%
Maryland	10,655	10,563	8,472	8,616	-0.9%	5,730	6,059	5,741	6,071	5.7%
Massachusetts	10,924	10,633	9,041	8,960	-2.7%	6,290	6,348	4,813	4,857	0.9%
Michigan	10,131	9,989	9,565	9,521	-1.4%	5,319	5,610	5,483	5,783	5.5%
Minnesota	7,936	8,017	7,225	7,320	1.0%	5,274	5,832	4,806	5,314	10.6%
Mississippi	9,493	9,190	10,046	9,837	-3.2%	4,961	5,443	6,097	6,690	9.7%
Missouri	8,610	8,486	8,698	8,627	-1.4%	5,442	5,517	6,062	6,145	1.4%
Montana	6,939	6,987	6,585	6,687	0.7%	5,654	5,876	5,654	5,876	3.9%
Nebraska	8,380	8,297	8,062	8,027	-1.0%	5,268	5,557	5,456	5,756	5.5%
Nevada	9,222	9,133	8,328	8,295	-1.0%	5,168	5,426	4,461	4,684	5.0%
New Hampshire	8,450	8,416	7,618	7,643	-0.4%	6,249	6,336	5,487	5,563	1.4%
New Jersey	10,972	10,849	9,556	9,587	-1.1%	6,200	6,447	5,215	5,422	4.0%
New Mexico	7,246	7,161	6,791	6,766	-1.2%	5,250	5,725	5,456	5,949	9.0%
New York	10,960	10,873	8,977	8,975	-0.8%	6,156	6,307	5,157	5,283	2.5%
North Carolina	8,296	8,209	8,158	8,160	-1.0%	5,218	5,593	5,813	6,230	7.2%
North Dakota	7,651	7,683	7,529	7,585	0.4%	5,330	5,521	5,330	5,521	3.6%
Ohio	9,537	9,440	9,492	9,406	-1.0%	5,679	5,930	6,244	6,520	4.4%
Oklahoma	8,884	8,691	9,182	9,102	-2.2%	5,129	5,649	6,102	6,721	10.1%
Oregon	7,021	7,066	6,300	6,380	0.6%	5,449	5,707	4,906	5,138	4.7%
Pennsylvania	9,780	9,618	9,391	9,302	-1.7%	5,582	5,888	5,890	6,212	5.5%
Rhode Island	9,610	9,637	8,557	8,594	0.3%	5,968	6,156	5,130	5,291	3.2%
South Carolina	8,413	8,311	8,529	8,519	-1.2%	5,426	5,850	6,178	6,661	7.8%
South Dakota	7,623	7,516	7,204	7,209	-1.4%	5,876	5,859	5,873	5,856	-0.3%
Tennessee	8,736	8,437	9,197	9,044	-3.4%	5,146	5,310	6,078	6,271	3.2%
Texas	10,152	9,990	10,135	10,067	-1.6%	5,386	5,740	5,807	6,188	6.6%
Utah	7,997	7,804	8,011	7,889	-2.4%	5,309	5,538	5,832	6,084	4.3%
Vermont	7,898	7,884	6,816	6,869	-0.2%	5,764	6,180	5,719	6,131	7.2%
Virginia	8,160	8,169	8,000	8,050	0.1%	5,408	5,422	5,800	5,815	0.3%
Washington	7,919	7,922	7,106	7,137	0.0%	5,690	5,910	5,031	5,226	3.9%
West Virginia	8,520	8,434	8,637	8,601	-1.0%	5,940	6,149	7,334	7,592	3.5%
Wisconsin	8,003	7,979	7,615	7,622	-0.3%	5,730	5,868	5,730	5,868	2.4%
Wyoming	7,715	7,518	6,818	6,701	-2.6%	6,301	5,840	6,258	5,801	-7.3%

Notes: (a) Medicare spending estimates exclude prescription drug costs and reflect only the age 65+ Medicare fee-for-service population. (b) Spending is standardized for state differences in input prices using CMS' hospital wage index and extra CMS payments for graduate medical education and for treating low-income patients are removed from Medicare spending estimates. (c) Average annual growth rate calculated on the unadjusted amounts. (d) Average annual growth rate of + or - 3.5% or more in a state's health insurance premiums represents a change of at least 0.5 standard deviations.

APPENDIX EXHIBIT F1. HEALTHY LIVES: DIMENSION AND INDICATOR RANKING



APPENDIX EXHIBIT F2. HEALTHY LIVES: DIMENSION RANKING AND INDICATOR RATES

	Mortality amenable to health care, deaths per 100,000 population		Years of potential life lost before age 75		Breast cancer deaths per 100,000 female population		Colorectal cancer deaths per 100,000 population		Suicide deaths per 100,000 population		Infant mortality, deaths per 1,000 live births	
	2010-11	2012-13	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
United States	**85**	**84**	**6,412**	**6,420**	**21.4**	**20.8**	**14.9**	**14.6**	**12.6**	**12.6**	**6.0**	**6.0**
Alabama	112	111	9,324	9,368	22.9	21.4 *	16.7	17.7 *	14.7	14.4	8.9	8.6
Alaska	72	72	7,194	7,308	17.6	19.3 *	15.6	16.4	23.1	23.1	5.1	5.8 *
Arizona	74	72	6,609	6,645	19.1	20.6 *	13.1	13.3	17.3	17.5	5.8	5.3
Arkansas	116	119	8,928	8,867	23.3	21.4 *	17.7	17.7	16.3	17.3	7.1	7.9 *
California	73	72	5,108	5,123	21.1	20.1	13.6	13.2	10.0	10.2	4.5	4.8
Colorado	62	59	5,538	5,555	20.3	18.1 *	12.6	12.3	19.7	18.6	4.6	5.1
Connecticut	64	61	5,146	5,109	19.2	18.7	12.1	11.9	9.9	8.7	5.3	4.8
Delaware	88	85	7,204	6,892	22.7	21.3 *	13.4	13.8	13.2	12.5	7.6	6.4 **
District of Columbia	130	124	7,831	7,285	31.1	29.8 *	12.8	14.3 *	5.7	5.8	7.9	6.7 **
Florida	81	80	6,556	6,502	20.6	19.6	13.8	13.7	14.3	13.8	6.1	6.1
Georgia	103	100	6,966	7,229	21.6	22.5	15.1	14.9	11.7	12.0	6.2	7.0 *
Hawaii	70	75	5,445	5,611	16.3	15.5	13.6	14.2	13.1	11.8	4.9	6.4 **
Idaho	66	67	5,809	6,201	15.8	22.1 **	14.2	13.4	19.0	19.2	5.4	5.6
Illinois	90	87	6,161	5,994	23.0	22.2	16.0	15.9	9.8	9.9	6.5	6.0
Indiana	93	91	7,342	7,487	21.8	21.8	16.4	15.4 *	14.3	14.3	6.7	7.2
Iowa	73	72	5,747	5,679	20.3	18.7 *	15.9	15.6	12.7	14.4	5.3	4.3 *
Kansas	78	78	6,643	6,555	23.0	18.5 **	14.7	15.4	17.5	14.7 *	6.3	6.5
Kentucky	107	106	8,869	8,374	23.4	21.1 *	17.1	17.1	16.2	15.5	7.2	6.4 *
Louisiana	121	123	8,952	9,232	24.4	23.9	17.7	18.4	12.4	12.4	8.1	8.7 *
Maine	65	62	6,128	6,252	17.3	18.8 *	14.2	12.5 *	14.5	17.4 *	7.0	7.1
Maryland	92	89	6,244	6,248	23.7	21.5 *	15.0	14.3	9.5	9.2	6.4	6.6
Massachusetts	64	60	4,892	5,009	19.5	18.4 *	13.4	13.1	8.7	8.2	4.2	4.2
Michigan	92	91	6,977	7,023	22.3	21.2 *	14.5	14.8	12.5	12.9	6.9	7.1
Minnesota	57	56	4,910	4,963	18.1	19.6 *	13.2	12.8	12.0	12.1	5.0	5.1
Mississippi	133	137	9,610	9,945	25.3	23.3 *	19.4	18.8	14.0	13.0	8.9	9.6 *
Missouri	95	95	7,487	7,480	22.5	22.0	16.6	15.7 *	14.9	15.6	6.6	6.5
Montana	69	70	6,963	7,197	20.7	19.9	14.3	12.4 **	22.6	23.7	5.9	5.6
Nebraska	66	65	5,701	5,607	21.2	21.0	16.0	15.2	12.5	11.6	4.7	5.2
Nevada	94	92	6,658	6,846	22.2	22.5	17.7	16.8 *	18.2	18.6	4.9	5.3
New Hampshire	60	58	5,097	5,329	19.0	19.8	13.7	12.8 *	14.1	12.8	4.2	5.6 **
New Jersey	79	75	5,325	5,345	22.7	23.2	15.9	14.9 *	7.4	8.0	4.4	4.5
New Mexico	78	79	7,998	7,686	18.0	17.3	13.9	14.5	21.3	20.3	6.8	5.3 **
New York	82	79	5,237	5,216	20.8	20.6	14.4	14.0	8.3	8.1	5.0	4.9
North Carolina	94	93	7,029	6,976	21.5	20.4 *	14.5	13.3 *	12.7	12.6	7.4	7.0
North Dakota	70	70	6,473	6,655	16.9	17.9	13.2	15.9 **	15.2	17.3 *	6.3	6.0
Ohio	96	94	7,282	7,365	22.8	22.9	16.4	16.3	13.0	12.9	7.5	7.3
Oklahoma	114	118	8,915	9,041	23.4	22.9	18.1	17.5	17.6	17.2	7.5	6.7 *
Oregon	65	62	5,799	5,736	20.3	19.9	13.8	14.4	17.8	16.8	5.4	4.9
Pennsylvania	86	82	6,726	6,648	22.6	21.8	16.0	15.9	12.4	13.4	7.1	6.7
Rhode Island	73	68	5,549	5,819	18.1	19.4 *	14.4	13.2 *	9.5	12.2 *	6.5	6.5
South Carolina	103	99	7,962	7,908	22.3	21.3	15.4	15.0	13.7	14.0	7.5	6.9 *
South Dakota	75	75	6,873	6,514	19.5	19.9	16.4	16.7	16.8	18.0	8.3	6.5 **
Tennessee	110	110	8,464	8,357	22.9	22.4	16.9	16.6	14.6	15.3	7.2	6.8
Texas	93	93	6,457	6,492	21.1	20.2	14.8	14.7	11.9	11.7	5.8	5.8
Utah	62	61	5,719	5,722	20.4	20.3	10.7	10.9	21.0	21.4	4.8	5.2
Vermont	58	57	5,102	5,596	19.4	18.5	13.5	14.3	13.1	16.8 *	4.3	4.4
Virginia	83	81	5,965	5,882	21.3	21.1	14.5	13.8	12.6	12.5	6.5	6.2
Washington	64	62	5,399	5,313	17.9	20.5 **	13.2	12.8	14.5	14.1	5.3	4.5 *
West Virginia	105	103	9,474	9,413	22.6	21.6	17.5	19.8 **	17.1	16.4	7.2	7.6
Wisconsin	72	69	5,696	5,863	20.4	20.4	13.8	14.1	12.3	14.4 *	5.7	6.3 *
Wyoming	76	68	7,046	6,761	15.7	20.5 **	15.8	12.6 **	29.6	21.5 **	5.6	4.8 *
Change		**0**		**0**		**21**		**14**		**7**		**18**
States Improved		0		0		13		10		2		10
States Worsened		0		0		8		4		5		8

Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more.

APPENDIX EXHIBIT F2. HEALTHY LIVES: DIMENSION RANKING AND INDICATOR RATES (CONTINUED)

	Adults with poor health-related quality of life		Adults who smoke		Adults who are obese		Children who are overweight or obese	Adults ages 18–64 who have lost six or more teeth	
	2013	2014	2013	2014	2013	2014	2011/12	2012	2014
United States	26%	27%	18%	17%	29%	29%	31%	10%	10%
Alabama	31	33 *	21	20	33	35 *	35	17	17
Alaska	24	24	22	19 *	28	30 *	30	9	9
Arizona	24	28 **	16	15	28	30 *	37	10	9
Arkansas	33	32	25	24	37	38	34	17	17
California	29	28	11	12	25	25	30	7	7
Colorado	23	24	17	14 *	22	21	23	7	7
Connecticut	21	25 **	15	14	25	26	30	8	8
Delaware	25	24	19	19	31	31	32	10	11
District of Columbia	21	19 *	18	15 *	23	21 *	35	7	7
Florida	28	29	16	17	27	27	28	11	11
Georgia	27	26	18	16 *	31	31	35	13	12
Hawaii	20	22 *	13	13	23	24	27	6	7
Idaho	23	23	17	15 *	30	30	28	9	8
Illinois	22	24 *	18	16 *	30	29	34	9	8
Indiana	26	28 *	21	22	32	34 *	31	13	14
Iowa	22	22	19	18	32	31	28	9	10
Kansas	23	24	20	17 *	31	32	30	10	9
Kentucky	32	34 *	25	25	34	33	36	16	18 *
Louisiana	30	29	23	23	33	36 *	40	17	14 *
Maine	25	27 *	20	19	29	29	30	14	13
Maryland	22	23	16	14 *	29	30	32	9	9
Massachusetts	22	25 *	16	14 *	24	23	31	9	10
Michigan	28	26 *	21	21	32	30 *	33	11	10
Minnesota	20	20	17	16	26	27	27	7	7
Mississippi	31	30	24	22 *	37	37	40	18	19
Missouri	28	25 *	22	20 *	31	31	28	12	13
Montana	25	25	19	19	25	26	29	11	11
Nebraska	22	21	18	17	30	31	29	8	8
Nevada	25	26	19	16 *	27	28	33	11	8 *
New Hampshire	22	22	16	17	27	27	26	10	10
New Jersey	22	23	15	14	27	27	25	9	10
New Mexico	29	30	19	18	28	30 *	33	10	10
New York	25	25	16	14 *	25	27 *	32	10	9
North Carolina	27	27	20	18 *	30	31	31	13	13
North Dakota	20	20	21	19 *	31	33 *	36	9	7 *
Ohio	26	27	22	21	31	32	31	13	13
Oklahoma	30	30	23	21 *	34	34	34	14	14
Oregon	26	28 *	17	16	27	28	26	10	8 *
Pennsylvania	24	27 *	20	19	30	31	26	11	10
Rhode Island	25	24	17	16	27	27	28	9	7 *
South Carolina	28	29	21	21	33	33	39	15	15
South Dakota	21	21	19	18	30	31	27	9	10
Tennessee	31	32	23	23	35	33 *	34	18	16 *
Texas	24	26 *	15	14	32	32	37	8	7
Utah	20	21	10	9	24	25	22	6	6
Vermont	22	24 *	16	16	25	25	25	11	10
Virginia	23	24	18	19	27	29 *	30	11	10
Washington	28	27	16	15	27	28	26	8	8
West Virginia	34	34	27	26	37	37	34	23	22
Wisconsin	24	24	18	17	29	31 *	29	11	10
Wyoming	23	23	20	19	29	31 *	27	11	10
Change		**16**		**16**		**14**			**7**
States Improved		3		16		3			6
States Worsened		13		0		11			1

Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more.

APPENDIX EXHIBIT F3. MORTALITY AMENABLE TO HEALTH CARE BY RACE, DEATHS PER 100,000 POPULATION, 2010–11 AND 2012–13

	Total				White				Black			
	2010-11	2012-13	Change in Rate	2015 Rank	2010-11	2012-13	Change in Rate	2015 Rank	2010-11	2012-13	Change in Rate	2015 Rank
United States	85	84	-1	--	78	77	-1	--	161	155	-6	--
Alabama	112	111	-1	46	96	97	1	43	175	166	-9	35
Alaska	72	72	0	18	63	64	1	14	83	98	15	2
Arizona	74	72	-2	18	70	69	-1	21	131	127	-4	12
Arkansas	116	119	3	48	107	111	4	50	196	197	1	43
California	73	72	-1	18	72	72	0	26	154	148	-6	22
Colorado	62	59	-3	4	59	56	-3	3	122	106	-16	7
Connecticut	64	61	-3	6	58	57	-1	4	113	109	-4	10
Delaware	88	85	-3	31	80	75	-5	29	138	133	-5	13
District of Columbia	130	124	-6	50	49	41	-8	1	190	186	-4	39
Florida	81	80	-1	28	78	77	-1	34	142	139	-3	15
Georgia	103	100	-3	42	87	86	-1	38	160	151	-9	23
Hawaii	70	75	5	22	59	59	0	6	70	106	36	7
Idaho	66	67	1	12	66	68	2	20	--	--	--	--
Illinois	90	87	-3	32	79	76	-3	32	183	178	-5	37
Indiana	93	91	-2	34	89	87	-2	39	160	159	-1	29
Iowa	73	72	-1	18	72	70	-2	22	146	151	5	23
Kansas	78	78	0	25	75	75	0	29	141	147	6	21
Kentucky	107	106	-1	44	104	104	0	48	164	155	-9	27
Louisiana	121	123	2	49	100	101	1	45	185	189	4	40
Maine	65	62	-3	8	66	63	-3	12	--	99	--	3
Maryland	92	89	-3	33	76	76	0	32	145	135	-10	14
Massachusetts	64	60	-4	5	62	60	-2	7	104	90	-14	1
Michigan	92	91	-1	34	79	77	-2	34	189	190	1	42
Minnesota	57	56	-1	1	55	53	-2	2	101	100	-1	5
Mississippi	133	137	4	51	104	109	5	49	198	198	0	44
Missouri	95	95	0	40	88	89	1	42	175	166	-9	35
Montana	69	70	1	16	66	66	0	16	--	--	--	--
Nebraska	66	65	-1	11	64	62	-2	10	139	141	2	18
Nevada	94	92	-2	36	98	97	-1	43	147	145	-2	20
New Hampshire	60	58	-2	3	61	60	-1	7	88	--	--	--
New Jersey	79	75	-4	22	73	71	-2	24	155	144	-11	19
New Mexico	78	79	1	26	73	72	-1	26	145	106	-39	7
New York	82	79	-3	26	73	71	-2	24	144	140	-4	16
North Carolina	94	93	-1	37	81	81	0	36	156	151	-5	23
North Dakota	70	70	0	16	65	66	1	16	--	--	--	--
Ohio	96	94	-2	39	88	87	-1	39	170	164	-6	33
Oklahoma	114	118	4	47	108	113	5	51	193	189	-4	40
Oregon	65	62	-3	8	66	63	-3	12	106	112	6	11
Pennsylvania	86	82	-4	30	78	75	-3	29	171	162	-9	32
Rhode Island	73	68	-5	13	73	70	-3	22	113	102	-11	6
South Carolina	103	99	-4	41	85	83	-2	37	163	156	-7	28
South Dakota	75	75	0	22	67	66	-1	16	--	--	--	--
Tennessee	110	110	0	45	101	101	0	45	183	179	-4	38
Texas	93	93	0	37	86	88	2	41	171	164	-7	33
Utah	62	61	-1	6	61	60	-1	7	115	161	46	31
Vermont	58	57	-1	2	58	57	-1	4	--	--	--	--
Virginia	83	81	-2	29	72	72	0	26	147	140	-7	16
Washington	64	62	-2	8	63	62	-1	10	111	99	-12	3
West Virginia	105	103	-2	43	104	103	-1	47	159	154	-5	26
Wisconsin	72	69	-3	15	67	64	-3	14	175	160	-15	30
Wyoming	76	68	-8	13	75	67	-8	19	--	--	--	--

Notes: * denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more.

APPENDIX EXHIBIT G1. EQUITY: DIMENSION AND SUBDIMENSION RANKING

Overall performance, 2015

Legend:
- Top quartile
- Second quartile
- Third quartile
- Bottom quartile

Rank	State	Income Subdimension	Race/Ethnicity Subdimension
1	Hawaii	Top quartile	Top quartile
2	Massachusetts	Top quartile	Top quartile
3	Connecticut	Top quartile	Top quartile
3	Vermont	Top quartile	Top quartile
5	New Hampshire	Top quartile	Top quartile
5	New York	Top quartile	Top quartile
7	Rhode Island	Top quartile	Top quartile
8	Washington	Top quartile	Top quartile
9	District of Columbia	Top quartile	Top quartile
9	Minnesota	Top quartile	Second quartile
11	Colorado	Second quartile	Top quartile
11	Oregon	Second quartile	Top quartile
13	Maryland	Second quartile	Top quartile
14	Delaware	Top quartile	Second quartile
15	Iowa	Top quartile	Second quartile
15	Maine	Top quartile	Second quartile
17	New Jersey	Second quartile	Second quartile
17	South Dakota	Top quartile	Third quartile
19	Pennsylvania	Second quartile	Third quartile
20	Nebraska	Second quartile	Second quartile
20	New Mexico	Second quartile	Second quartile
22	California	Second quartile	Second quartile
22	Idaho	Second quartile	Second quartile
24	Arizona	Third quartile	Second quartile
24	Illinois	Second quartile	Third quartile
24	Utah	Second quartile	Third quartile
24	Virginia	Third quartile	Second quartile
28	Missouri	Bottom quartile	Second quartile
29	Alaska	Bottom quartile	Second quartile
29	Wisconsin	Second quartile	Bottom quartile
31	Florida	Bottom quartile	Second quartile
31	Michigan	Second quartile	Third quartile
31	Texas	Third quartile	Third quartile
31	West Virginia	Third quartile	Third quartile
35	Wyoming	Third quartile	Third quartile
36	Kansas	Third quartile	Third quartile
36	Montana	Third quartile	Third quartile
36	North Dakota	Third quartile	Third quartile
39	Nevada	Third quartile	Third quartile
39	Tennessee	Third quartile	Third quartile
41	Ohio	Bottom quartile	Third quartile
42	Alabama	Bottom quartile	Third quartile
43	North Carolina	Third quartile	Bottom quartile
44	Louisiana	Bottom quartile	Third quartile
45	Georgia	Bottom quartile	Bottom quartile
45	Kentucky	Bottom quartile	Bottom quartile
47	Indiana	Bottom quartile	Bottom quartile
48	South Carolina	Bottom quartile	Bottom quartile
49	Mississippi	Bottom quartile	Bottom quartile
49	Oklahoma	Bottom quartile	Bottom quartile
51	Arkansas	Bottom quartile	Bottom quartile

APPENDIX EXHIBIT G2. EQUITY : SUMMARY OF INDICATOR CHANGE OVER TIME

	Total			Race/Ethnicity			Income		
	Number of indicators improved	Number of indicators with data	Percent of indicators improved	Number of indicators improved	Number of indicators with data	Percent of indicators improved	Number of indicators improved	Number of indicators with data	Percent of indicators improved
Alabama	10	27	37%	5	12	42%	5	15	33%
Alaska	9	26	35%	6	11	55%	3	15	20%
Arizona	18	28	64%	8	13	62%	10	15	67%
Arkansas	10	27	37%	2	12	17%	8	15	53%
California	14	28	50%	8	13	62%	6	15	40%
Colorado	12	28	43%	6	13	46%	6	15	40%
Connecticut	13	28	46%	2	13	15%	11	15	73%
Delaware	11	28	39%	4	13	31%	7	15	47%
District of Columbia	15	27	56%	6	12	50%	9	15	60%
Florida	14	28	50%	8	13	62%	6	15	40%
Georgia	10	28	36%	5	13	38%	5	15	33%
Hawaii	9	25	36%	1	10	10%	8	15	53%
Idaho	9	27	33%	3	12	25%	6	15	40%
Illinois	18	28	64%	8	13	62%	10	15	67%
Indiana	10	27	37%	6	12	50%	4	15	27%
Iowa	7	27	26%	4	12	33%	3	15	20%
Kansas	8	28	29%	1	13	8%	7	15	47%
Kentucky	13	27	48%	5	12	42%	8	15	53%
Louisiana	13	27	48%	6	12	50%	7	15	47%
Maine	5	24	21%	1	9	11%	4	15	27%
Maryland	13	28	46%	6	13	46%	7	15	47%
Massachusetts	14	28	50%	6	13	46%	8	15	53%
Michigan	8	27	30%	1	12	8%	7	15	47%
Minnesota	11	27	41%	4	12	33%	7	15	47%
Mississippi	7	28	25%	4	13	31%	3	15	20%
Missouri	11	27	41%	7	12	58%	4	15	27%
Montana	12	28	43%	6	13	46%	6	15	40%
Nebraska	10	28	36%	5	13	38%	5	15	33%
Nevada	14	27	52%	5	12	42%	9	15	60%
New Hampshire	8	24	33%	2	9	22%	6	15	40%
New Jersey	14	28	50%	6	13	46%	8	15	53%
New Mexico	9	28	32%	2	13	15%	7	15	47%
New York	17	28	61%	8	13	62%	9	15	60%
North Carolina	18	27	67%	8	12	67%	10	15	67%
North Dakota	8	27	30%	5	12	42%	3	15	20%
Ohio	8	28	29%	5	13	38%	3	15	20%
Oklahoma	16	28	57%	8	13	62%	8	15	53%
Oregon	15	28	54%	7	13	54%	8	15	53%
Pennsylvania	7	28	25%	2	13	15%	5	15	33%
Rhode Island	19	28	68%	7	13	54%	12	15	80%
South Carolina	6	28	21%	3	13	23%	3	15	20%
South Dakota	11	28	39%	6	13	46%	5	15	33%
Tennessee	13	26	50%	5	11	45%	8	15	53%
Texas	12	28	43%	4	13	31%	8	15	53%
Utah	7	26	27%	2	11	18%	5	15	33%
Vermont	9	24	38%	3	9	33%	6	15	40%
Virginia	12	28	43%	7	13	54%	5	15	33%
Washington	11	28	39%	5	13	38%	6	15	40%
West Virginia	13	27	48%	4	12	33%	9	15	60%
Wisconsin	6	27	22%	2	12	17%	4	15	27%
Wyoming	10	26	38%	7	11	64%	3	15	20%

1. Percent of adults ages 19-64 uninsured: Authors' analysis of 2013 and 2014 1-year American Community Survey (ACS) Public Use Micro Sample (PUMS)(U.S. Census Bureau, ACS PUMS, 2013, 2014).

2. Percent of children ages 0-18 uninsured: Authors' analysis of 2013 and 2014 1-year American Community Survey (ACS) Public Use Micro Sample (PUMS)(U.S. Census Bureau, ACS PUMS, 2013, 2014).

3. Percent of adults who went without care because of cost in the past year: Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2013, 2014).

4. Percent of individuals under age 65 with high out-of-pocket medical spending relative to their annual income: Out-of-pocket medical expenses equaled 10 percent or more of income, or five percent or more of income if low-income (under 200% of Federal Poverty Level), not including health insurance premiums. C. Solis-Roman, Robert F. Wagner School of Public Service, New York University, analysis of 2014 and 2015 Current Population Survey, Annual Social and Economic Supplement (U.S. Census Bureau, CPS ASES 2014, 2015).

5. At-risk adults without a routine doctor visit in past two years: Percent of adults age 50 or older, or in fair or poor health, or ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma who did not visit a doctor for a routine checkup in the past two years. Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2013, 2014).

6. Percent of adults without a dental visit in the past year: Percent of adults who did not visit a dentist, or dental clinic within the past year. Authors' analysis of 2012 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2012, 2014).

7. Percent of adults with a usual source of care: Percent of adults ages 18 and older who have one (or more) person they think of as their personal healthcare provider. Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2013, 2014).

8. Percent of adults age 50 and older received recommended screening and preventive care: Percent of adults age 50 and older who have received: sigmoidoscopy or colonoscopy in the last ten years or a fecal occult blood test in the last two years; a mammogram in the last two years (women only); a pap smear in the last three years (women only); and a flu shot in the past year and a pneumonia vaccine ever (age 65 and older only). Authors' analysis of 2012 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2012, 2014).

9. Percent of children with a medical home: Percent of children who have a personal doctor or nurse, have a usual source for sick and well care, receive family-centered care, have no problems getting needed referrals, and receive effective care coordination when needed. For more information, see www.childhealthdata.org. Authors' analysis of 2011/12 National Survey of Children's Health (CAHMI, NSCH 2011/12).

10. Percent of children with a medical and dental preventive care visit in the past year: Percent of children 0-17 with a preventive medical visit and, if ages 1-17, a preventive dental visit in the past year. For more information, see www.childhealthdata.org. Authors' analysis of 2011/12 National Survey of Children's Health (CAHMI, NSCH 2011/12).

11. Percent of children with emotional, behavioral, or developmental problems who received needed mental health care in the past year: Percent of children ages 2-17 who had any kind of emotional, developmental, or behavioral problem that required treatment or counseling and who received treatment from a mental health professional (as defined) during the past 12 months. For more information, see www.childhealthdata.org. Authors' analysis of 2011/12 National Survey of Children's Health (CAHMI, NSCH 2011/12).

12. Percent of children ages 19-35 months who received all recommended doses of seven key vaccines: Percent of children ages 19-35 months who received at least 4 doses of diphtheria, tetanus, and accellular pertussis (DTaP/DT/DTP) vaccine; at least 3 doses of poliovirus vaccine; at least 1 dose of measles-containing vaccine (including mumps-rubella(MMR) vaccine); full series of Haemophilus influenza type b (Hib) vaccine (3 or 4 doses depending on product type); at least 3 doses of hepatitis B vaccine (HepB); at least 1 dose of varicella vaccine, and at least 4 doses of pneumococcal conjugate vaccine (PCV). Data from the 2012 and 2013 NNational Immunization Survey (NIS) Public Use Files and 2014 as published in the August 28, 2015 Morbidity and Mortality Weekly Report, Vol.64 No.33 (NCHS, NIS 2013, 2014). (2012 and 2013 data used for stratification by income and race/ethnicity for equity analysis.)

13. Percent of Medicare beneficiaries received at least one drug that should be avoided in the elderly: Percent of Medicare beneficiaries age 65 and older received at least one drug from a list of 13 classes of high-risk prescriptions that should be avoided by the elderly. Y. Zhang and S.H. Baik, University of Pittsburgh, analysis of 2011 and 2012 5% sample of Medicare beneficiaries enrolled in stand-alone Medicare Part D plans.

14. Percent of Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure received prescription in an ambulatory care setting that is contraindicated for that condition: Y. Zhang and S.H. Baik, University of Pittsburgh, analysis of 2011 and 2012 5% sample of Medicare beneficiaries enrolled in stand-alone Medicare Part D plans.

15. Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them: Percent of Medicare fee-for-service patients who had a doctor's office or clinic visit in the last 12 months whose health providers always listened carefully, explained things clearly, respected what they had to say, and spent enough time with them. Data from National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Benchmarking Database (AHRQ, CAHPS n.d.), reported in *National Healthcare Quality Report* (AHRQ 2013).

16. Risk-adjusted 30-day mortality among Medicare patients hospitalized for heart attack, heart failure or pneumonia: Risk-standardized, all-cause 30-day mortality rates for Medicare patients age 65 and older hospitalized with a principal diagnosis of heart attack, heart failure or pneumonia between July 2009 and June 2012 and July 2010 and June 2013. All-cause mortality is defined as death from any cause within 30 days after the index admission, regardless of whether the patient dies while still in the hospital or after discharge. Authors' analysis of Medicare enrollment and claims data retrieved April 2015 from CMS Hospital Compare (DHHS n.d.).

17. Percent of hospitalized patients who were given information about what to do during their recovery at home: Authors' analysis of Hospital Consumer Assessment of Healthcare Providers and Systems Survey data (HCAHPS n.d.) retrieved April 2015 from CMS Hospital Compare (DHHS n.d.).

18. Percent of patients reported hospital staff always managed pain well, responded when needed help to get to bathroom or pressed call

button, and explained medicines and side effects: Authors' analysis of Hospital Consumer Assessment of Healthcare Providers and Systems Survey data (HCAHPS n.d.) retrieved April 2015 from CMS Hospital Compare (DHHS n.d.).

19. Home health patients who get better at walking or moving around: Percent of all home health episodes in which a person improved at walking or moving around compared to a prior assessment. Episodes for which the patient, at start or resumption of care, was able to ambulate independently are excluded. Authors' analysis of 2013 and 2014 Outcome and Assessment Information Set (CMS, OASIS n.d.) as reported in CMS Home Health Compare. Data retrieved April 2014 and April 2015 from CMS Home Health Compare (DHHS n.d.).

20. Home health patients whose wounds improved or healed after an operation: Percent of all home health episodes in which a person's surgical wound is more fully healed compared to a prior assessment. Episodes for which the patient, at start or resumption of care, did not have any surgical wounds or had only a surgical wound that was unobservable are excluded. Authors' analysis of 2013 and 2014 Outcome and Assessment Information Set (CMS, OASIS n.d.) as reported in CMS Home Health Compare. Data retrieved April 2014 and April 2015 from CMS Home Health Compare (DHHS n.d.).

21. High-risk nursing home residents with pressure sores: Percent of long-stay nursing home residents impaired in bed mobility or transfer, comatose, or malnourished who have pressure sores (Stages 1–4) on target assessment. Authors' analysis of 2013 and 2014 Minimum Data Set (CMS, MDS n.d.) as reported in CMS Nursing Home Compare, 2013 and 2014 single quarter quality measure summary files. Data retrieved October 2015 from CMS Nursing Home Compare.

22. Long-stay nursing home residents with an antipsychotic medication: The percent of long-stay nursing home residents that received an antipsychotic medication, excluding residents with Schizophrenia, Tourette's syndrome, and Huntington's disease. Authors' analysis of 2013 and 2014 Minimum Data Set (CMS, MDS n.d.) as reported in CMS Nursing Home Compare, 2013 and 2014 single quarter quality measure summary files. Data retrieved October 2015 from CMS Nursing Home Compare.

23. Hospital admissions for pediatric asthma, per 100,000 children (ages 2-17): Excludes patients with cystic fibrosis or anomalies of the respiratory system, and transfers from other institutions. Authors' analysis of 2011 and 2012 Healthcare Cost and Utilization Project State Inpatient Databases; not all states participate in HCUP. Estimates for total U.S. are from the Nationwide Inpatient Sample (AHRQ, HCUPT-SID 2011, 2012). Reported in the *National Healthcare Quality Report* (AHRQ 2011, 2012).

24. Hospital admissions for ambulatory care-sensitive conditions, per 1,000 beneficiaries:

Medicare beneficiaries ages 65-74:

Medicare beneficiaries ages 75 and older:

Hospital admissions of fee-for-service Medicare beneficiaries age 65-74 and 75 and older for one of the following eight ambulatory care–sensitive (ACS) conditions: long-term diabetes complications, lower extremity amputation among patients with diabetes, asthma or chronic obstructive pulmonary disease, hypertension, congestive heart failure, dehydration, bacterial pneumonia, and urinary tract infection. Authors' analysis of 2007-2013 Chronic Conditions Warehouse (CCW) data, retrieved from the February 2015 CMS Geographic Variation Public Use File (CMS, Office of Information Products and Analytics (OPIDA) 2015).

25. Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries: All hospital admissions among Medicare beneficiaries age 65 and older that were readmitted within 30 days of an acute hospital stay for any cause. A correction was made to account for likely transfers between hospitals. Authors' analysis of 2007-2013 Chronic Conditions Warehouse (CCW) data, retrieved from the February 2015 CMS Geographic Variation Public Use File (CMS, Office of Information Products and Analytics (OPIDA) 2015).

26. Percent of short-stay nursing home residents readmitted within 30 days of hospital discharge to the nursing home: Percent of newly admitted nursing home residents (never been in a facility before) who are re-hospitalized within 30 days of being discharged to nursing home. V.Mor, Brown University, analysis of 2010 and 2012 Medicare enrollment data and Medicare Provider and Analysis Review (CMS, MEDPAR 2010, 2012).

27. Percent of long-stay nursing home residents hospitalized within a six-month period: Percent of long-stay residents (residing in a nursing home for at least 90 consecutive days) who were ever hospitalized within six months of baseline assessment. V.Mor, Brown University, analysis of 2010 and 2012 Medicare enrollment data, Medicare Provider and Analysis Review File (CMS, MEDPAR 2010, 2012).

28. Home health patients also enrolled in Medicare with a hospital admission: Percent of acute care hospitalization for home health episodes that occurred in 2013 and 2014. Authors' analysis data from CMS Medicare claims data retrieved April 2014 and April 2015 from CMS Home Health Compare (DHHS n.d.).

29. Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries: Potentially avoidable emergency department visits were those that, based on diagnoses recorded during the visit and the health care service the patient received, were considered to be either non-emergent (care was not needed within 12 hours), or emergent (care needed within 12 hours) but that could have been treated safely and effectively in a primary care setting. This definition excludes any emergency department visit that resulted in an admission, as well as emergency department visits where the level of care provided in the ED was clinically indicated. J. Zheng, Harvard University, analysis of 2012 and 2013 Medicare Enrollment and Claims Data 20% sample, Chronic Conditions Warehouse (CMS, CCW 2012, 2013), using the New York University Center for Health and Public Service Research emergency department algorithm developed by John Billings.

30. Total single premium per enrolled employee at private-sector establishments that offer health insurance: Data from Medical Expenditure Panel Survey–Insurance Component (AHRQ, MEPS-IC 2008, 2013, 2014).

31. Total Medicare (Parts A&B) reimbursements per enrollee: Total Medicare fee-for-service reimbursements include payments for both Part A and Part B but exclude Part D (prescription drug costs) and extra CMS payments for graduate medical education and for treating low-income patients. Reimbursements reflect only the age 65 and older Medicare fee-for-service population. Authors' analysis of 2007-2013 Chronic Conditions Warehouse (CCW) data, retrieved from the February 2015 CMS Geographic Variation Public Use File (CMS, Office of Information Products and Analytics (OPIDA) 2015).

32. Mortality amenable to health care, deaths per 100,000 population: Number of deaths before age 75 per 100,000 population that resulted from causes considered at least partially treatable or preventable with timely and appropriate medical care (see list), as described in Nolte and McKee (Nolte and McKee, BMJ 2003). Authors' analysis of mortality data from CDC restricted-use Multiple Cause-of-Death file and U.S. Census Bureau population data, 2004-2013 (NCHS, MCD n.d.).

Causes of death	Age
Intestinal infections	0–14
Tuberculosis	0–74
Other infections (diphtheria, tetanus, septicaemia, poliomyelitis)	0–74
Whooping cough	0–14
Measles	1–14
Malignant neoplasm of colon and rectum	0–74
Malignant neoplasm of skin	0–74
Malignant neoplasm of breast	0–74
Malignant neoplasm of cervix uteri	0–74
Malignant neoplasm of cervix uteri and body of uterus	0–44
Malignant neoplasm of testis	0–74
Hodgkin's disease	0–74
Leukemia	0–44
Diseases of the thyroid	0–74
Diabetes mellitus	0–49
Epilepsy	0–74
Chronic rheumatic heart disease	0–74
Hypertensive disease	0–74
Cerebrovascular disease	0–74
All respiratory diseases (excluding pneumonia and influenza)	1–14
Influenza	0–74
Pneumonia	0–74
Peptic ulcer	0–74
Appendicitis	0–74
Abdominal hernia	0–74
Cholelithiasis and cholecystitis	0–74
Nephritis and nephrosis	0–74
Benign prostatic hyperplasia	0–74
Maternal death	All
Congenital cardiovascular anomalies	0–74
Perinatal deaths, all causes, excluding stillbirths	All
Misadventures to patients during surgical and medical care	All
Ischaemic heart disease: 50% of mortality rates included	0–74

33. Years of potential life lost before age 75: Robert Wood Johnson Foundation analysis of National Vital Statistics System Mortality Data, 2012 and 2013, using the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control Web-based Injury Statistics Query and Reporting System (WISQARS). Retrieved September 2015 from Robert Wood Johnson Foundation National DataHub. (NVSS 2012 and 2013).

34. Breast cancer deaths per 100,000 female population: Authors' analysis of NVSS–Mortality Data, 2012 and 2013 (NCHS, NVSS n.d.), retrieved using the CDC Wide-ranging OnLine Data for Epidemiologic Research (WONDER) (NVSS 2012 and 2013).

35. Colorectal cancer deaths per 100,000 population: Authors' analysis of NVSS–Mortality Data, 2012 and 2013 (NCHS, NVSS n.d.), retrieved using the CDC Wide-ranging OnLine Data for Epidemiologic Research (WONDER) (NVSS 2012 and 2013).

36. Suicide deaths per 100,000 population: Authors' analysis of NVSS–Mortality Data 2012 and 2013 (NCHS NVSS), retrieved using the CDC Wide-ranging OnLine Data for Epidemiologic Research (WONDER) (NVSS 2012 and 2013).

37. Infant mortality, deaths per 1,000 live births: Authors' analysis of National Vital Statistics System–Linked Birth and Infant Death Data, 2012 and 2013 (NCHS, NVSS), retrieved using the CDC Wide-ranging OnLine Data for Epidemiologic Research (WONDER) (NVSS 2012 and 2013).

38. Percent of adults ages 18–64 report being in fair or poor health, or who have activity limitations because of physical, mental, or emotional problems: Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2013, 2014).

39. Percent of adults who smoke: Percent of adults age 18 and older who ever smoked 100+ cigarettes (five packs) and currently smoke every day or some days. Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2013, 2014).

40. Percent of adults ages 18-64 who are obese (Body Mass Index [BMI] ≥ 30): Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2013, 2014).

41. Children (ages 10–17) who are overweight or obese (Body Mass Index [BMI] ≥ 85th percentile): Overweight is defined as an age- and gender-specific body mass index (BMI-forage) between the 85th and 94th percentile of the CDC growth charts. Obese is defined as a BMI-for-age at or above the 95th percentile. BMI was calculated based on parent-reported height and weight. For more information, see www.nschdata.org. Data from the National Survey of Children's Health, assembled by the Child and Adolescent Health Measurement Initiative (CAHMI, NCHS 2011/2012).

42. Percent of adults ages 18–64 who have lost 6 or more teeth due to tooth decay, infection, or gum disease: Authors' analysis of 2012 and 2014 Behavioral Risk Factor Surveillance System (NCCDPHP, BRFSS 2012, 2014).

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Realizing Health Reform's Potential

DECEMBER 2015

Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015

Jon Gabel, Heidi Whitmore, Matthew Green, Sam Stromberg, and Rebecca Oran

Abstract Using data from 49 states and Washington, D.C., we analyzed changes in cost-sharing under health plans offered to individuals and families through state and federal exchanges from 2014 to 2015. We examined eight vehicles for cost-sharing, including deductibles, copayments, coinsurance, and out-of-pocket limits, and compared findings with cost-sharing under employer-based insurance. We found cost-sharing under marketplace plans remained essentially unchanged from 2014 to 2015. Stable premiums during that period do not reflect greater costs borne by enrollees. Further, 56 percent of enrollees in marketplace plans attained cost-sharing reductions in 2015. However, for people without cost-sharing reductions, average copayments, deductibles, and out-of-pocket limits under catastrophic, bronze, and silver plans are considerably higher than under employer-based plans on average, while cost-sharing under gold plans is similar employer-based plans on average. Marketplace plans are far more likely than employer-based plans to require enrollees to meet deductibles before they receive coverage for prescription drugs.

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BACKGROUND

Cost-sharing has been at the center of health care policy debates for more than 45 years. Proponents of cost-sharing maintain that people with health insurance are subject to "moral hazard": they overuse services because out-of-pocket expenses are low. Opponents of substantial cost-sharing maintain that it is a tax on sick people, and that it amounts to rationing by income class. Opponents of significant cost-sharing also contend that high deductibles are a blunt instrument, reducing the use of both cost-effective and cost-ineffective services.

In the 1970s and 1980s, the RAND Corp. conducted perhaps the largest study to date in health economics and health services research. One overview of that study found that when deductibles apply to physician services and prescription drugs, use of these services declines substantially.[1]

In December 2014, we reported that average premiums for health insurance plans for individuals and families obtained through state and federal

marketplaces had not changed from 2014 to 2015.[2] A common response to this finding was the question: "Did this mean that insurers increased patient cost-sharing by imposing higher deductibles and copayments?"

To answer that question, we used data from 49 states and Washington, D.C., to analyze changes in cost-sharing under marketplace plans in all metal tiers from 2014 to 2015. We also compared cost-sharing in those tiers with employer-based insurance, because employers have used high-deductible plans as a major cost-control strategy since 2004.

As of June 30, 2015, 68 percent of individuals and families that obtained health insurance through state and federal exchanges had enrolled in silver plans, while 21 percent had enrolled in bronze plans. Some 56 percent of individuals and families enrolled through these marketplaces—47.37 percent in states with their own exchange, and 59.29 percent in states that rely on the federal exchange—receive reductions in the cost-sharing they would normally have to pay.[3]

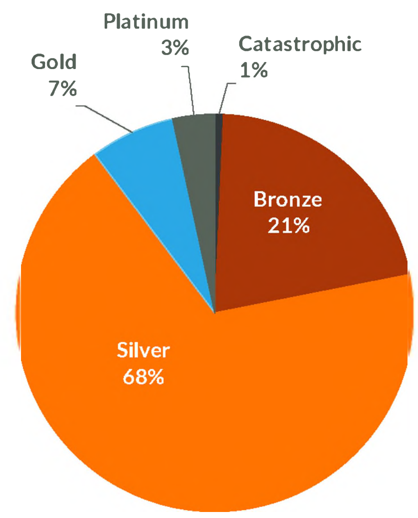
At the time of the passage of the ACA, the median "actuarial value" (i.e., the percent of costs covered on average by a health plan) for an employer-based plan was 83 percent and for an individual plan 59 percent. Restated, the typical employer plan was a gold plan and the actuarial value for a typical individual plan would not qualify to be sold on the exchange.[4]

Households earning 100 percent to 250 percent of the federal poverty level that purchase silver plans are eligible for cost-sharing reductions. For example, households earning 100 percent to 200 percent of the federal poverty level with silver plans are eligible for deductibles, copayments, coinsurance, and out-of-pocket limits equivalent to the cost-sharing available to households that enroll in platinum or gold plans. Households earning 200 percent to 250 percent of the federal poverty level with silver plans face slightly higher cost-sharing—equivalent to plans with an actuarial value of 73 percent.[5] Individuals and families earning more than 250 percent of the federal poverty level do not qualify for subsidies that reduce their cost-sharing.

For background purposes Exhibit 1 shows enrollment by metal tier on June 30, 2015. Silver plans account for 68 percent of enrollment and bronze plans account for 21 percent. Data in this issue brief are for people with individual marketplace coverage who do not qualify for cost-sharing reduction subsidies (i.e., they earn more than 250 percent of the federal poverty level).

Exhibit 1

Percentage of Marketplace Enrollment by Metal Tier, June 2015

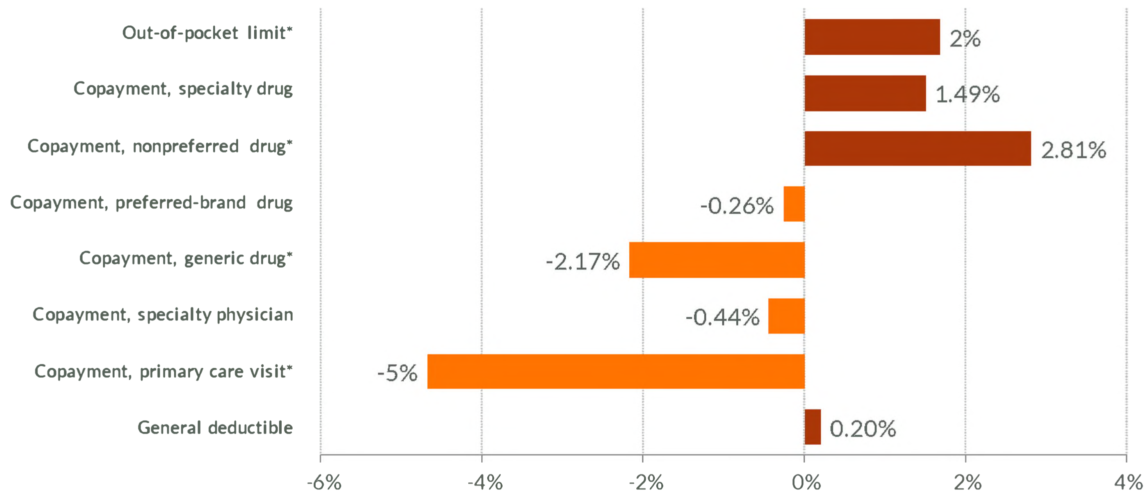


Source: U.S. Department of Health and Human Services, June 30, 2015 Effectuated Enrollment Snapshot, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html.

FINDINGS

Trends in Cost-Sharing

Of eight types of cost-sharing under marketplace plans we examined, only two increased significantly from 2014 to 2015 (Exhibit 2). Out-of-pocket limits rose by nearly 2 percent, while copayments for nonpreferred drugs rose by nearly 3 percent.[6] Deductibles remained statistically unchanged.



* Significant at $p<.05$.

Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

Four types of cost-sharing actually fell from 2014 to 2015, two of which were statistically significant. Copayments for generic drugs declined by about 2 percent, and copayments for primary care visits fell by nearly 5 percent. We conclude that stable prices for nonemployer health insurance plans obtained through the state and federal exchanges do not reflect greater cost-sharing by enrollees.

Deductibles

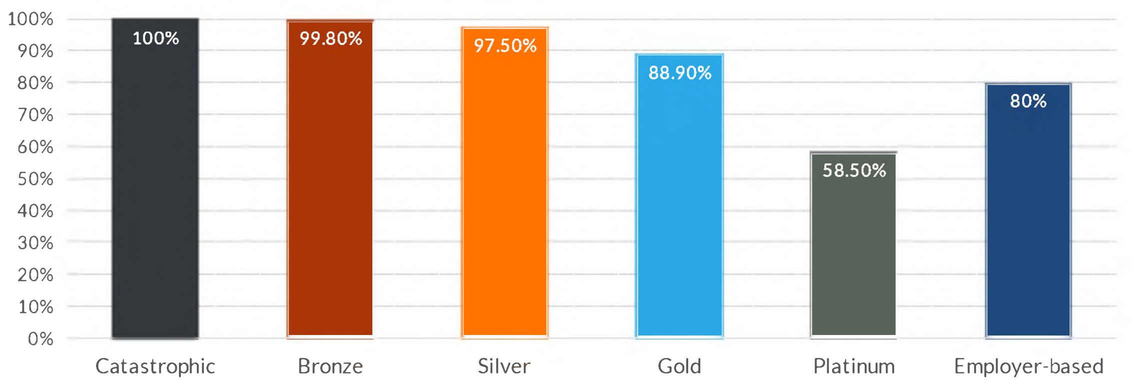
Actuaries often regard the presence and size of deductibles as the most important determinant of the share of health care expenses borne by enrollees versus their insurance plan. In 2015, the share of plans with general deductibles varied from 100 percent for catastrophic plans, to 97.5 percent for silver plans, to 58.5 percent for platinum plans (Exhibit 3). Under employer-based coverage, 80 percent of insured workers and their dependents face a general deductible.[7]

Among marketplace plans with deductibles, catastrophic plans averaged $6,577, silver plans $2,951, and platinum plans $574. For employer-based coverage, the average deductible in 2014 was $1,217—the equivalent of a gold plan obtained through a marketplace (Exhibit 4).

Although deductibles remained unchanged, on average, from 2014 to 2015, they dropped for gold and platinum plans by 7 and 14 percent, respectively, but rose slightly for plans under the

Exhibit 3

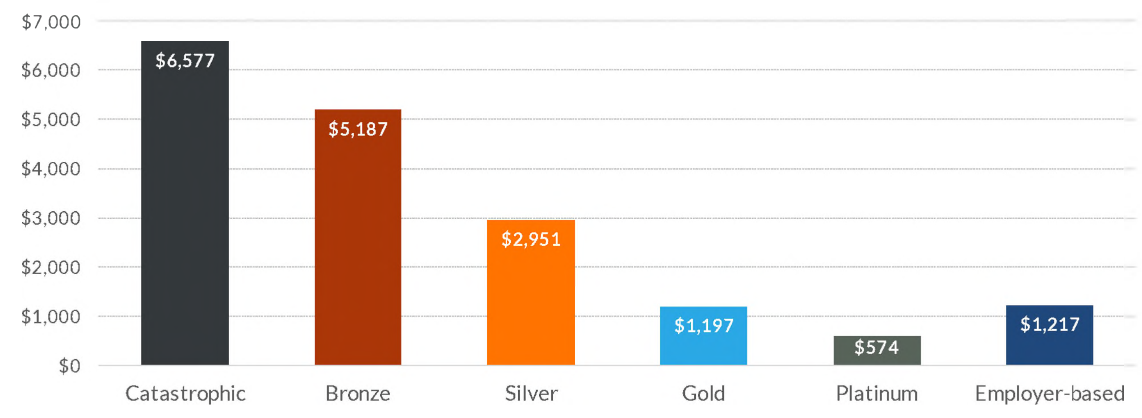
Percentage of Plans with General Deductible for Marketplace and Employer-Based Plans



Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

Exhibit 4

Average General Deductible for Marketplace and Employer-Based Plans (for plans with deductibles)

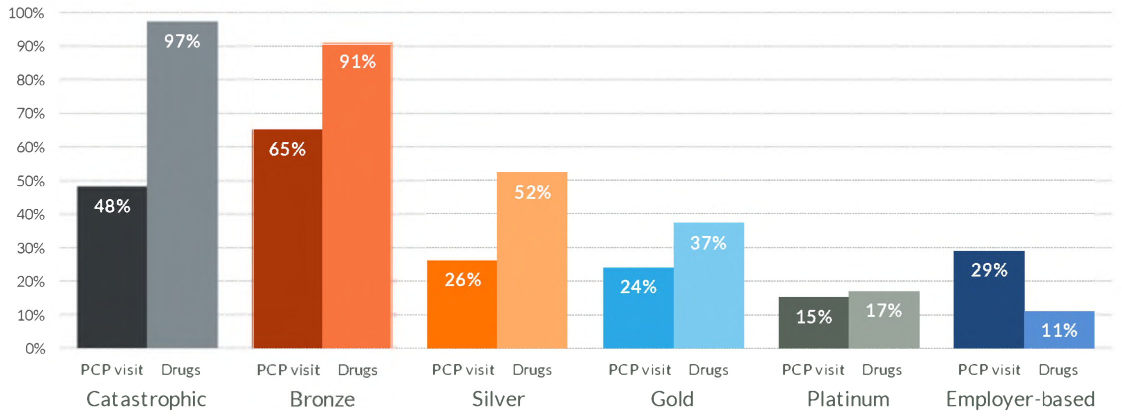


Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

lower-cost tiers: 4 percent for catastrophic plans, and 2 percent for bronze and silver plans. Insurers seem to have viewed purchasers of lower-cost plans as seeking low premiums, and purchasers of higher-cost plans as seeking low cost-sharing.

The share of enrollees who must meet a deductible before their plan pays for primary care office visits ranges from 48 percent for catastrophic plans, to 26 percent for silver plans, to 15 percent for platinum plans. Under employer-based coverage, some 29 percent of employees and dependents must meet a deductible before their plan pays for primary care visits[8] (Exhibit 5).

Exhibit 5



Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

The share of plans requiring enrollees to meet a deductible before prescription drug coverage begins ranges from 97 percent for catastrophic plans, to 52 percent for silver plans, to 17 percent for platinum plans. For employer-based plans, this figure is 11 percent[9] (Exhibit 5).

Of course, these figures vary from state to state. The states with the highest share of plans under which enrollees must meet a deductible before insurers pay for primary care visits include Maryland (100 percent of plans) Vermont (80 percent), Minnesota (63 percent), and Utah (61 percent). States with the lowest share of plans under which enrollees must meet a deductible before insurers pay for primary care visits are New Mexico (17 percent), Oklahoma and Kansas (22 percent), and Arkansas (26 percent).

For prescription drugs, states with the highest share of plans under which enrollees must meet a deductible are Maryland and Montana (100 percent), Arkansas (90 percent), and North Dakota and New Hampshire (88 percent). States with the lowest share of plans under which enrollees must meet a deductible are Hawaii (14 percent), Nevada (39 percent), and Rhode Island and West Virginia (40 percent).

Copayments and Coinsurance for Office Visits

Copayments require patients to pay a fixed fee such as $25 per visit regardless of the costs incurred related to that visit. Coinsurance obligates patients to pay a share of the cost—commonly 20 percent under employer-based coverage.

Coinsurance requires patients to assume greater financial risk for the cost of care, but provides greater incentive for them to monitor that cost. Under employer-based coverage, growing reliance on high-deductible health plans with options for tax-preferred savings to pay out-of-pocket medical expenses, and declining HMO enrollment, have spurred a slight increase in the use of coinsurance.[10]

Copayments are the major vehicle for cost-sharing for primary care and specialist office visits under marketplace plans. Enrollees in these plans contribute copayments nearly four times as often

as they pay coinsurance when visiting primary care clinicians, and three times as often when visiting specialists. The average copayment for primary care visits ranges from $39 under bronze plans to about $17 under platinum plans. The average copayment for such visits under all marketplace plans—28.64—is more than the average under employer-based plans ($24) (Exhibit 6).

Exhibit 6. Share of Plans Using Copayments and Coinsurance for Primary Care and Specialty Care, and Average Copayment and Coinsurance by Plan Tier, 2015

	Catastrophic	Bronze	Silver	Gold	Platinum	All marketplace plans	Employer-based
Primary care visit							
Use copayment	52.3%	38.7%	75.1%	82.5%	94.5%	66.4%	73%
Use coinsurance	0.4%	34.9%	15.3%	12.6%	3.3%	18.6%	18%
Average copayment	$34.83	$39.05	$30.39	$23.16	$17.24	$28.64	$24
Specialist care visit							
Use copayment	1.1%	31.9%	71.8%	81.2%	95.0%	60.0%	72%
Use coinsurance	1.6%	39.7%	18.3%	14.9%	3.4%	21.6%	71%
Average copayment	$63.69	$66.47	$57.66	$45.23	$31.24	$52.15	$36

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

Copayments for visits to specialty clinicians are higher, averaging $52, and range from $66 for bronze plans to $31 per visit for platinum plans. The average copayment for these visits is substantially higher than the $36 average under employer-based coverage (Exhibit 6).

Out-of-Pocket Limits

Out-of-pocket limits protect consumers from incurring catastrophic bills. From 2014 to 2015, out-of-pocket limits for marketplace plans declined by 1.7 percent (Exhibit 7). For households earning 250 percent or more of the federal poverty level, the Department of Health and Human Services raised out-of-pocket limits about 3.2 percent during that period.[11] Platinum plans saw the largest increase—4.3 percent—while catastrophic plans had the sharpest decline: –3.6 percent. In contrast, out-of-pocket limits increased on average in employer plans by 4.6 percent.

The out-of-pocket limit for all marketplace plans averaged $5,519 in 2015, and ranged from $6,581 for catastrophic plans to $5,866 for silver plans to $2,347 for platinum plans. Under employer-based coverage, the out-of-pocket limit averaged $3,409 (Exhibit 8).

Catastrophic plans have different cost-sharing provisions from those of other metal tiers. Under most catastrophic plans, the deductible and the out-of-pocket limit are the same dollar figure. When enrollees exceed this threshold amount, they do not pay for additional services.

Exhibit 7. Average Out-of-Pocket Limit by Plan Tier and Percentage Change, 2014–2015

Category	Catastrophic	Bronze	Silver	Gold	Platinum	All plans	Employer-based
2014	$6351.25	$6272.15	$5869.40	$4538.16	$2452.00	$5428.68	$3260*
2015	$6580.92	$6375.80	$5865.84	$4634.20	$2346.52	$5519.10	$3409
Percent change	–3.6%	–1.7%	0.1%	–2.1%	4.3%	–1.7%	4.6%

* Authors estimate from Kaiser Family Foundation, ***Employer Health Benefits: 2014 Annual Survey*** (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, ***Employer Health Benefits: 2014 Annual Survey*** (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

Exhibit 8

Average Out-of-Pocket Limit and Percentage Change, 2014–2015

$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$6,351 $6,581
$6,272 $6,376
$5,869 $5,866
$4,538 $4,634
$2,452 $2,346
$3,260 $3,409
2014 2015 Catastrophic
2014 2015 Bronze
2014 2015 Silver
2014 2015 Gold
2014 2015 Platinum
2014 2015 Employer-based*

* Authors' calculation.

Sources: Qualified health plan landscape files for federally facilitated marketplace, Nov. 2014; state insurance websites and marketplace websites.

Copayments and Coinsurance for Prescription Drugs

Copayments are the dominant form of cost-sharing for generic drugs, used by 69 percent of plans (Exhibit 9). For more expensive drugs, the use of copayments declines and the use of coinsurance increases. Some 62 percent of plans require copayments for preferred-brand drugs, 44 percent require them for nonpreferred drugs, and 14 percent require them for specialty drugs.[12] Comparable figures for employer-based plans are 85 percent for generics, 77 percent for preferred drugs, 73 percent for nonpreferred drugs, and 39 percent for specialty drugs.

Higher-tier marketplace plans require copayments more often than coinsurance. Some 53 percent of bronze plans, 78 percent of silver plans, 83 percent of gold plans, and 95 percent of platinum plans require copayments for generic drugs, while the share of higher-tier plans using coinsurance declines. The average copayment increases for more expensive drugs, rising from $13 for generics, to $44 for preferred-brand drugs, to $79 for nonpreferred drugs, to $142 for specialty drugs (Exhibit 10).

Exhibit 9. Share of Plans Using Copayments and Coinsurance for Generic, Preferred, Nonpreferred, and Specialty Drugs, 2015

Category	Catastrophic	Bronze	Silver	Gold	Platinum	All plans	Employer-based (2014)
Copayments, generic drugs	0.2%	53.0%	78.1%	82.5%	94.6%	68.5%	85%
Coinsurance, generic drugs	1.78%	25.3%	9.3%	5.5%	2.4%	12.1%	11%
Copayments, preferred-brand drugs	–	36.4%	74.0%	82.1%	96.5%	62.4%	77%
Coinsurance, preferred-brand drugs	1.8%	36.4%	18. 9%	14.7%	3.1%	20.8%	72%
Copayments, nonpreferred drugs	–	27.0%	46.9%	61.4%	79.9%	44.2%	73%
Coinsurance, nonpreferred drugs	1.45%	46.5%	41.7%	34.6%	19.5%	37.6%	25%
Copayments, specialty drugs	–	3.8%	17.2%	20.3%	29.2%	14.0%	39%
Coinsurance, specialty drugs	2.8%	68.9%	70.1%	74.2%	68.2%	66.8%	49%

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

Exhibit 10. Average Copayment for Generic, Preferred, Nonpreferred, and Specialty Drugs, 2015

Category	Catastrophic	Bronze	Silver	Gold	Platinum	All plans	Employer-based (2014)
Average copayment, generic drugs	$13.95	$19.03	$12.98	$11.00	$7.43	$13.22	$11
Average copayment, preferred-brand drugs	–	$60.59	$47.55	$37.07	$25.42	$44.11	$31
Average copayment, nonpreferred drugs	–	$102.34	$83.72	$72.61	$46.96	$78.66	$53
Average copayment, specialty drugs	–	$149.72	$163.09	$126.99	$107.25	$141.72	$83

Sources: Qualified health plan landscape file for federally facilitated marketplaces, Nov. 2014; state insurance websites and state marketplace websites for state-based marketplaces, Nov. 2014; Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2014).

As one would expect, the average copayment usually drops as the actuarial value of the tiers increases. For example, the average copayment for generic drugs is $19 for bronze plans, $13 for silver plans, $11 for gold plans, and $7 for platinum plans. Copayments under employer-based plans are considerably lower than under marketplace plans for all formulary tiers except generics.

OVERALL FINDINGS AND DISCUSSION

Our analysis shows that stable premiums from 2014 to 2015 do not reflect more cost-sharing. Overall, cost-sharing is greater under catastrophic, bronze, and silver plans than under employer-based coverage, while cost-sharing under the typical gold plan is roughly equivalent to that under employer-based coverage.

Silver plans—which account for 68 percent of marketplace enrollment—have daunting deductibles and out-of-pocket limits: $2,951 and $5,866, respectively. However, the majority of enrollees in silver plans qualify for and are enrolled in coverage with reduced cost-sharing.

For prescription drugs, marketplace plans lack the financial protection provided by employer-based plans. Some 91 percent of bronze plans, 52 percent of silver plans, and 37 percent of gold plans require enrollees to meet a deductible before receiving coverage for prescription drugs, compared with only 11 percent of enrollees with employer-based coverage. Out-of-pocket limits are also notably higher under marketplace plans than under employer-based plans. However, a majority of enrollees in marketplace plans—56 percent—obtain reduced cost-sharing.

States with their own health insurance exchanges—which account for 27.5 percent of all enrollees in marketplace plans—usually have lower shares of enrollees with reduced cost-sharing than states that rely on the federal exchange. Most of the former have expanded Medicaid, while most of the latter have not. States with their own exchanges also tend to have higher per capita income than states that rely on the federal exchange. The result is that a much greater share of insured residents in the federal marketplace states who earn 100 percent to 138 percent of the federal poverty level are enrolled in marketplace plans rather than Medicaid.

Low-income households—those earning 100 percent to 250 percent of the federal poverty level—rate their coverage more highly than moderate-income households: those earning more than 250 percent of the federal poverty level. Some 70 percent of low-income households rate their coverage as "excellent," very good," or "good," while 20 percent rate it "poor" or "fair." Comparable figures for moderate-income households are 64 and 27 percent, respectively.[13] Reduced cost-sharing for low-income households may be a major factor in this disparity.

ABOUT THIS STUDY

We analyzed data on 2,964 plans offered in 2014 and 4,153 offered in 2015 in 49 states and Washington, D.C. Data on plans in states that rely on the federal exchange are from Qualified Health Plan Landscape Files maintained by the Centers for Medicare and Medicaid Services. Data from states with their own exchanges are from marketplace websites maintained by state departments of insurance.

Within each state, we downloaded data from all carriers and plans within three "rating areas," which all insurers must use to set their rates: one urban, one suburban, and one rural. Weights reflect the probability that we would have selected the rating area from among the sample, as well as the population of the rating area. We designated statistical significance when $p<.05$.

NOTES

1. J. P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

2. J. Gabel, H. Whitmore, S. Stromberg, M. Green, D. Weinstein, R. Oran, "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *The Commonwealth Fund Blog,* Dec. 22, 2014.

3. Centers for Medicare and Medicaid Services, "June 30, 2015 Effectuated Enrollment Snapshot" (Washington, D.C.: CMS, Sept. 8, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html.

4. J. Gabel, R. Lore, R. McDevitt et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs* Web First, May 23, 2012.

5. Silver plans have an actuarial value of 0.7, meaning that the plan will cover about 70 percent of the medical costs of a large standard population. Gold plans have an actuarial value of about 0.8, while platinum plans have an actuarial value of 0.9.

6. The U.S. Department of Health and Human Services raised out-of-pocket limits about 3.2 percent from 2014 to 2015. To achieve the actuarial targets for each metal tier, many insurers also raised the out-of-pocket limit.

7. Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif., Henry J. Kaiser Family Foundation, 2014), http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report.

8. Authors' calculation from Kaiser Family Foundation, *Employer Health Benefits, 2014 Annual Survey.*

9. Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif., Henry J. Kaiser Family Foundation, 2014), http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report.

10. Kaiser Family Foundation, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif., Henry J. Kaiser Family Foundation, 2014), http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report.

11. Out-of-pocket limits increased by $250 for single coverage (from $6,350 to $6,600) and $500 for family coverage (from $12,700 to $13,200) from 2014 to 2015.

12. Preferred drugs are drugs for which generic equivalents are not available. They have been on the market for a while, are widely accepted, and are on the plan's formulary. The insurer has typically negotiated discounts with the supplier. Nonpreferred drugs are not on the formulary and the plan has not negotiated discounts. Nonpreferred drugs are typically higher-cost medications that have recently come on the market. Specialty drugs are structurally complex and typically priced much higher than traditional drugs, and often require special handling or delivery.

13. P. W. Rasmussen, S. R. Collins, M. M. Doty, and S. Beutel, *Are Americans Finding Affordable Coverage in the Health Insurance Marketplaces?* (New York: The Commonwealth Fund, Sept. 2014).

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Improving and Expanding Health Insurance Coverage through State Flexibility

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REPORT

This report was produced by BPC staff, under the leadership of former Senate Majority Leader Tom Daschle and former House Speaker Newt Gingrich, in collaboration with a distinguished group of senior advisers and experts. BPC would like to thank Sheila Burke, Stuart Butler, Chris Jennings, Sean Kennedy, and Timothy Westmoreland, who shaped and strengthened the content of this paper by providing substantial feedback, support, and direction. BPC thanks our leaders on this report, former Senate Majority Leader Tom Daschle and former House Speaker Newt Gingrich, for their guidance and feedback.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

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Introduction

Recommendations

1. Advance new and innovative approaches to health insurance coverage by convening governors and the secretaries of Health and Human Services and Treasury to seek agreement on a reasonable interpretation of “guardrails” for Section 1332 State Innovation Waivers. The secretaries should issue guidance based on those convenings.
2. Define the guardrail requiring federal deficit neutrality to permit the requirement to be applied across programs waived (i.e., tax-credits and Medicaid), to demonstrate neutrality over the entire term of the waiver, and require strong standards to assure federal deficit neutrality.
3. Improve consumer choice and competition in insurance markets by implementing federal law permitting states to form interstate compacts to sell insurance across state lines (Section 1333 of the Affordable Care Act).
4. Assure access to affordable coverage for spouses and children by fixing the so-called “family glitch” and fully offsetting the cost at the federal level.

The Affordable Care Act (ACA) has been the subject of controversy since its enactment in March 2010. Over the past six years, the ACA has faced legal challenges, problems with its first open-enrollment period, votes to repeal or defund the law in whole or in part, and opposition by many state legislatures and governors. Further, polls continue to show deep divisions in public opinion on the law.[i]

Despite the controversy, an additional 13.2 million individuals have enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[1] Some of the new enrollment is the result of states expanding coverage to "newly eligible" individuals; however, many were previously eligible but not enrolled.[2] Further, an estimated 8.3 million individuals purchasing health insurance coverage through state and federal health insurance exchanges received federal financial assistance in the form of tax credits or cost-sharing assistance.[3]

Although dozens of bipartisan changes to the ACA have been enacted since the ACA was signed into law,[4] most have been clarifying amendments, or changes designed to provide offsets for other legislation, such as extensions of expiring Medicare provisions.[5] Some changes have been more substantive. For example, in 2011, Congress passed legislation and the president signed into law, a repeal of business reporting requirements to the Internal Revenue Service (IRS).[6] In October 2015, a law was enacted to block implementation of a provision combining small- and mid-sized employers into a single insurance market.[7] Business and insurance industry experts estimated the combining of these two employers would have resulted in insurance premium increases for both groups of employers.[8] The prospects for repeal or major modifications to the law are slim before a new president and Congress take office in January 2017. There remain in addition, however, important opportunities to influence policymaking at the agencies and to focus on the states as a frontier for innovation and reforms in health care.

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[i] RWJF Tracking of the ACA, September 2015: 45 percent unfavorable, 41 percent favorable. Question: "As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?"

Opportunities for State Flexibility using State Innovation Waivers

The Bipartisan Policy Center's (BPC) health leaders agree on several principles, including the importance of: (1) expanding coverage to the uninsured; (2) reducing health care costs; and (3) improving the quality of health care delivery. Achieving these goals will require changes in the law. Given the ongoing discord, BPC's leaders encourage dialogue among federal and state policymakers to identify opportunities to maintain and expand coverage, simplify administration, and provide increased choice to families and individuals through increased state flexibility.

Significant opportunities (and limitations) to advance this dialogue lie with the ACA itself. Section 1332 of the ACA, based on a provision in bipartisan legislation offered by Senators Ron Wyden (D-OR) and Bob Bennett (R-UT),[9] permits states to test alternative means of providing coverage while upholding the principles of expanding coverage, reducing costs, and improving quality of care.

This paper outlines Section 1332 of the ACA, including its opportunities and limitations. This paper also discusses the potential of 1332 and its interactions with Section 1115 of the Social Security Act (SSA), a wavier authority that allows states to expand Medicaid coverage with certain restrictions, and Section 1115A, which offers opportunities for delivery system reform. This paper describes BPC leaders' recommendations on the implementation of Section 1332 and other provisions of the ACA that are designed to make health insurance more affordable and to improve consumer choice in health plans, such as the implementation of laws permitting interstate compacts to improve choice in health insurance plans and fixing the "family glitch." These proposals are outlined in the following pages.

Overview of State Innovation Waivers (Section 1332)

Beginning in 2017, states will have the opportunity to test alternative health insurance coverage models through State Innovation Waivers, authorized under Section 1332 of the ACA. Section 1332 gives states the opportunity to redesign health care delivery by permitting states to request waivers of certain provisions of law related to the structure of health insurance markets. These waivers must adhere to four constraints, or "guardrails," required by the law. Section 1332 was included in the Senate Finance Committee chairman's mark, which was considered and reported by the Finance Committee. Citing his home state of Oregon, Senator Wyden indicated that innovation in health care typically comes from the states, and the provision was designed to encourage and support that innovation.[10]

Although the waiver offers states broad discretion in reforming their health care delivery systems, the statute also requires that a state's suggested reforms meet certain requirements or guardrails, which include:

- Providing coverage that is at least as comprehensive as the Essential Health Benefits package;
- Providing coverage and cost-sharing protections that are at least as affordable as under current law;
- Providing coverage to at least a comparable number of residents; and
- Not increasing the federal deficit.[11]

The secretaries of Health and Human Services (HHS) and Treasury released a final rule governing the application process under

Section 1332 on February 27, 2012; however, the rule did not address how the guardrails would be interpreted.[12]

States may submit applications for waiver authority provided under Section 1332 along with waivers available under Medicare, Medicaid, and CHIP, and any other federal law providing health care items or services.[13] Although waivers may be combined, Section 1332 does not change existing waiver authorities. For example, should a state choose to submit a single application combining a Section 1332 waiver with a Medicaid waiver using authority under Section 1115 of the Social Security Act, existing requirements under Section 1115 would apply.

Under the law, states would have access to the same amount of revenue that would otherwise have been available to residents of the state in the form of small-business tax credits, premium tax credits, and cost-sharing assistance. Each year, the HHS secretary would determine the aggregate amount of those subsidies, and those amounts would be available to the state.[14]

According to some policy analysts, Section 1332 has the potential to be a significant and unpredictable game-changer of federal and state health care policy, a "super waiver" for states to explore new frontiers.[15] Section 1332 offers an enormous amount of technical and political opportunity to bridge the divide over major provisions of the ACA.[16] However, other analysts argue that Section 1332 is not broad enough, that the states will need to enact more substantial changes than the waiver permits, and that it does not allow states to waive some of the ACA's more costly requirements.[17]

In recent months, a number of states have begun considering options under the law. Among the ideas are ways to increase enrollment to promote sustainability in the individual insurance market, streamlining the operations of state-based insurance marketplaces, and considering how to mitigate the impact of premium and cost-sharing requirements for lower-income populations.[18]

When combined with other waiver authorities, states could have significant flexibility to test new ways to provide access to quality health care to their residents. Whether Section 1332 provides sufficient flexibility or is too restrictive remains to be seen and will depend on how the guardrails are interpreted by federal agencies. Implementation of Section 1332 will require an open dialogue between states and the federal government, a willingness to consider new ideas, and leadership at both the state and federal levels.

Provisions Subject to State Innovation Waiver

Section 1332 permits waiver of the following provisions:

1. Qualified Health Plan (QHP) Requirements [19]

QHPs must meet certain requirements to be offered through the state or federal health insurance exchange (now marketplace). Under current law, QHPs must:

- Be certified or recognized by each exchange through which the plan is offered;
- Provide essential health benefits;
- Be offered by an insurer licensed in each state in which the plan is offered;
- Must be offered at the silver level and the gold level in each exchange the QHP issuer offers coverage;
- Charge the same premium rate whether offered through the exchange or outside the exchange.[20]

2. Essential Health Benefits (EHB)

Non-grandfathered plans in the individual and small-group markets both inside and outside of the marketplaces must include the ten statutorily defined EHB, which include:

- Ambulatory patient services;

- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance-use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.[21]

In defining the benefits, the HHS secretary must meet a series of requirements relating to the scope of benefits, balance among categories of benefits, non-discrimination provisions, and other requirements.[22] In addition, the law sets requirements relating to annual limits on cost-sharing and on deductibles for employer-sponsored plans, establishes levels of benefits (i.e., bronze, silver, gold, and platinum), and permits the purchase of catastrophic health insurance plans for certain populations.[23]

Under federal regulation, states may define EHB by choosing one of the following four types of health plans (at least through plan year 2017):

- The largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program plan options by enrollment; or
- The largest insured commercial non-Medicaid Health Maintenance Organization operating in the state.[24]

3. Rules Governing Health Insurance Exchanges

The ACA sets forth criteria for the establishment of health insurance exchanges and related exchange functions. The HHS secretary established criteria for certification of health plans as QHPs such as:

- Meet marketing requirements;
- Ensure a sufficient choice of providers;
- Include within plan networks essential community providers that serve predominately low-income medically underserved individuals;
- Meet quality and data requirements, including those regarding pediatric quality;
- Be accredited by the secretary;
- Use standard enrollment forms;
- Use standard format for health plan options; and
- Provide information to enrollees and prospective enrollees and the exchange on certain quality measures.[25]

4. Reduced Cost-Sharing for Individuals Enrolling in QHPs[26]

QHPs must reduce cost-sharing for lower-income individuals enrolled in a silver-level qualified health plan by reducing out-of-pocket spending limits and by decreasing the cost-sharing amounts.

For eligible individuals with incomes between 100 and 250 percent of poverty, the out-of-pocket cost-sharing limit for in-network coverage of EHB is reduced as follows:

- 100–200 percent of FPL: 2/3 reduction
- 201–250 percent of FPL: 1/5 reduction
- 251 percent of FPL and above: No reduction[27]

Plans must also increase the actuarial value of plans for certain populations adjusted by family size:

- 94 percent for individuals with incomes from 100–150 percent of FPL;
- 87 percent for individuals with incomes from 151–200 percent of FPL; and
- 73 percent for individuals with incomes from 201–250 percent of FPL.

5. Premium Tax Credits[28]

Premium tax credits are available to taxpayers (1) with household incomes between 100 percent and 400 percent of the FPL ($11,670–$46,680 for an individual in 2015); (2) who may not be claimed as a dependent by another taxpayer; (3) who purchase coverage through the marketplace; and (4) who are unable to get affordable coverage through employment or through government programs.[29]

The premium tax credit is calculated using the amount the individual should be able to pay for the premium of the second-lowest priced silver plan available to each member of the household (the "benchmark plan"). The expected contribution, adjusted annually after 2014, is calculated as a percentage of the individual's household income as follows for taxable years starting in 2015:

- Less than 133 percent of FPL: 2.01 percent
- At least 133 but less than 150 percent of FPL: 3.02–4.02 percent
- At least 150 but less than 200 percent of FPL: 4.02–6.34 percent
- At least 200 but less than 250 percent of FPL: 6.34–8.10 percent
- At least 250 but less than 300 percent of FPL: 8.10–9.56 percent
- 300 to 400 percent of FPL: 9.56 percent[30]

Eligible individuals may choose to have the tax credit paid directly to their insurer in advance so that monthly premiums are lowered, or the eligible individual can claim the credit when the eligible taxpayers files their tax return for the year. If the individual chooses to have the tax credit paid in advance, the amount of the tax credit will be reconciled when they file their tax return.[31]

6. Employer Requirement[32]

The ACA requires large employers to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or pay a penalty. Large employers are those with at least 50 full-time employees (including full-time equivalents) during the preceding year. For 2015, large employers are defined as those with at least 100 full-time employees. Employers with 50–99 full-time employees (including full-time equivalents) have until 2016 to comply.[33] Employers must pay a penalty if at least one full-time employee receives a premium tax credit or cost-sharing reduction.

7. Individual Requirement[34]

Beginning in 2014, the ACA requires that most individuals obtain minimum essential coverage for themselves and their dependents or pay a penalty.[35] Minimum essential coverage is generally defined as government-sponsored or private health insurance. The penalty is the greater of a percentage of the individual's household income that exceeds the tax-filing threshold for that tax year or a flat-dollar amount.[36] The percentage of household income is 2 percent for 2015 but increases to 2.5 percent for 2016 and beyond, and the flat-dollar amount increases each year from $325 in 2015 to $695 in 2016. So, for example, in 2015, the penalty would be the greater of 2 percent of yearly household income (only above $10,150 for an individual) or $325 per person ($162.50 per child under 18).

The maximum penalty per family, however, cannot be more than the cost of the national average bronze-level plan (for the relevant family size) offered through the marketplaces.

There are certain individuals who are exempt from the mandate:

- Members of a recognized religious sect who are conscientiously opposed to medical care;
- Members of a health care sharing ministry;
- Individuals who are incarcerated; and
- Individuals who are not lawfully present.

Other individuals who are subject to the mandate but exempt from the penalty:

- Individuals who cannot afford coverage (self-only coverage contribution exceeds 8.05 percent of household income);
- Individuals who have household income less than the filing threshold for federal income taxes;
- Members of Indian tribes;
- Individuals who lose coverage for less than three months;
- Individuals who the HHS secretary determines have suffered a hardship (these individuals are eligible for catastrophic coverage).[38] HHS has identified some hardships, including individuals that are not eligible for Medicaid because their state did not opt to expand the Medicaid program.[39]

Individuals will report whether they have maintained minimal essential coverage annually on their federal income tax returns. In addition, every entity that provides minimum essential coverage must present a return to the IRS as well as a statement to the individual covered.[40]

Provisions That May Not Be Waived

Other than provisions expressly listed under Section 1332 as subject to waiver, no other provisions of the ACA may be waived as part of the Waivers for State Innovation. For example, states would not be able to waive the following private insurance market reforms:

- Prohibiting plans from imposing preexisting-condition exclusions;
- Prohibiting plans from varying premiums within a rating area except for family size, age, and tobacco use. Age variation is limited to 3:1 and tobacco use by 5:1;
- Requiring plans to guarantee issue and guarantee renewal of policies;
- Prohibiting discrimination based on health status;
- Requiring coverage of EHB in the individual and small-group market[ii]; and
- Limiting waiting periods to no longer than 90 days.

The inability of states to waive insurance market reforms, have led some analysts to conclude that states will have difficulty maintaining stable insurance markets, while at the same time waiving some of the more controversial aspects of the law. For example, if a state would like to develop an approach that eliminated the individual requirement to purchase insurance coverage and, instead, implement a late-enrollment penalty similar to the structure applied in Medicare parts B and D, the inability to waive premium-rating requirements would likely prevent states from implementing the penalty.

[ii] ACA Section 1201 amended the Public Health Service Act by adding section 2707, which applies the EHB requirement in ACA section 1302(a) (which is subject to a 1332 waiver) to all insurers in the individual or small-group market, both inside and outside the marketplace.

Opportunities for State Flexibility using Waiver Authority under the Social Security Act

States may combine the application process for State Innovation Waivers (Section 1332) with the processes of any existing health program waiver authority such as Medicaid waivers using Section 1115 of Social Security Act (SSA) or models tested through the Center for Medicare and Medicaid Innovation (CMMI) (Section 1115A of SSA). Medicaid waivers under Section 1115 are one of the most likely candidates to be included in a combined application with Section 1332. States have commonly utilized research and demonstration authority under Section 1115 of the SSA to expand Medicaid eligibility and to make other changes to state Medicaid programs. Section 1115 permits waivers of health and welfare programs authorized under the SSA, including Medicaid and CHIP.[41] A research and demonstration waiver under Section 1115 must further the goals of the program in order to be approved by the secretary. Upon approval, states may use funds for purposes not otherwise permissible under the law, such as covering individuals not traditionally eligible for Medicaid.[42] Section 1115 permits states to seek waivers of Section 1902 of the Medicaid program, which establishes federal requirements for a state plan for medical assistance, such as eligibility, benefits, payments to providers, enrollment requirements, fair hearings, program administration requirements, and other provisions.[43]

Historically, the secretary of HHS has required 1115 waivers to be budget neutral; however, this is not required by statute or by regulation. Some states have used Section 1115 of the SSA to improve the scope of benefits or to expand eligibility to individuals who would not otherwise qualify, while others have used Section 1115 to limit eligibility or benefits, such as providing a limited set

Figure 1. *Current Status of State Medicaid Expansion Decisions*

ADOPTED (31 States including DC) | ADOPTION UNDER DISCUSSION (1 State) | NOT ADOPTING AT THIS TIME (19 States)

*Notes: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.*

Source: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 1, 2015. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

of benefits, setting limits on enrollment, or seeking changes in beneficiary cost-sharing.[44]

Since the Supreme Court ruling in NFIB v. Sebelius,[45] which essentially made the ACA provision expanding Medicaid coverage to individuals with incomes up to 138 percent of the FPL optional for states, Section 1115 has become a means of permitting states that chose not to expand Medicaid under the ACA to provide coverage to certain low-income populations. Likewise, some states have used Section 1115 waivers to make changes to impose premiums and cost-sharing. Currently 30 states and the District of Columbia have expanded Medicaid coverage, either by a state plan amendment or through Section 1115.[46]

The ACA added a new section 1115A under the SSA, creating the CMMI to test new models of health care delivery and reimbursement. A number of states have included delivery system reforms in new demonstrations.[47] CMMI has the authority to "test innovative payment and service delivery models to reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care furnished to individuals under such titles."[48]

Although 1115A provides broad authority to CMMI to test innovative delivery models, the law directs the HHS secretary to "give preference to models that also improve the coordination, quality, and efficiency" of care for Medicare beneficiaries, Medicaid beneficiaries, and dual eligibles.[49] The law cites a number of

delivery models, including accountable care organizations and patient-centered medical homes, among others.[50]

A number of states have expressed interest in testing new models of care. And a number of states have actively begun testing new models of health care delivery under Section 1115A.[51] Arkansas, for example has begun implementation of a patient-centered medical home model through the Center for Medicare and Medicaid Services (CMS) State Innovation Models Initiative. Among the states awarded funding to test models in the initial round are Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont.[52] These and similar waivers will likely be used in combination with Section 1332 waivers to test new reimbursement models.

Recommendations

Recommendation 1:

Advance new and innovative approaches to health insurance coverage by convening governors and the secretaries of Health and Human Services and Treasury to seek agreement on a reasonable interpretation of "guardrails" for Section 1332 State Innovation Waivers. The secretaries should issue guidance based on those convenings.

States' ability to use Section 1332 depends largely on how the four guardrails are interpreted by the secretaries of HHS and Treasury, as well as the director of the Office of Management and Budget. States need clear guidelines. Governors play an integral part in the implementation of a state's health care delivery system and health care budget. Their expertise should be used to negotiate how the guardrails are defined to accomplish the goals of the ACA while still allowing states the flexibility to reform their health care systems to fit the needs of their citizens while maintaining fiscal viability. Guardrails should be interpreted to foster state innovation, permitting new approaches to health insurance coverage that can be adopted by other states or applied at the federal level. Toward that end, the secretaries of HHS and Treasury should convene discussions with governors to negotiate and define guardrails, and the secretaries should issue regulations based on that convening.

Recommendation 2:

Define the guardrail requiring federal deficit neutrality to permit the requirement to be applied across programs waived (i.e., tax-credits and Medicaid), to demonstrate neutrality over the entire term of the waiver, and require strong standards to assure federal deficit neutrality.

As part of the negotiations between federal and state officials, the guardrails should be designed in a way that permits flexibility for states in designing alternative health insurance and delivery models, while also assuring that those models do not add to the federal deficit. Strong safeguards should assure federal deficit neutrality. At the same time, deficit neutrality should be applied across the provisions of law that have been waived. For example, if the state seeks to combine 1115 waivers and Section 1332 waivers in a single waiver request, the impact on the federal deficit should be calculated across these programs instead of individually within each program.

Calculating budget neutrality across programs gives states the flexibility to be creative in designing proposals to provide high-quality health care coverage to their residents while still maintaining fiscal responsibility. In doing so, the secretary and the state should ensure that such coordinated calculations and proposals assure full and appropriate health coverage to the state's lower-income citizens before moving to assist those with higher incomes. Similar to existing 1115 waivers, for the purposes of determining impact on the deficit, the secretary should assume that the state expanded Medicaid pursuant to the ACA, provided the state covers these individuals in the waiver. Deficit neutrality should be calculated over the full five-year term of the waiver rather than on a yearly basis to permit states to make necessary investments in infrastructure and to address unmet needs of currently eligible individuals, including those with mental illness.

Recommendation 3:

Improve consumer choice and competition in insurance markets by implementing federal law permitting states to form interstate compacts to sell insurance across state lines (Section 1333 of the ACA).

At least 22 state legislatures have considered permitting the sale of insurance across state boundaries to increase competition and coverage options, but only six have enacted legislation.[53] Those states include Rhode Island, Washington, Wyoming (prior to passage of the ACA), Georgia, Kentucky, and Maine.[54]

Section 1333(a) permits two or more states to form health care choice interstate compacts in which the states enter into an agreement under which qualified health plans could be offered in all participating states' individual markets, subject to regulation by the state in which the plan was written or issued. Insurers will be subject to the market conduct, unfair trade practices, network adequacy, consumer protection, and dispute-resolution standards of any state in which the insurance was sold; must be licensed in each state; and must notify consumers that the insurer is not otherwise subject to the laws of the selling state.[55]

States should have the option of permitting the sale of insurance across state lines. This is especially important in states with rural or frontier areas in which residents have limited choices. Recent consolidation in the insurance industry has the potential to further limit those choices. This policy, however should assure that state insurance commissioners have the ability to enforce regulations and contracts between carriers, employers, and plan enrollees in their states.

Section 1333 required the secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), to issue regulations regarding health care choice compacts by

July 1, 2013. No such regulations have been issued and these compacts are scheduled to take effect beginning January 1, 2016. The secretary should work with NAIC to create regulations that establish standards and best practices as well as oversight of these interstate compacts.

Recommendation 4:

Assure access to affordable coverage for spouses and children by fixing the so-called "family glitch" and fully offsetting the cost at the federal level.

Under the ACA, individuals with access to employer-sponsored health insurance are not eligible for premium and cost-sharing subsidies to purchase health insurance coverage through the state or federal marketplaces. An exception applies if the employer's coverage is not "affordable." A premium is affordable under the ACA if the premium cost to the employee is less than a specific percentage of the employee's household income, currently 9.56 percent. The affordability test is based on the cost of the premium for only *individual* coverage not for that of *family* coverage. Under this interpretation, no family member qualifies for federal subsidies through an exchange, even if the cost of family coverage exceeds 9.56 percent of the family's income, resulting in what is known as the "family glitch." Congress should address this issue to assure that spouses and children of workers have access to affordable coverage.

Estimates of the number of family members affected by the family glitch vary between two to four million.[56] Those adults most affected would be workers in the lowest 25 percent wage category, as they typically pay a higher portion of their income to obtain employer-sponsored coverage than those workers in the highest 25 percent wage category.[57] The number of people affected would be higher in those states that have not expanded Medicaid through the ACA's expansion option because families with incomes between 100 and 138 percent of FPL will not have access to Medicaid if they fall in the glitch.[58] The cost of addressing the family glitch should be offset at the federal level.

Conclusion

Controversy around the enactment, implementation, and repeal of the ACA will continue in the near-term and could continue well into the next decade. The use of Section 1332, which is designed to permit states the flexibility to implement alternatives, has the potential to allow states to expand coverage, make health insurance more affordable, and improve consumer choice in health plans. The ability of states to effectively utilize this option will depend on the interpretation of this Section by federal policymakers.

Changes should be made to improve the availability and affordability of health insurance. Allowing states to form interstate compacts has the potential to increase choice of plans, while at the same time assuring state insurance commissioners have the ability to enforce state insurance laws. Likewise, fixing the family glitch will permit greater access to affordable coverage through state and federal marketplaces, if coverage offered to the employed spouse or parent is unaffordable. Policymakers should acknowledge the tremendous variation in health care delivery that can work from state to state, and Section 1332 can serve as a critical tool in allowing states to test alternatives. Lessons learned may ultimately lead to additional bipartisan modifications to the law. The ACA should permit variation consistent with the principle that individuals should have access to meaningful, quality, and affordable health insurance coverage.

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How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Incomes?

Linda J. Blumberg, John Holahan, and Matthew Buettgens

Timely Analysis of Immediate Health Policy Issues

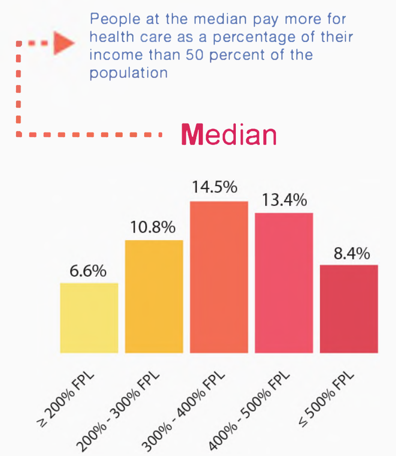
DECEMBER 2015

In-Brief

The Affordable Care Act (ACA) improved health insurance affordability for many by expanding Medicaid and providing financial assistance for marketplace-based coverage for those with incomes below 400 percent of the federal poverty level (FPL). Together with new insurance regulations and a requirement for many to enroll in coverage or pay a penalty, these affordability provisions were intended to substantially reduce the number of uninsured. In recent months, however, an increasing number of voices have drawn attention to high deductibles and out-of-pocket costs and the affordability of marketplace insurance in general. While the "right" or "just" level of health care financial burdens is inherently subjective, financial burdens that are high relative to income can lower enrollment levels and compromise the ability of the ACA to reach its goals.

In this paper, we examine premiums and out-of-pocket costs, as well as total financial burdens for individuals with different characteristics enrolled in ACA-compliant nongroup coverage. We show that despite the additional assistance available, individuals across the income distribution who are ineligible for Medicaid can still face very high expenditures. At the median, financial burdens can be reasonably high, particularly for those with incomes between 300 and 400 percent of FPL (Figure 1). As medical care needs increase, however, financial burdens grow appreciably across the income distribution. Even with federal financial assistance, 10 percent of 2016 nongroup marketplace enrollees with incomes below 200 percent of FPL will pay at least 18.5 percent of their income toward premiums and out-of-pocket medical costs. Ten percent of marketplace enrollees with incomes between 200 and 500 percent of FPL will spend more than 21 percent of their income on health care costs. Those in fair or poor health and those over age 45 are most likely to face high median financial burdens. We conclude that the affordability of marketplace premiums and out-of-pocket limits need to be further addressed to reduce the risk that enrollment and reductions in the number of uninsured will be well below the law's objectives.

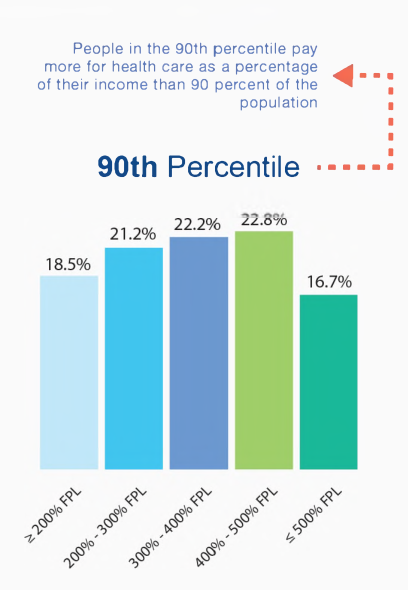
Household Spending on Premiums & Out-of-Pocket Expenses by Marketplace Enrollees, Relative to Income



The percentage of non elderly adults who report problems paying their medical bills in the previous year fell from 22.0 percent in 2013 to 17.3 percent in 2015 -- representing a significant improvement in affordability.[2] Despite this, affordability remains an issue.

Federal Poverty Level amounts used for this analysis:

Single person - $11,770
2 person family - $15,930



Source: *The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015*

Note: *Sample includes those individuals and families with incomes below 400 percent of the FPL enrolling in nongroup marketplace coverage with a premium tax credit and all those with incomes above 400 percent of the FPL buying nongroup coverage either inside or outside the marketplaces in 2016. ACA is simulated as fully phased-in in 2016. Financial burdens are calculated at the family (health insurance unit) level, i.e., family health expenses relative to family income.*

Introduction

Since the implementation of the ACA's coverage reforms, insurance coverage among nonelderly adults has increased by 15 million people, or 42.5 percent (comparing September 2013 with March 2015).[1] During that same period, the share of nonelderly adults who reported having problems paying their medical bills in the previous year fell from 22.0 percent to 17.3 percent.[2] This decrease in financial hardship, a 21 percent decline, represents a significant improvement in affordability. But with over 17 percent of nonelderly adults continuing to report challenges paying their families' medical bills, affordability remains an issue; it is central to concerns that further marketplace enrollment gains will be increasingly difficult.

The ACA has expanded insurance coverage through several mechanisms, chief among them an expansion of Medicaid coverage (taken up in 30 states and Washington, D.C.) and income-related premium tax credits and cost-sharing reductions for the purchase of private nongroup health insurance through health insurance marketplaces. Those eligible for Medicaid have the most affordable insurance available to them, facing no premiums[3] and little or no cost-sharing requirements to impinge their access to services. And although the tax credits and cost-sharing reductions have significantly improved affordable access to care for many, some still face substantial medical financial burdens. While it is impossible to know the "right" amount for people to pay at each income level, we do know that affordability is the most common reason given for those remaining uninsured. It is the most frequent response given by navigators, concerning remaining barriers to enrollment in the ACA's qualified health plans.[4]

Recent reports suggest that many individuals eligible for financial assistance remain uninsured because the cost of available plans is still too high, particularly at income levels where tax credits and cost-sharing reductions are phased out. Buettgens, Kenney, and Pan find that take-up rates among the tax credit–eligible population decline sharply with income.[5] Nationally, plan selection rates in 2015 among states whose marketplaces used HealthCare.gov averaged 62 percent of eligible individuals with incomes below 200 percent of FPL, 29 percent of those eligible with incomes between 200 and 300 percent of FPL, and 13 percent of those eligible with incomes between 300 and 400 percent of FPL. Thus, as financial assistance falls and income increases, the share of eligible individuals enrolling in coverage drops precipitously.

This analysis assesses (1) the health care financial burdens facing the modest-income population enrolling in marketplace coverage using federal financial assistance (those with incomes below 400 percent of FPL) as well as (2) the health care financial burdens facing higher-income individuals and families who are purchasing qualified health plans in the nongroup market entirely with their own funds. We define health care financial burdens in this analysis as direct household payments for premiums and out-of-pocket requirements for the family (e.g., deductibles, co-payments, coinsurance) relative to family income.[6] We provide financial burdens at the median and at the 90th percentile for those enrolled in nongroup insurance plans with tax credits and for those with higher family incomes (above 400 percent of FPL) in the nongroup market both inside and outside the marketplaces. We simulate the ACA as if it were fully phased-in in 2016.

What Financial Assistance Is Currently Available for the Purchase of Marketplace-Based Coverage?

To assess the health care financial burdens of those enrolling in marketplace-based coverage, we must take the available financial assistance into account. Those eligible for financial assistance through the ACA's nongroup marketplaces have the following characteristics:

- They have incomes below 400 percent of FPL but are not eligible for Medicaid or Medicare. In states that have expanded Medicaid, those with incomes between 138 and 400 percent of FPL are potentially eligible for tax credits; in states that have not expanded Medicaid, those with incomes between 100 and 400 percent of FPL are potentially eligible.[7]
- They do not have access to an employer-sponsored insurance offer (either through their own employer or a family member's) that the law deems adequate and affordable.
- They are legal residents.

Those who meet such criteria are eligible for advanced premium tax credits, and those below 250 percent of FPL are also eligible for cost-sharing reductions. The premium and cost-sharing financial assistance at each income level are summarized in Table 1. Those with family income below 138 percent of FPL are required to pay no more than 2.03 percent of income in 2016 toward the premium for the second-lowest-cost silver plan available to them in their marketplace.[8] The maximum required contribution increases rapidly as the percentage of income relative to FPL rises, increasing to 6.41 percent of family income at 200 percent of FPL. Maximum premium contributions increase to 8.18 percent of income at 250 percent of FPL and 9.66 percent of income at 300 percent of FPL. Those between 300 and 400 percent of FPL pay a maximum of 9.66 percent of family income for the second-lowest-cost silver plan available to them. Those who pick a less expensive plan pay less; those who pick a more expensive plan pay more. The caps on percentage of income consumers pay increase each year if medical costs grow faster than the consumer price index. Those with incomes above 400 percent of FPL receive no premium assistance for marketplace coverage.

Cost-sharing reductions (CSRs) are also available for those receiving premium tax credits who have incomes below 250 percent of FPL. To receive a CSR, eligible individuals must purchase a

Table 1. Premium Tax Credit Caps as a Percentage of Income and Cost-Sharing Reductions Under the ACA, 2016

Income Relative to Federal Poverty Level (% of FPL)	Premium Tax Credit Schedule: Household Premium as Percentage of Income for the Applicable Income Category[a]	Cost-Sharing Reduction Schedule: Actuarial Value Level of Plan Provided to Eligibles Enrolling in Silver Level of Coverage (70 % AV)
≤ 100 - 138	2.03	94
138 - 150	3.05 - 4.07	94
150 - 200	4.07 - 6.41	87
200 - 250	6.41 - 8.18	73
250 - 300	8.18 - 9.66	70
300 - 400	9.66	70
400 and higher	NA	70

Source: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; n.a. = not applicable

[a] Premium tax credit amounts are set to limit household premium contirbutions for the second lowest cost silver premium available to the given percentage of income. If enrollees choose a more expensive plan, they pay more; if they choose a less expensive plan, they pay less.

silver-tier marketplace plan (those with actuarial value [AV] of 70 percent; that is, plans that reimburse an average of 70 percent of the costs of covered benefits across an average population). The CSRs increase the AV of a silver plan to 94 percent for those with incomes up to 150 percent of FPL, to 87 percent for those with incomes between 150 and 200 percent of FPL, and to 73 percent for those with incomes between 200 and 250 percent of FPL. The cost-sharing requirements across silver plans vary, but without CSRs the median deductible is $3,600 for single coverage in 2016 and $7,600 for family coverage.[9] The median silver plan's out-of-pocket maximum is $6,500 for single policies and $13,000 for family policies. The limits under the ACA for out-of-pocket maximums for those not eligible for cost sharing reductions are $6,850 for single policies and $13,700 for family policies. Thus, both premiums and out-of-pocket costs can be high relative to income, particularly for those above 200 percent of FPL, who are not eligible for any significant CSRs.

What We Did

We estimate the health care financial burdens of those enrolled in nongroup marketplace coverage with marketplace financial assistance and of those with higher incomes who are enrolled in ACA-compliant nongroup coverage either inside or outside of the marketplace. The analysis does not include those in Medicaid or Medicare, those who have employer-sponsored insurance or those who remain uninsured. We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[10] Health care financial burdens for those eligible for tax credits are simulated here as if they were enrolled in silver marketplace plans. This approach allows us to assess financial burdens without the added complexity of adjusting for how the population is distributed across different AV plans. Silver plans are the most frequently chosen among those eligible for financial assistance. In addition, individuals choosing a bronze, gold, or platinum plan are not eligible for CSRs even if their incomes are below 250 percent of FPL. Those with incomes above 400 percent of FPL are assumed to predominantly choose silver plans, but some also choose bronze, gold, or platinum. We then estimate total health expenditures for each individual enrolled in an ACA-compliant plan. These expenditures are based upon their previous spending levels and previous health insurance status (comprising health status, out-of-pocket spending requirements, income, education, and other factors) adjusted to take into account changes in utilization resulting from enrollment in qualified health plans. The individuals' direct expenditures depend on their eligibility for premium tax credits and CSRs, the premiums available to them, and their simulated health care needs (premiums for qualified health plans are benchmarked to national average reference premiums). We then calculate the median and 90th percentile of the distribution of direct household spending relative to income separately for premiums, out-of-pocket expenses, and total financial burdens, accounting for available financial assistance.

Results

In this section we provide data on how much individuals receiving financial assistance pay for marketplace nongroup coverage and how much higher-income individuals ineligible for assistance pay for nongroup coverage inside or outside the marketplaces relative to income at both the median and 90th percentile. We include both household contributions toward premiums and payments for out-of-pocket costs. Table 2 shows premiums and out-of-pocket payment burdens by income level. Premium contributions relative to income increase as income increases and tax credits phase down. The median financial burden for individuals below 200 percent of FPL is 4.4 percent of income devoted to health insurance premiums. The median financial burden for persons with incomes between 300 and 400 percent of FPL is 9.6 percent of their income for premiums. Premiums as a share of income then decline as income increases beyond the CSR eligibility levels. Out-of-pocket payments change similarly: they increase as a share of income as CSRs phase down, and they fall as a percentage of income as incomes increase. For those with incomes below 200 percent of FPL who do not have high medical care needs (most of that demographic), financial burdens are well-contained because of

Table 2. Health Care Financial Burdens for Nongroup Enrollees Under the ACA, by Income, 2016 (Direct Household Payments for Premiums and Out-of-Pocket Expenses Relative to Income)

	Median			90th Percentile		
Income relative to FPL	Premium contribution	Out-of-pocket payments	Total	Premium contribution	Out-of-pocket payments	Total
Less than 200% of FPL	4.4%	2.3%	6.6%	6.1%	13.9%	18.5%
200% to 300% of FPL	7.7%	2.8%	10.8%	9.2%	13.6%	21.2%
300% to 400% of FPL	9.6%	4.9%	14.5%	9.6%	12.6%	22.2%
400% to 500% of FPL	9.2%	3.4%	13.4%	15.6%	10.4%	22.8%
Over 500% of FPL	5.8%	2.1%	8.4%	11.3%	6.8%	16.7%

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015.

Notes: FPL = the federal poverty level. Sample includes those individuals and families with incomes below 400 percent of FPL enrolling in nongroup marketplace coverage with a premium tax credit and those with incomes above 400 percent of FPL buying nongroup coverage either inside or outside the marketplaces in 2016. The Affordable Care Act is simulated as fully phased in in 2016. Calculations are family health expenses relative to family income. Component percentages do not sum to the total because median and 90th percentile values are computed separately for premium contributions, out-of-pocket payments, and total household spending.

the combination of generous premium tax credits and substantial CSRs. But for those with incomes between 300 and 500 percent of FPL, median financial burdens range from 13.4 percent to 14.5 percent.

At the 90th percentile, financial burdens are dramatically higher, even for the lowest-income population. Although those with incomes below 400 percent of FPL have their premium contributions capped as a percentage of income, the premium caps vary for individuals of different incomes within each income category, and these differences are reflected in the different financial burdens between the median and 90th percentile. As discussed, premium contributions relative to income increase as income increases and as premium tax credits phase down. For those with incomes above 400 percent of FPL there are no income-related caps on premiums. Those at the 90th percentile of financial burdens with incomes from 400 percent to 500 percent of FPL pay 15.6 percent of their income toward their premiums. The difference in premium contributions relative to income at the 90th percentile compared with the median reflects the fact that age rating allows higher premiums to be charged to older adults for the same coverage. In addition, even if they are the same age and face the same premium, individuals at the lower end of that income range have to devote a higher percentage of their income to purchase that coverage than do individuals at the higher end of that income range. At the 90th percentile, out-of-pocket expenses consume over 13 percent of income for those with incomes below 300 percent of FPL; the out-of-pocket financial burdens decline as income increases (though they remain high). Out-of–pocket financial burdens at the high end of the distribution are surprisingly high for those with incomes below 200 percent of FPL given the significant CSRs, but these burdens largely reflect their very low incomes. CSRs are extremely modest, however, for those with incomes between 200 percent and 250 percent of FPL, and there are none for those with higher incomes.

The total financial burdens at the 90th percentile are very high for all income groups. The combination of high premium contributions relative to income and high out-of-pocket costs for those with significant health care needs leads to individuals at those income levels paying 16.7 percent to 22.8 percent of income for their medical care. Thus, even with all of the ACA's financial protections, individuals across the income distribution who are ineligible for Medicaid can still face very high expenditures.

Table 3 provides data on health care financial burdens by health status. At the median, premiums account for about 6 percent of income and do not vary noticeably with health status. However, out-of-pocket financial burdens do increase as health status worsens, even at the median. Median financial burdens for premiums and out-of-pocket costs combined rise from 8.7 percent of income for those in excellent health to 11.4 percent for those in fair or poor health. At the 90th percentile, financial burdens increase with health status because of rising out-of-pocket costs. For those in excellent health, out-of-pocket costs at the 90th percentile consume 9.2 percent of income; for those in fair or poor health, out-of-pocket costs at the 90th percentile consume about 14.9 percent of income. Total burdens at the 90th percentile are 18.1 percent of income and 19.5 percent of income for those in excellent and very good health, respectively. For those in fair or poor health, total burdens amount to 23.2 percent of income. Again, burdens for the sickest are high despite the ACA's financial protections.

In Table 4 we examine the distribution of financial burdens by age group. We limit this analysis to singles and couples without children in order to avoid the complexities of premiums that vary because of different numbers of children in the family Expenditures for singles

Table 3. Health Care Financial Burdens for Nongroup Enrollees Under the ACA, by Health Status, 2016
(Direct Household Payments for Premiums and Out-of-Pocket Expenses Relative to Income)

	Median			90th Percentile		
	Premium contribution	Out-of-pocket payments	Total	Premium contribution	Out-of-pocket payments	Total
Excellent	6.3%	1.8%	8.7%	9.6%	9.2%	18.1%
Very good	6.2%	2.5%	9.3%	9.6%	10.6%	19.5%
Good	6.5%	3.1%	10.2%	9.6%	12.7%	21.5%
Fair to poor	6.1%	4.4%	11.4%	9.6%	14.9%	23.2%

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015.

Notes: FPL = the federal poverty level. Sample includes those individuals and families with incomes below 400 percent of FPL enrolling in nongroup marketplace coverage with a premium tax credit and those with incomes above 400 percent of FPL buying nongroup coverage either inside or outside the marketplaces in 2016. The Affordable Care Act is simulated as fully phased in in 2016. Calculations are family health expenses relative to family income. Component percentages do not sum to the total because median and 90th percentile values are computed separately for premium contributions, out-of-pocket payments, and total household spending.

Table 4. Health Care Financial Burdens for Nongroup Enrollees Under the ACA, by Age Group, Singles and Couples Without Children, 2016
(Direct Household Payments for Premiums and Out-of-Pocket Expenses Relative to Income)

	Median			90th Percentile		
Age	Premium contribution	Out-of-pocket payments	Total	Premium contribution	Out-of-pocket payments	Total
18 - 24	4.9%	1.2%	6.7%	7.8%	7.3%	12.7%
25 - 34	5.6%	1.0%	7.2%	8.2%	8.1%	14.8%
35 - 44	5.9%	1.3%	7.8%	9.2%	8.6%	15.7%
45 - 54	6.4%	2.6%	9.6%	9.6%	11.5%	20.1%
55 - 64	7.4%	4.0%	12.0%	12.8%	15.2%	24.5%

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015.

Notes: FPL = the federal poverty level. Ages are of oldest adult in family without dependents. Sample includes those individuals and families with incomes below 400 percent of FPL enrolling in nongroup marketplace coverage with a premium tax credit and those with incomes above 400 percent of FPL buying nongroup coverage either inside or outside the marketplaces in 2016. The Affordable Care Act is simulated as fully phased in in 2016. Calculations are family health expenses relative to family income. Component percentages do not sum to the total because median and 90th percentile values are computed separately for premium contributions, out-of-pocket payments, and total household spending.

and couples without children provide a clearer idea of spending across ages. For those with median financial burdens, premiums as a percentage of income increase modestly with age, from 4.9 percent for those ages 18 to 24 to 7.4 percent for those ages 55 to 64. The increase reflects the effect of age rating on the population ineligible for tax credits. Premium contributions relative to income also increase by age at the 90th percentile for the same reason. Differences between the 90th percentile and the median reflect both (a) that some individuals are eligible for premium tax credits and others are not, and (b) that even within an age category of those ineligible for credits, older individuals are charged higher premiums than younger individuals (i.e., the premium charged a 24-year-old is higher than that charged an 18 year old). Out-of-pocket financial burdens increase with age because health care utilization increases with age. Younger adults tend to have lower incomes than older adults, and therefore they more frequently benefit from financial assistance. The increase in out-of-pocket costs is particularly striking at the 90th percentile, at which point spending as a share of income increases from 7.3 percent of income for those ages 18 to 24, to 11.5 percent of income for those ages 45 to 54, and to 15.2 percent of income for those ages 55 to 64.

Because of the increase in both premiums and out-of-pocket costs across ages, total financial burdens for those with median expenditures increase from 6.7 percent of income for those ages 18 to 24 to 12.0 percent of income for those ages 55 to 64. At the 90th percentile, total financial burdens increase from 12.7 percent of income for those ages 18 to 24, to 20.1 percent of income for those ages 45 to 54, and to 24.5 percent of income for those ages 55 to 64. Thus, the combination of premium age rating and higher out-of-pocket costs as health utilization increases with age leads to particularly high financial burdens for those over age 45.

Conclusion

In this paper we have shown that, for those enrolling in marketplace coverage using federal financial assistance, at both the median and the 90th percentile, premium payments relative to income increase as household incomes increase and the ACA's premium tax credits phase down. Premium payments then decline as incomes increase further and individuals are ineligible for financial assistance. Premium contributions relative to incomes also increase with age but do not vary with health status. However, financial burdens related to out-of-pocket expenses increase with worsening health status and for older individuals. Out-of-pocket expenses increase with incomes up to a point because cost-sharing assistance decreases, eventually disappearing for those with incomes above 250 percent of FPL. Ultimately, financial burdens are high for many individuals, particularly those with substantial health care needs. For those at the median, expenditures are over 10 percent of income for those with incomes between 200 percent and 500 percent of FPL. Expenditures are also over 10 percent of income at the median for those in good, fair, or poor health. Median financial burdens for those aged 45 to 64 are 9.6 percent; they are 12.0 percent for those ages 55 to 64. But financial burdens are extremely high for a significant segment of the population. For those at the 90th percentile, total health care financial burdens are close to or exceed 20 percent of income for those with incomes up to 500 percent of FPL, for those across the health status distribution, and for those ages 45 to 64. Thus, the combination of high premiums for silver plans coupled with high deductibles and high out-of-pocket limits mean that coverage and access to care are difficult for many to afford despite the ACA's substantially increased assistance relative to the previous system. Many who have modest income have high financial burdens even with average medical expenses. But as is well-known, health care utilization is highly skewed: a small share of the population accounts for the bulk of expenditures.[11] For those at the top of the spending distribution, financial burdens are very high.

Under current law, options for improving the affordability of marketplace coverage are limited. Massachusetts and Vermont have supplemented federal financial assistance with their own funds. The ACA also offers a state option for a basic health program (BHP). Minnesota and New York now use a BHP (called MinnesotaCare and the Essential Plan, respectively) to provide coverage to people with incomes up to 200 percent of FPL, offering lower premiums and cost sharing than would be available in the marketplaces. But BHPs have serious problems, for example, they reduce the size of marketplaces and the amount of federal dollars available to them each year is uncertain, rendering state obligations uncertain in turn.

ACA reforms could improve the affordability of marketplace coverage.[12] Linking tax credits to gold plans (those with 80 percent AV), rather than silver plans (those with 70 percent AV), would reduce deductibles and out-of-pocket payments from current levels for tax credit–eligible individuals. Additional targeted assistance could be provided through improved CSRs for low-income marketplace enrollees. Introducing an additional tax credit category that limits the percentage of income that those above 400 percent of FPL would be required to contribute toward marketplace coverage would reduce financial burdens for middle-income older adults, who are most affected by age rating.

The risk of not making coverage more affordable is that more individuals may choose not to purchase coverage, pay the tax penalty instead, and hinder the ACA's ability to achieve and maintain its coverage objectives.

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ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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6 We use family here to refer to the tax unit. The tax unit includes…

7 Some documented immigrants with incomes below those lower income thresholds, who would otherwise be eligible for Medicaid but who have been in the US for less than 5 years, are also eligible for marketplace tax credits.

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12 For a full discussion of affordability concerns in the ACA and an array of potential reforms to address them, see Blumberg LJ and Holahan J. *After King v. Burwell: Next Steps for the Affordable Care Act*. Washington: Urban Institute, 2015. http://www.urban.org/research/publication/after-king-v-burwell-next-steps-affordable-care-act. Household financial burdens presented here differ somewhat from those presented in the paper cited above, due to incorporating updated data and including those over 400 percent of FPL purchasing nongroup coverage outside marketplaces.

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In Second Year Of Marketplaces, New Entrants, ACA 'Co-Ops,' And Medicaid Plans Restrain Average Premium Growth Rates

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ABSTRACT **Premiums for health insurance plans offered through the federally facilitated and state-based Marketplaces remained steady or increased only modestly from 2014 to 2015. We used data from the Marketplaces, state insurance departments, and insurer websites to examine patterns of premium pricing and the factors behind these patterns. Our data came from 2,964 unique plans offered in 2014 and 4,153 unique plans offered in 2015 in forty-nine states and the District of Columbia. Using descriptive and multivariate analysis, we found that the addition of a carrier in a rating area lowered average premiums for the two lowest-cost silver plans and the lowest-cost bronze plan by 2.2 percent. When all plans in a rating area were included, an additional carrier was associated with an average decline in premiums of 1.4 percent. Plans in the Consumer Operated and Oriented Plan Program and Medicaid managed care plans had lower premiums and average premium increases than national commercial and Blue Cross and Blue Shield plans. On average, premiums fell by an appreciably larger amount for catastrophic and bronze plans than for gold plans, and premiums for platinum plans increased. This trend of low premium increases overall is unlikely to continue, however, as insurers are faced with mounting medical claims.**

After more than five years, the Affordable Care Act (ACA) remains a source of intense political controversy. Research has increased understanding of the changes the ACA has brought about. For example, national health care spending in the period 2010–13 rose at the slowest four-year rate since 1965.[1] There is no consensus, however, as to how much of this slowing of spending growth is attributable to the ACA, to increased cost sharing in employer-based insurance, or to a slowly recovering economy. [2] The Congressional Budget Office (CBO) nonetheless has estimated the cost of the ACA to the federal government over the next ten years to be 29 percent less than the CBO forecast in 2010.[3]

Several research organizations—including the Henry J. Kaiser Family Foundation,[4] Avalere Health,[5] Breakaway Policy,[6] the Urban Institute,[7] and McKinsey and Company—have analyzed premium increases from 2014 to 2015 in the state-based and federally facilitated Marketplaces, also known as health insurance exchanges. With the exception of McKinsey and Company,[8] these organizations concluded that observed premium growth has been very modest.

We found that the average national premium for a plan offered in the Marketplaces did not increase at all during this time.[9] In the twenty-

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eight years of the Kaiser Family Foundation/ Health Research and Educational Trust Employer Health Benefits Survey and its predecessors, the zero percent premium increase is the lowest ever recorded.[10,11]

One explanation for the unexpectedly low premium increases is that more carriers entered the individual insurance market. On average between 2014 and 2015, the number of carriers competing in a geographic rating area increased by 25 percent, while the number of unique plans they offered increased by 28 percent.[9]

This market entry has fostered greater competition in the individual insurance market, which before passage of the ACA was dominated by carriers affiliated with Blue Cross and Blue Shield. These carriers held the largest share of the individual insurance market in all but two states, Ohio and Utah. For example, in 2010 across the country the median market share of each state's largest carrier was 55 percent, and the largest three carriers in each state held a median of 85 percent of the market.[12]

This article analyzes patterns of premiums and premium increases in the Marketplaces for the period 2014–15. We used descriptive and multivariate analyses to increase understanding of the factors that contributed to the lower-than-expected rates of average premium increases.

Study Data And Methods

DATA We used data on plan offerings from 2,964 unique plans offered in 2014 and 4,153 offered in 2015. The sample consisted of plans in forty-nine states and the District of Columbia (data from New York were not usable at the time of our analysis). Plan data from the states with federally facilitated Marketplaces were from the Qualified Health Plan Landscape Files. Data for state-based Marketplaces came from those Marketplaces' websites, state departments of insurance, and insurers' websites.

Under the ACA, each state has divided itself into geographic "rating areas," which are used by carriers in price setting. We first sorted each rating area in each state into one of three sampling strata, based on whether the rating area was within an urban, suburban, or rural region. We then selected one rating area within each stratum for analysis—the largest urban area in the state plus one suburban and one rural area that were chosen by random selection—which resulted in three rating areas per state. For states that had only one rating area, we collected information for all plans statewide. For individual rural or suburban rating areas, the probability of random selection was based on the population of the rating area. The rating areas we selected contained 52 percent of the US population.

Our sample included all plans from all metal tiers within the chosen rating areas. A separate observation was recorded for each plan for each rating area in which it was sold, which allowed us to tie geographic and sociodemographic data about the rating area to the premiums for the plans in that area. Sociodemographic data, which included median family income and the proportion of uninsured individuals, were from the 2013 American Community Survey conducted by the Census Bureau.

WEIGHTING AND STATISTICAL ISSUES Premium costs were those of the typical plan offered, as opposed to the typical plan purchased. Detailed plan enrollment data for 2014 were available only in a few states with state-based Marketplaces and for none of the states with federally facilitated Marketplaces, although some minor highlights were released by the Department of Health and Human Services. These very limited enrollment data were insufficient to allow us to develop a model for plan choice with any confidence.

Observations were weighted either by stratum populations, for the national estimates, or by the population of the rating area in which they are sold, for the regression results discussed below.[13] Because of design effects from weighting, we used Stata, version 14.0, to calculate robust standard errors. We used p values of <0.05 as our threshold of significance.

DESCRIPTIVE AND MULTIVARIATE ANALYSIS In our descriptive analysis we examined variations in premiums and changes in premiums using a host of independent variables, such as the number of insurers in the rating area; the type of carrier; the type of plan; the type of Marketplace (state based or federally facilitated); and whether the plan was offered in an urban, suburban, or rural area. Of particular interest was the role of new entrants into the Marketplaces.

In our multivariate analysis, which used pooled data from 2014 and 2015, we estimated an ordinary least squares regression as to how different variables affect the premium of a forty-year old nonsmoker with single coverage.[14] We estimated one regression for a pooled sample of plans in 2014 and 2015.

Another regression estimated the relationship between premiums in 2014 and 2015 using the same set of independent variables, but for only the lowest-cost bronze plan and the two lowest-cost silver plans. The second-lowest-cost silver plan is the basis for determining the government's premium subsidy for all plans in the exchange in the rating area, whereas the lowest-cost bronze plan represents the plan that enrollees would choose if they wished to minimize their out-of-pocket expenses.

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We used a log-level specification in both regressions so that the coefficients represent percentage-point changes in premiums for a one-unit change in the dependent variable. The number of carriers in each rating area was normalized to the national mean for each plan year. Thus, the coefficient was scaled in the exhibits to represent the effect of one additional carrier (relative to the national mean) on the percentage change in premiums.

Our independent variables included plan year; whether the state had a state-based or federally facilitated Marketplace; metal tier; plan type; carrier category;[15] whether the area was urban, suburban, or rural; market concentration in the individual insurance market before passage of the ACA;[16] number of carriers competing in the Marketplace in the rating area, normalized to the national mean for each plan year; median family income in the rating area; percentage of the rating area population that was uninsured; and an indicator variable for each state.

LIMITATIONS Our work had a number of limitations. First, the measure of price was premiums for plans offered instead of for those purchased. As noted above, enrollment data by plan were available in only a few states, and such data were necessary to calculate the average premium for purchased plans.

Second, we did not have data on whether provider networks were broad or narrow. McKinsey and Company has reported that about 70 percent of the lowest-price products available in the Marketplaces are built around narrow, ultra-narrow, or tiered networks.[17]

Third, we did not have data on concentration in hospital and physician markets. Greater concentration in these markets gives providers greater leverage in their negotiations with carriers and likely raises the cost of insurance.

Study Results

PREMIUMS To better understand the workings of the Marketplaces, we examined variations in premiums and premium increases by plan and market characteristics (Exhibit 1). There were six major findings.

EXHIBIT 1

Average Single Coverage Monthly Premiums And Premium Changes From 2014 To 2015, By Selected Market Characteristics

	Premium in 2015 ($)			Premium increase from 2014 to 2015 (%)		
Characteristic	Bronze	Silver	Gold	Bronze	Silver	Gold
National average[a]	254.84**	313.54	370.90**	−8.0**	−1.6	−0.9
TYPE OF MARKETPLACE						
State-based	244.74**	300.93**	368.14	−1.0**	0.3	0.5
Federally facilitated[b]	257.33	316.02	371.69	−10.5	−2.4	−1.4
TYPE OF PLAN						
HMO or EPO[b]	246.46	303.73	362.79	−15.9	−5.1	−3.5
PPO	271.94**	328.36**	383.69**	−0.6**	2.1**	2.6
HDHP	247.18	303.09	354.35	−1.9**	5.8**	1.5
URBANICITY						
Urban[b]	252.24	309.67	366.55	−10.3	−3.3	−1.5
Suburban	255.67	314.08	373.65	−0.7*	2.3**	1.5
Rural	260.46**	323.05**	377.92**	−12.7	−3.8	−3.9
NUMBER OF CARRIERS IN RATING AREA						
1	241.16**	289.13**	350.29**	−5.6	−3.7	2.7
2–4[b]	250.82	306.41	362.06	−3.1	0.5	0.5
5–8	257.72**	315.74**	375.64**	−12.3	−3.6	−3.1
9 or more	252.60	313.73*	368.17	−5.3	−2.7*	−0.3
TYPE OF CARRIER						
Blue Cross and Blue Shield[b]	255.77	317.55	382.55	2.0	3.7	4.2
National commercial	261.78	325.07	363.78**	−3.4	−0.5	−1.9
Co-op	238.95**	281.74**	343.69**	−5.7**	−12.4**	−7.0**
Medicaid	240.61**	297.16**	364.94**	−26.9**	−10.2**	−7.5**
Other	293.08**	354.32**	416.54**	15.5**	12.0**	11.2**

SOURCE Authors' analysis of data for federally facilitated Marketplaces from the Qualified Health Plan Landscape Files and for state-based Marketplaces from state departments of insurance, insurers' websites, and the Marketplaces' websites. **NOTES** Premiums are for single coverage for a forty-year-old nonsmoker. Information about catastrophic and platinum plans is not included because of space limitations but can be found in Appendix Exhibit 3 (see Note 18 in text). HMO is health maintenance organization. EPO is exclusive provider organization. PPO is preferred provider organization. HDHP is high-deductible health plan. Co-op is a plan in the Consumer Operated and Oriented Plan Program. Medicaid is a Medicaid managed care plan. [a]The comparison group for national average is silver plans. [b]The comparison group used to calculate whether differences within the category were significant. $*p < 0.10$ $**p < 0.05$

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First, premiums for bronze plans fell by an appreciably larger average amount (−8.0 percent) than premiums for silver (−1.6 percent) or gold (−0.9 percent) plans. The largest increases in premiums were for platinum plans, which rose an average of 10.1 percent (data not shown). Premiums for catastrophic plans fell by 8.5 percent, on average.

Second, premiums for bronze plans in states with federally facilitated Marketplaces declined significantly more than those in states with state-based Marketplaces (Exhibit 1). There were no significant differences by type of Marketplace in premium trends for silver or gold plans.

Third, bronze-level preferred provider organization (PPO) plans in 2015 cost about 9 percentage points more than bronze-level health maintenance organization (HMO) or exclusive provider organization (EPO) plans—a significant difference—and had substantially smaller decreases in premiums from 2014. Across bronze, silver, and gold plans, HMO or EPO plans were significantly cheaper in 2015 than were corresponding PPO plans. Premiums for HMO or EPO bronze plans declined 15 percentage points more than those of bronze PPO plans. Similarly, premiums for silver HMO or EPO plans declined 5.1 percent, while those for silver PPO plans rose 2.1 percent.

Fourth, premiums for bronze and silver plans offered in suburban areas declined less than those for plans in those tiers offered in urban areas—in fact, premiums for silver plans in suburban areas rose instead of fell. Premium changes in rural areas were not significantly different from those in urban areas.

Fifth, rating areas with nine or more carriers had significantly larger declines in silver plan premiums, compared to rating areas with 2–4 carriers.

Sixth, for bronze, silver, and gold plans, Blue Cross and Blue Shield plans raised their premiums, while premiums fell for plans in all three tiers offered by national commercial carriers; plans in the Consumer Operated and Oriented Plan Program (widely known as "co-ops"), established by the ACA; and carriers offering Medicaid managed care plans. Co-ops and Medicaid managed care plans had significant decreases from 2014 to 2015 compared to Blue Cross and Blue Shield plans across all three tiers.

MULTIVARIATE RESULTS Our first regression model used 2014 and 2015 premium data for plans from all tiers. (Detailed regression results are shown in online Appendix Exhibit 1.)[18] Exhibit 2 shows the percentage change in premiums associated with selected characteristics compared to reference groups. For example, when other factors are held constant, premiums increased by 4 percent in 2015, compared to 2014.

Unlike descriptive statistics, multivariate results controlled for changes in the mix of plans that occurred in the period 2014–15, such as the addition of more silver and bronze plans compared to gold and platinum plans, although the number of plans in each tier grew from 2014 to 2015. Regression results indicated that catastrophic and bronze plans cost 40 and 20 percent, respectively, less than silver plans, while gold and platinum plans cost 17 and 29 percent, respectively, more than silver plans.

One noteworthy finding was the effect of competition among carriers, as represented by the number of carriers competing in a rating area. The addition of a carrier in a rating area resulted in a decline in premiums of 1.4 percent across all metal tiers, with other factors held constant. The implication is that the entry of new carriers into Marketplaces in 2015 modestly reduced the growth of plan premiums.

Many carriers entering the individual insurance market in 2014 and 2015 were co-ops or Medicaid managed care plans. Their premiums were 3 percent and 1 percent lower, respectively, than Blue Cross and Blue Shield plans, which have long had a dominant share of this market. National commercial carriers had premiums 2 percent greater than those of Blue Cross and Blue Shield plans. PPO premiums were 11 percent higher than those of HMOs or EPOs.

For the second regression model, we limited the sample to the lowest-cost bronze and the two lowest-cost silver plans (Exhibit 3). The results were similar to those of the first model. For example, premiums in 2015 were 5 percent higher than in 2014. Perhaps because all plans in this regression model were low cost and the sample size was smaller than in the first regression model, the type of plan and of carrier were no longer significant. Importantly, the addition of a carrier in the rating area reduced the average premium of the low-cost plans by 2.2 percent.

Discussion

Using a variety of data sources, we identified patterns of premium increases in the Marketplaces. From 2014 to 2015 there was essentially no increase in unadjusted average premiums for Marketplace plans available nationwide. However, when we controlled for the mix of plans and their characteristics through regression analysis, we found that premiums rose 4 percent in the period.

Premiums generally rose more for metal tiers with higher actuarial values (they increased by 10.1 percent for platinum plans, while declining

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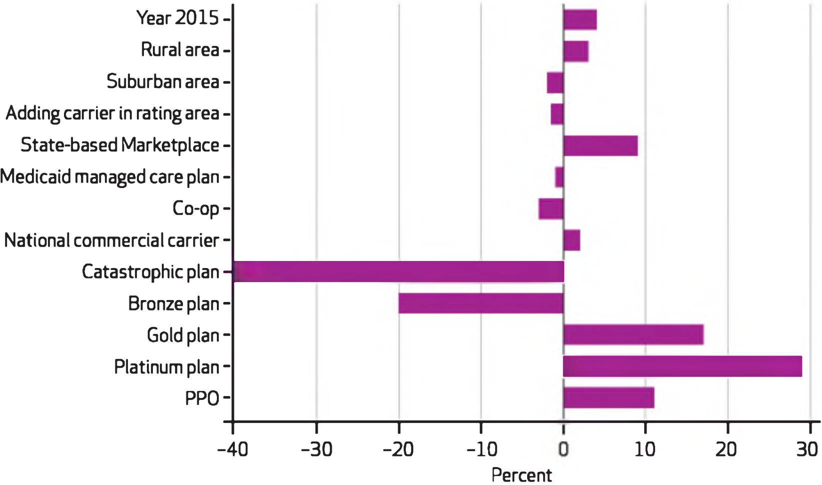
EXHIBIT 2

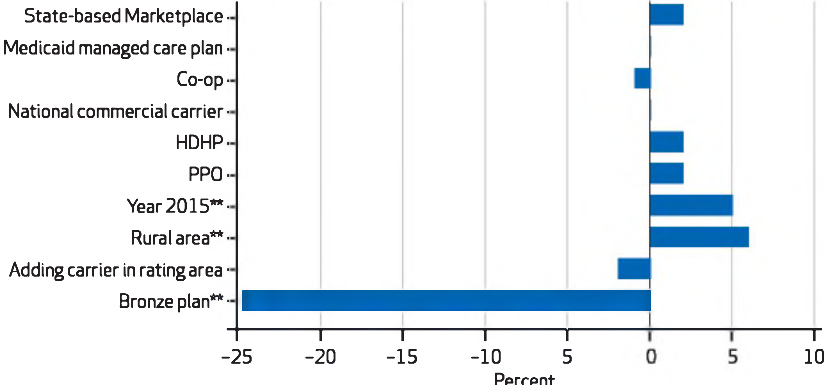
Effects Of Selected Plan And Market Characteristics On Monthly Premiums For Plans In A Rating Area, 2015



SOURCE Authors' analysis of data for federally facilitated Marketplaces from the Qualified Health Plan Landscape Files and for state-based Marketplaces from state departments of insurance, insurers' websites, and Marketplace websites. **NOTES** Premiums are for single coverage for a forty-year-old nonsmoker. All variables were significant ($p < 0.05$). The reference groups are as follows: for 2015, 2014; for rural and suburban areas, urban area; for adding one carrier in rating area, not changing the number of carriers; for state-based Marketplace, federally facilitated Marketplace; for Medicaid managed care plan, plan in the Consumer Operated and Oriented Plan Program (co-op), and national commercial carrier, Blue Cross and Blue Shield plans; for catastrophic, bronze, gold, and platinum plans, silver plan; and for preferred provider organization (PPO), health maintenance organization and exclusive provider organization.

EXHIBIT 3

Effects Of Selected Plan And Market Characteristics On Monthly Premiums For The Lowest-Cost Bronze And Two Lowest-Cost Silver Plans In A Rating Area, 2015



SOURCE Authors' analysis of data for federally facilitated Marketplaces from the Qualified Health Plan Landscape Files and for state-based Marketplaces from state departments of insurance, insurers' websites, and Marketplace websites. **NOTES** Premiums are for single coverage for a forty-year-old nonsmoker. The reference groups are as follows: for state-based Marketplace, federally facilitated Marketplace; for Medicaid managed care plan, plan in the Consumer Operated and Oriented Plan Program (co-op), and national commercial carrier, Blue Cross and Blue Shield plans; for high-deductible health plan (HDHP) and preferred provider organization (PPO), health maintenance organization and exclusive provider organization; for 2015, 2014; for rural area, urban area; for adding one carrier in rating area, not changing the number of carriers; and for bronze plan, silver plan. $^{**}p < 0.05$

substantially for catastrophic and bronze plans). This pattern of premium changes suggests that insurers saw more pronounced risk segmentation than they had originally forecasted.

Our findings indicate that the 25 percent increase in competing carriers from 2014 to 2015 at the rating-area level has altered the workings of the individual insurance market from the time before passage of the ACA. Before 2010 Blue Cross and Blue Shield plans had the largest market share in forty-eight states and had the majority of enrollees in a typical state. Presumably, this larger market share enabled Blue Cross and Blue Shield to gain larger discounts from hospitals and doctors than their competitors obtained, and thus to charge lower premiums.

Now Blue Cross and Blue Shield plans and those of national commercial carriers are priced higher, on average, than co-ops and Medicaid managed care plans. Blue Cross and Blue Shield also increased the premiums for their silver plans from 2014 to 2015 by 3.7 percent, while most other carriers lowered their premiums—national commercial plans by 0.5 percent, co-ops by 12.4 percent, and Medicaid managed care plans by 10.2 percent.

In early 2015 co-ops were significant market players in Connecticut, Illinois, Kentucky, Maine, Maryland, New Mexico, New York, South Carolina, Tennessee, and West Virginia.[19] However, twenty-one of the twenty-three co-ops across the country suffered financial losses in 2014, and their sustainability remains in question.[20] By November 2015, twelve of the nation's twenty-three co-op plans had closed down.[21] Co-ops in Iowa, Louisiana, and Nevada have ceased operations, and New York State insurance regulators recently ordered Health Republic Insurance, the co-op with the largest enrollment in the nation, to shut down.[22]

Our regression estimates from a sample of the lowest-cost bronze plan and two lowest-cost silver plans in each rating area indicated that having an additional carrier in the market reduced premiums by 2.2 percent. When all plans in the rating area were included, an additional carrier was associated with a 1.4 percent decline in premiums. Because the lowest-cost bronze plan and the two lowest-cost silver plans are benchmarks of affordability, the first estimate may be of greater importance for public policy.[23]

The effects of new entrants in the market are also indicated by the participation of insurers—such as co-ops and Medicaid managed care plans—that were not competing before the Marketplaces became operational. Many new carriers and existing insurers offer HMO or EPO plans, which on average cost 11 percent less than PPO plans. HMO or EPO plans have been declin-

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ing in market share in the group insurance market since 2000.[24] While such historical information is not available for the individual insurance market, HMO and EPO plans likely have a larger share of the individual insurance market today than before implementation of the ACA.[11]

Buyers' price sensitivity underlies the price competitiveness of the Marketplaces. In 2014 the two lowest-cost plans in each tier in a rating area accounted for 64 percent of enrollment.[20] The structure of the Marketplaces—in which buyers qualifying for the federal premium subsidy must pay the difference between the premium of the second-lowest-cost silver plan (the benchmark plan) and any other plan—provides a strong incentive for consumers to purchase lower-cost plans. Enrollees qualifying for subsidies are typically low- or middle-income people with little disposable income, which makes them more responsive to price differences among plans, compared to people with employer-based insurance. Marketplace websites allow buyers to compare premiums among different carriers far more easily than they could in the individual insurance market before the ACA.

A recent survey of 3,037 Marketplace shoppers found that 22 percent of people who were enrolled in 2014 enrolled in a different health plan in 2015.[25] This is 10 percentage points more than the share found in a recent study of people with employer-based coverage who switched plans.[26] We would expect new enrollees, who represented nearly half of Marketplace enrollees in 2015, to be as price sensitive as they were in 2014.

Faced with price-sensitive buyers, insurers have priced Marketplace plans aggressively. The "three Rs"—risk adjustment, reinsurance, and risk corridors—may have further encouraged aggressive pricing by protecting carriers against the financial losses associated with adverse selection or underpricing of plans.[27] Risk adjustment transfers funds from insurers with lower-risk enrollees to insurers with higher-risk enrollees. Reinsurance provides stop-loss coverage when an enrollee claims expenses beyond some threshold amount ($50,000 in 2015). Risk corridors allow insurers to share with the government losses beyond some threshold amount, but they also require profit sharing with the government beyond some amount. Since financial losses are shared with the government, risk corridors reduce the risk to carriers of underpricing health plans. However, 2016 will be the last year for risk corridors.[27]

In May and June 2015 it was widely reported that many insurers were requesting double-digit premium increases for 2016. The justification for such increases was that insurers, unlike in earlier years, knew their Marketplace population's medical expenses, which was higher per member than had previously been estimated. The extent to which these requests are granted is contingent on the responses of state insurance regulators and the requested premium increases for other insurers in the state. In any case, the long-run trajectory for premiums of Marketplace plans, like those of employer-sponsored plans, is likely to follow trends in medical claims expenses.

Conclusion

In the next few years the financial penalty for most individuals with no insurance will rise from $95 to $325 per person to a maximum of $965 per family. This is likely to induce additional uninsured people who are younger and healthier, on average, than current Marketplace enrollees to purchase Marketplace plans and thereby to constrain inflationary forces. Offsetting factors are the rapid rise in the cost of specialty drugs and the sustainability of the co-ops that contributed significantly to the low inflation in Marketplace coverage of 2014–15. The comparative strengths of these countervailing factors should be more apparent in a year or two. ■

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Insurer Competition In Federally Run Marketplaces Is Associated With Lower Premiums

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ABSTRACT **Federal subsidies for health insurance premiums sold through the Marketplaces are tied to the cost of the benchmark plan, the second-lowest-cost silver plan. According to economic theory, the presence of more competitors should lead to lower premiums, implying smaller federal outlays for premium subsidies. The long-term impact of the Affordable Care Act on government spending will depend on the cost of these premium subsidies over time, with insurer participation and the level of competition likely to influence those costs. We studied insurer participation and premiums during the first two years of the Marketplaces. We found that the addition of a single insurer in a county was associated with a 1.2 percent lower premium for the average silver plan and a 3.5 percent lower premium for the benchmark plan in the federally run Marketplaces. We found that the effect of insurer entry was muted after two or three additional entrants. These findings suggest that increased insurer participation in the federally run Marketplaces reduces federal payments for premium subsidies.**

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Policy makers have increasingly relied upon competition among insurers to help restrain spending on public health insurance programs,[1] such as the Medicare Advantage and Medicare Part D prescription drug benefit programs. Similarly, an important reason for the creation of the health insurance exchanges, or Marketplaces, under the Affordable Care Act (ACA) was to use competition among insurers to help dampen private health insurance spending and reduce the federal costs of subsidizing enrollees. A key question about any of these programs and the Marketplaces in particular is the extent to which competition actually lowers premiums in these markets.

Under the ACA, a state can establish its own Marketplace, known as a state-based Marketplace, through which people can purchase health insurance. If a state does not choose to do so, the federal government will run a Marketplace in the state by itself (known as a federally facilitated Marketplace) or a Marketplace in partnership with the state. We refer to both federally facilitated Marketplaces and Marketplaces run by the federal and state governments together as federally run Marketplaces.

Only a handful of analyses have looked at competition and premium dynamics in the Marketplaces, given their fairly recent development. Our study adds to this literature by employing more data on plan offerings than other studies have used and by adopting an analytical approach that mitigates estimation bias, which was a limitation of previous efforts. As an additional expansion upon previous work, we used data at two distinct geographic levels, the county and the rating area, to assess the robustness of our results and to compare our findings for federally run Marketplaces to those for state-based Marketplaces. A rating area is a geographical unit consisting of one or more counties, ZIP

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codes, or Metropolitan Statistical Areas.

The effect of competition on federal spending can be measured by changes in the premium for the second-lowest-cost silver plan in a rating area, which is the benchmark for premium subsidies. Given the wide array of available plans, however, it is also important to assess the effects of competition on other plans. We examined premiums of the second-lowest-cost, mean, and median plans at the silver and bronze levels of benefit generosity, which accounted for 67 percent and 22 percent, respectively, of all plans chosen in 2015.[2]

Our results suggest that competition among insurers can have an economically meaningful effect. Although we cannot rule out null findings for some premium measures, for others we found that the presence of one additional insurer in a county reduced premiums for silver plans by between 1.2 percent (for the average cost plan) and 3.5 percent (for the benchmark plan).

Background

Insurers participating in the Marketplaces can offer plans at four levels of benefit generosity, or metal tiers, based on their actuarial values; all plans offered must cover a defined set of essential health benefits.[3] There is also a fifth tier for "catastrophic" plans that have very high deductibles, but premium subsidies are not available for those plans.

Individuals with incomes at 100–400 percent of the federal poverty level who purchase a benchmark plan through a Marketplace are generally eligible to receive a subsidy that covers the difference between a specified percentage of their income and the premium of the benchmark plan. For example, in 2015 those with incomes at 150 percent of poverty ($17,655) would pay 4.02 percent of their income, and those with incomes at 400 percent of poverty ($47,080) would pay 9.56 percent. The federal subsidy is defined as the premium for the benchmark plan less the applicable share of the individual's income. Enrollees who are eligible for a subsidy and who select a plan with a premium above that of the benchmark plan are responsible for paying the difference.

In 2013 insurers that were considering competing in the Marketplaces in 2014 faced much uncertainty regarding the health risk of potential enrollees, the ultimate size of the market, and the participation of other insurers. Even in early 2014, when insurers were required to decide whether to participate in 2015, the health risk of current and prospective enrollees was still largely uncertain. Insurers participating in 2014 had only slightly more information than did insurers newly entering the market in 2015 regarding enrollment and had only preliminary assessments as to whether they had over- or underestimated their costs. Thus, insurers in the Marketplaces made strategic decisions on the basis of preliminary information that was mostly available to all potential players.

Generally speaking, the more insurers there are in a market, the greater the uncertainty each will face regarding its own competitive position. In the context of the Marketplaces, that uncertainty likely encourages insurers to charge lower premiums than would otherwise be the case. As a result, the benchmark premium is likely to be lower than in a comparable market with fewer insurers, and federal spending on Marketplace subsidies would be reduced. In addition to explicit competitive pressures, areas with more insurers—and consequently a wider range of pricing assumptions—may have experienced lower growth in premiums than areas with fewer insurers simply because the variance in premiums may be wider with more insurers. A wider variance can cause the benchmark plan's premium to grow more slowly.

Because of the importance of the benchmark premium for federal spending and enrollee payments, we focused on the combined effects of entry, including explicit competitive pressures and the effect of a larger number of plans entering the market, which could have widened the distribution of premiums.[4] Of course, both consumers and insurers will adapt to the new competitive landscape. Therefore, the effects of insurer entry into a market may be different over the long run than has been the case in the early years of the Marketplaces.

In an examination of insurer competition, a related concern is the price negotiated between insurers and health care providers. Greater insurer consolidation may serve to strengthen insurers' bargaining power vis-à-vis hospitals. Thus, markets with fewer insurers may see lower premiums if insurers can take advantage of that leverage and pass gains along to consumers.[5] Ultimately, the degree to which insurer competition actually reduces premiums—after offsetting reductions in bargaining power with providers are accounted for—is an empirical question, which we investigate below.

Previous Research

Previous research has shown that competition between health insurers tends to reduce the level and rate of growth of both premiums and profits. In the Medicare Part D market, a Congressional Budget Office study found that insurers tended to charge lower premiums in regions with more

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Our results suggest that competition among insurers can have an economically meaningful effect.

competitors, with each additional entrant into the market reducing premiums by an estimated 0.4 percent.[6] Other research confirms that concentration among health insurers leads to upward pressure on premiums.[7] And a study of the market for private coverage in the 1990s concluded that each additional competitor in a market reduces the average profit rate across insurers by 0.4 percentage points.[8]

Early research on the competitiveness of the ACA Marketplaces found that after health costs and measures of hospital pricing and consolidation were controlled for, premiums were lower in areas where more insurers participated, compared to areas with fewer insurers.[9,10] One of these studies[10] examined changes in premiums and competitors and found roughly similar results to what we show below for the first additional entrant in a county. However, neither of the two studies allowed for differential effects by number of net entrants.[11]

The weight of the evidence confirms that the presence of more insurers tends to result in lower premiums. Nonetheless, there is no consensus on how many insurers are sufficient to ensure competitive behavior. A common concern among policy makers is that commercial health insurance markets are too heavily concentrated.[12] The anticompetitive effects of concentration are probably greater, however, in markets where consumers cannot easily compare plans. In addition to federal premium subsidies, the ACA brought about reforms to improve the consumer's ability to compare plans, including standardized benefits and specified actuarial or metal tiers. Compared to less regulated health insurance markets, such as those for employer-sponsored insurance, the ACA Marketplaces may require fewer insurers to maintain a robust competitive environment. Thus, new research on the implications of insurer participation in the Marketplaces is important for evaluating future policy proposals.

Study Data And Methods

We examined data on insurer participation and premiums during the first two years of the health insurance Marketplaces (2014 and 2015). We analyzed how changes in county-level premiums from 2014 to 2015 were associated with changes in the number of competitors in each county. Our primary specifications were two-year differenced regressions, in which we analyzed the percentage change in average premiums from 2014 to 2015 as a function of the net change in the number of insurers, controlling for other potential confounders.

Many factors that might be confounded with the number of insurers in a given year are less likely to be associated with the change in the number of insurers over time. For example, an association between lower premiums and more insurers in the first year of the ACA Marketplaces may or may not be attributable to the competitive effect of more insurers. It could be that lower costs encouraged more participation. However, such reverse causality is less likely in an analysis of changes in premiums as a function of changes in the number of insurers. Because medical cost growth is uncertain and the nature of the ACA's first few years was unpredictable, it would have been difficult for insurers to systematically enter areas that had different growth rates.

DATA We used health plan data for 2014 and 2015 released by the Centers for Medicare and Medicaid Services.[13] We first examined plans offered in the thirty-five states that used a federally run Marketplace in both 2014 and 2015. We preferred these data, which provide information on plans and premiums at the county level, to data at the level of the rating area, a region that usually consists of one or more counties. Because insurers may choose to offer plans in some but not all counties in a rating area, county-level analyses are more accurate for identifying the effects of the number of competitors in a market.

Our county-level analyses were weighted by January 2015 enrollment in the Marketplaces, so that premium changes in each county were counted in proportion to overall enrollment.[14] For counties that had no reported enrollment, we imputed a de minimis enrollment of ten covered lives.[15]

We also analyzed premiums and insurer entry using the Health Insurance Exchange Compare data sets (now known as the 2014 and 2015 ACA Silver Plan Datasets).[16,17] These include both the federally run and the state-based Marketplaces, but their data are presented at the level of the rating area instead of the county. In addition to being less precise for measuring insurer participation, these data are limited to silver plans. Finally, analyses with these data are limited by

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the lack of rating area–level enrollment weights, which are not available for states with state-based Marketplaces.[18]

OUTCOME VARIABLES We examined percentage changes from 2014 to 2015 in the monthly plan premium for single coverage of a twenty-seven-year-old nonsmoker in each area.[19] Because of the implications for federal spending, we were primarily interested in the effects on the second-lowest-cost silver plan. Although most individuals enrolled in silver coverage chose the lowest- or second-lowest-cost plan, the effects of competition on enrollee payments are best assessed by analyzing a wider range of plan offerings. Our analysis focused on the second-lowest-cost, average, and median premiums at the silver and bronze levels.

EXPLANATORY VARIABLES

▶ **NET CHANGE IN THE NUMBER OF INSURERS:** Our primary independent variables were the net change in the number of insurers (all entrants into the market minus those who exited) in each area between 2014 and 2015 and that number squared. Net insurer entry served as a proxy for the change in the overall competitiveness of the local market, while the squared term provided a nonlinear relationship between changes in premiums and number of competitors. Because changes in premiums may be more volatile when more insurers enter a market, we used robust standard errors to correct for potential heteroskedasticity.

We show below how premiums in the Marketplaces would change under two scenarios: first, the addition, on average, of one insurer per county nationwide; and second, if each insurer operating in a state in 2015 entered the market in all counties in that state. Both of these estimates are helpful for considering the effects of policies and for comparing our results to previous estimates.

To isolate the effect of insurer entry on premiums, we controlled for a variety of factors that might be associated with changes in Marketplace premiums between 2014 and 2015 but that should not be attributed to the effects of insurer entry.[20] For most of these measures, we used the variables that underlie the 2014 County Health Rankings data developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, which summarize geographical variation prior to 2014.[21] We note below when variables were derived from other sources.

▶ **DEMOGRAPHIC FACTORS:** Insurers may enter a market because of expectations regarding its size, the number of enrollees who are eligible for a subsidy, and the geographical concentration of providers. Therefore, we controlled for

Jockeying to be the lowest- or second-lowest-cost plan is an important part of the mechanism of competition in the Marketplaces.

the 2012 US census population estimate; the percentages of the population younger than age eighteen and older than age sixty-four; the percentage of the population living in rural areas; median household income; the percentage of uninsured adults; and the percentage of the population with incomes below poverty.[22]

▶ **HEALTH RISK AND SPENDING CONTROLS:** Because insurers decide whether or not to enter markets partly based on expectations about the health of their prospective enrollees, we included proxies for health risk and per capita costs. Health risk controls were the percentage of the county population reporting themselves to be in fair or poor health; the proportion diagnosed with diabetes; and the average number of days in a month that individuals reported being sick.[23] To control for medical care utilization and geographical variation in wages, we included average per capita Medicare fee-for-service spending in each county in 2011 (unfortunately, better utilization measures for the nonelderly population are not widely available at the county level). We also controlled for provider market power by including the Herfindahl-Hirschman Index for the hospitals in each rating area (personal correspondence with analysts in the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, February 2015).

▶ **PLAN CHARACTERISTICS:** Federal regulations allow insurers to vary the actuarial values of their plans by 2 percentage points above or below the target (for example, silver plans may have an actuarial value of 68–72 percent). To account for this potential source of variation, we included changes in the deductible and out-of-pocket maximum for single coverage for the second-lowest-cost silver or bronze plans or changes in the county-level mean or median for these cost-sharing amounts.

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▶ STATE-LEVEL CONTROLS: All of our analyses included state-level fixed effects. Marketplace premiums may be influenced by legal and policy decisions at the state level, including decisions to participate in the expansion of Medicaid coverage or state laws governing how insurers can set premiums in the individual market, which should not be attributed to insurer entry.

LIMITATIONS Our study had several limitations. First, factors that were related to insurer entry but that did not arise from competition may threaten the validity of our findings. For instance, insurers entering markets in 2015 did so believing that the entry would be profitable for them.[24] Our finding of reduced premiums in counties with greater insurer entry may thus be an upper bound, if insurers had entered counties with unusually low levels of competition or unusually high profits in 2014. Alternatively, our estimates may be a lower bound: If insurers in 2015 selectively entered markets where they believed enrollment would increase, and if premiums in those markets increased more than in other areas, the premium-reducing effects of competition may be greater than our estimates.

We addressed these threats to validity in two ways. First, we relied on differenced regressions to remove bias that might exist in cross-sectional estimates. Second, we used an extensive set of county- and state-level controls.

A second limitation is that our analysis used data exclusively from the first two years of the ACA Marketplaces. Therefore, our inferences were limited by the time span of the data. Third, because of low enrollment, we did not explore the effects of competition on premiums for gold or platinum plans. Finally, because we lacked plan-specific enrollment data, our estimates of changes in premiums would differ from estimates in an analysis that used enrollment-weighted means.

Study Results

There were an average of 3.6 insurers per county in 2014, weighted by exchange enrollment (Exhibit 1). In 2015 this increased to 5.2 insurers, representing an average increase of about 1.6 insurers. The net change in the number of insurers from 2014 to 2015 varied from a loss of one to a gain of five (data not shown). In 2015, 1,500 counties—almost 60 percent of all counties in the federally run Marketplaces—experienced a net increase in the number of insurers (Exhibit 1). Counties that experienced new entrants were more densely populated and had higher per capita health spending than counties that had no new entry (online Appendix Exhibit A1).[25]

The total number of plans at all metal tiers available to the average Marketplace consumer also increased, from 54.4 in 2014 to 63.5 in 2015 (Exhibit 1). Simultaneously, the number of plans per insurer fell from 15.3 to 12.4. This was because new entrants limited their offerings to about eight plans per insurer (data not shown). Silver and bronze plans made up roughly two-thirds of the plans offered in both 2014 and 2015.

Among counties in states with federally run

EXHIBIT 1

Insurers, Qualified Health Plans, And Monthly Premiums In The Federally Run Marketplaces, 2014 And 2015

	All counties ($N = 2,545$)			Counties with positive net entry in 2015 ($n = 1,500$)			Counties without positive net entry in 2015 ($n = 1,045$)		
	2014	2015	Change	2014	2015	Change	2014	2015	Change
AVERAGE PER COUNTY NUMBER OF:									
Insurers	3.6	5.2	43.7%	3.7	5.6	50.5%	3.1	3.0	−4.6%
Plans	54.4	63.5	16.8	57.1	67.6	18.4	38.4	39.7	3.5
Plans per insurer	15.3	12.4	−19.2	15.8	12.2	−22.7	12.5	13.3	7.0
Silver plans per insurer	5.1	4.6	−10.3	5.3	4.6	−13.7	4.0	4.7	15.7
Bronze plans per insurer	4.4	3.6	−17.9	4.5	3.5	−22.0	3.7	4.2	11.4
AVERAGE MONTHLY PREMIUM FOR:									
Silver plan	$257	$266	3.7%	$259	$268	3.6%	$244	$255	4.7%
Second-lowest-cost silver plan	218	222	2.0	218	221	1.5	217	228	5.0
Bronze plan	211	217	3.0	213	219	2.7	196	206	4.6
Second-lowest-cost bronze plan	174	180	3.7	175	180	3.1	168	180	7.4

SOURCE Authors' analysis of data from HealthCare.gov. Health and dental plan datasets for researchers and issuers (Note 13 in text). **NOTES** Monthly premiums (rounded to the nearest dollar) are for single coverage for a twenty-seven-year-old nonsmoker; they exclude premium tax credits. Counties with positive net entry are those in which the number of insurers entering a federally run Marketplace in 2015 exceeded the number of insurers leaving. All statistics are county-level averages weighted by enrollment in the Marketplace as of January 2015. For counties with no reported enrollment, a de minimis enrollment of ten people was imputed. Plans offered in Virginia with a rider covering treatments for morbid obesity were excluded (for an explanation, see Note 15 in text).

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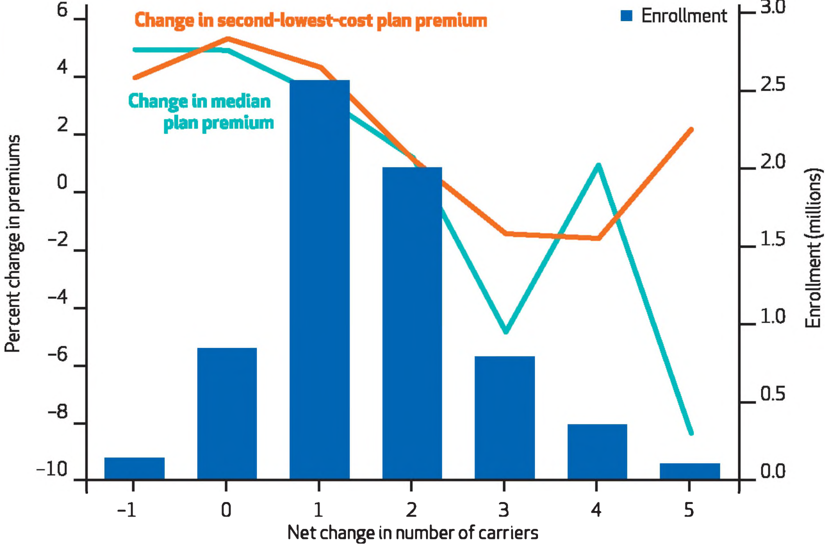
Marketplaces, average premiums for the second-lowest-cost silver plan for a twenty-seven-year-old nonsmoker increased 2.0 percent, from $218 in 2014 to $222 in 2015 (Exhibit 1). At the same time, average silver plan premiums increased 3.7 percent, from $257 to $266. In counties with positive net entry in 2015, the average second-lowest-cost silver plan premium increased just 1.5 percent, from $218 to $221. However, in counties without positive net entry, the average such premium rose 5.0 percent, from $217 to $228. The pattern was similar for second-lowest-cost bronze plan premiums.

In 2014, average silver plan premiums were $259 in counties with positive net entry and $244 in counties without it (Exhibit 1). Nevertheless, average silver plan premiums rose only 3.6 percent from 2014 to 2015 in counties with positive net entry, compared to 4.7 percent in counties without such entry. For average bronze plan premiums, the increases were 2.7 percent and 4.6 percent, respectively.

Exhibits 2 and 3 highlight the key relationships we analyzed. They illustrate total enrollment in the federally run Marketplaces associated with a particular net change between 2014 and 2015 in the number of insurers and a change in premiums. There is a negative, nonlinear relationship between the change in the number of insurers operating in a county and the change in the second-lowest-cost silver and median silver plan premiums (Exhibit 2). A similar relationship exists for bronze plans (Exhibit 3).

EXHIBIT 2

Changes In Second-Lowest-Cost And Median Silver Plan Premiums, By Net Change In Number Of Insurance Carriers From 2014 To 2015



SOURCE Authors' analysis of data from HealthCare.gov. Health and dental plan datasets for researchers and issuers (Note 13 in text). **NOTES** Monthly premiums are for single coverage for a twenty-seven-year-old nonsmoker in federally run Marketplaces. Plans offered in Virginia with a rider covering treatments for morbid obesity were excluded (for an explanation, see Note 15 in text). Change in premiums is denoted by the lines and relates to the left-hand y axis. Change in enrollment is denoted by the bars and relates to the right-hand y axis.

Exhibit 4 presents our multivariate results for the federally run Marketplaces at the county level and for the combined federally run and state-based Marketplaces at the rating area level. In the federally run Marketplaces, one additional insurer was associated with reductions in the average premiums for the second-lowest-cost silver plan of 3.5 percent and for the average silver plan of 1.2 percent. The average premiums for the second-lowest-cost bronze plan and the median bronze plan were both 2.2 percent lower with one additional insurer. A negative relationship was evident across all six measures of federally run Marketplace premiums, although two of these were insignificant at conventional levels (Appendix Exhibit A2).[25]

When we examined federally run and state-based Marketplaces together, we found that one additional insurer was associated with a 2.0 percent reduction in the median silver premium (Exhibit 4). However, the other two results were small and not significantly different from zero. States with state-based Marketplaces had fewer net new insurers per rating area in 2015 (0.5), compared to states with federally run Marketplaces (1.3; data not shown), which may partly explain these findings.

We next considered only federally run Marketplaces in the rating area analysis. The results confirmed our finding of a reduction in the average premium for the second-lowest-cost silver plan (a reduction of 2.2 percent, compared with 3.5 percent in the county-level analysis). The magnitudes for other points in the distribution, although not significant, were similar to our county-level analysis of federally run Marketplaces.

Because of our nonlinear specification, the effect of more than one insurer on premiums was not simply the number of additional insurers multiplied by the coefficients reported in Exhibit 4. If each insurer operating in a state in 2015 entered all counties in that state—in all likelihood, an upper bound on potential insurer entry—the average number of insurers in a county would increase by 3.4 (from 5.2 to 8.6; data not shown). When we applied the results of the county-level analysis, we found premium reductions of 4.5 percent for the second-lowest-cost silver plan, 3.7 percent for the average silver plan, 2.8 percent for the second-lowest-cost bronze plan, and 4.3 percent for the median bronze plan. These results suggest that the effect of entry is muted after the entry of two or three additional insurers.

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Our results support the idea that competitive effects in the Marketplaces are partly a result of incumbent responses to new entry. When we recalculated county-level changes in premiums excluding new entrants in 2015, we found a similar relationship between entry and premiums (Appendix Exhibit A4).[25] Incumbent insurers may have anticipated that certain insurers would enter their market in 2015, given the number of people who participated in the Marketplaces in 2014.

Discussion

Enrollment in the Marketplaces was projected to double from 2014 to 2015,[26] which made it likely that insurers would consider entering the Marketplaces or expanding participation in them. But increased insurer participation might not have led to lower growth in premiums, because insurers set premiums in 2015 with only preliminary information on costs. There was also great uncertainty about the operational success of the Marketplaces in the second year, which had little to do with the number of insurers in the Marketplaces.

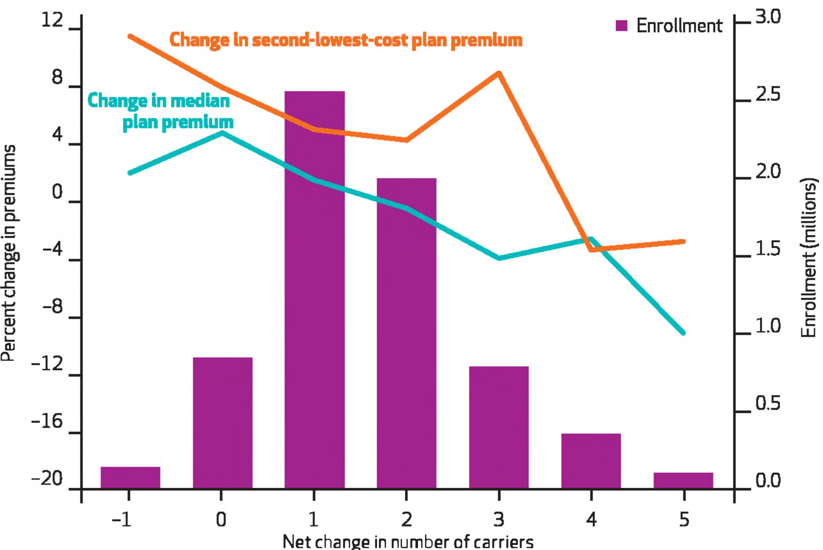
Because we compared regions with more or fewer insurers entering the market in 2015, our descriptive and multivariate results show that expanded entry did seem to have an effect on premiums. And because we used differenced regressions with a variety of controls, our results were consistent with a causal interpretation that an increase in the number of insurers reduces premiums. However, the size of the effects differed by the premium measure and level of analysis.

Our results indicate that jockeying to be the lowest- or second-lowest-cost plan is an important part of the mechanism of competition in the Marketplaces. Using early data from the Marketplaces, we found that both incumbent insurers and new entrants appeared to be actively competing to position their plans at the low end of premiums for plans in the silver and bronze tiers. For insurers attempting to gain market share, this may be logical because the premium subsidy is a fixed amount determined by the cost of the second-lowest-cost silver premium and family income. Individuals and families aiming to minimize their out-of-pocket premium expenses will likely prefer the lowest- or second-lowest-cost silver plan. They can reduce premium expenses further by selecting one of the bronze options (although in that case they might have to forgo cost-sharing subsidies if they are eligible for them).

Our estimates of changes in premiums in the Marketplaces due to competition are generally

EXHIBIT 3

Changes In Second-Lowest-Cost And Median Bronze Plan Premiums, By Net Change In Number Of Insurance Carriers From 2014 To 2015



SOURCE Authors' analysis of data from HealthCare.gov. Health and dental plan datasets for researchers and issuers (Note 13 in text). **NOTES** Monthly premiums are for single coverage for a twenty-seven-year-old nonsmoker in federally run Marketplaces. Plans offered in Virginia with a rider covering treatments for morbid obesity were excluded (for an explanation, see Note 15 in test). Change in premiums is denoted by the lines and relates to the right-hand y axis. Change in enrollment is denoted by the bars and relates to the left-hand y axis.

EXHIBIT 4

Changes In Monthly Premiums From 2014 To 2015 Arising From A Net Increase Of One Insurer In A Marketplace

Plan tier	Geographical scope	Second-lowest-cost plan	Average plan	Median plan
COUNTY-LEVEL ANALYSIS IN FEDERALLY RUN MARKETPLACES				
Silver	FFM	−3.5%****	−1.2%*	−1.1%
Bronze	FFM	−2.2***	−0.8	−2.2*
RATING AREA-LEVEL ANALYSIS IN FEDERALLY RUN AND STATE-BASED MARKETPLACES				
Silver	All	−0.2	0.1	−2.0*
Silver	FFM only	−2.2*	−0.6	−2.4

SOURCE Authors' analysis of data from the following sources: (1) HealthCare.gov. Health and dental plan datasets for researchers and issuers (Note 13 in text); and (2) Breakaway Policy Strategies. 2014 and 2015 ACA silver plan datasets (Notes 16 and 17 in text). **NOTES** Changes in monthly premiums are for single coverage a twenty-seven-year-old nonsmoker. Percentage changes were calculated as the sum of the variable net change in insurers and its squared term in each of the multivariate differenced regressions. Plans offered in Virginia with a rider covering treatments for morbid obesity were excluded (for an explanation, see Note 15 in text). Results of the county-level analysis were derived from regressions reported in Appendix Table A2 (see Note 25 in text) and were weighted by enrollment in the Marketplaces as of January 2015. Results of the rating area-level analysis were derived from regressions reported in Appendix Table A3 (see Note 25 in text) and were weighted by estimated nonelderly adult population in 2012. Colorado and Massachusetts were excluded from the rating area-level analysis because Colorado altered the boundaries for its rating areas between 2014 and 2015, and Massachusetts's rating areas are not counties but collections of ZIP codes, which made it difficult to use consistent control variables. Significance was calculated using Huber-White standard errors to correct for heteroscedasticity. $^{*}p < 0.10$ $^{***}p < 0.01$ $^{****}p < 0.001$

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larger than similar estimates for non-ACA markets, such as employer-sponsored insurance markets. The ACA standardized many features of health plans—for example, requiring coverage of a set of minimum essential benefits. And unlike enrollees in employer-sponsored plans, Marketplace enrollees are not partially insulated from premium costs through provisions in the tax code. Both of these factors may help explain these differences.

Our estimates of the effect of one additional insurer on premiums are comparable to two recent studies of the effect of insurer entry on ACA premiums.[9,10] However, in contrast to the results of these studies, our models suggest that competitive effects dissipate after two or three additional entrants.

In our analysis that combined results from all states, the effects of insurer participation appeared weaker than in our analysis of only states with federally run Marketplaces. States that ran their own Marketplaces were more likely to be "active purchasers," with officials soliciting insurer participation and directly negotiating with insurers to set premiums for 2014 and 2015. For instance, officials from California's Marketplace bargained for lower 2015 premiums by supplying their own analysis of the health risk of enrollees.[27] States with state-based Marketplaces had fewer new insurers entering on net in 2015 compared to states with federally run Marketplaces. This was the result of more exits by insurers from state-based Marketplaces than from federally run Marketplaces. While we cannot rule out the smaller sample size at the rating area level as a cause of this finding, insurer exit in state-based Marketplaces may have largely offset the potential for lower premiums from insurer entry.

The effects of competition on enrollee payments for Marketplace coverage are less certain than the effects of competition on premiums. Our results suggest that competition may have varying effects across plans. Although premium reductions can benefit all enrollees, unsubsidized enrollees are most likely to benefit. Because subsidized enrollees pay any difference between the premiums for the benchmark plan and their chosen plan, reductions in premiums for the benchmark plan will also reduce their subsidy. Thus, out-of-pocket expenses for non-benchmark plans may increase if the premiums for those plans do not fall by the same magnitude as the premium for the benchmark plan.

Our results for mean and median premiums differed somewhat by the level of analysis. Nonetheless, the strong effects on premiums for the second-lowest-cost silver plans suggest that the benefits of competition will likely have meaningful effects on federal spending on subsidies. As policy makers consider further legislative or regulatory changes to the Marketplaces, it will be important to consider the likely impact of any such change on insurer participation and the subsequent effect on overall premiums and federal costs.

Conclusion

Given the limited experience with the Marketplaces so far, future competitive dynamics are far from certain. In particular, it is not clear whether the new entrants in 2015 will be able to maintain any competitive position they have established, or whether their premiums were set as loss leaders to gain longer-run market share. Finally, it is not possible to know whether the chief effect of competition is to reduce premiums in the short run, or whether it might also have longer-run impacts on the underlying growth of premiums in the Marketplaces. ■

This article has not been subject to the regular review and editing process of the Congressional Budget Office (CBO). The views expressed in this article are those of the authors, and no official endorsement by the CBO, the Department of Health and Human Services, or the Agency for Healthcare Research and Quality is intended or should be inferred.

NOTES

1 Enthoven AC. Managed competition: an agenda for action. Health Aff (Millwood). 1988;7(3):25–47.

2 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health Insurance Marketplaces 2015 open enrollment period: March enrollment report [Internet]. Washington (DC): HHS; 2015 Mar 10 [cited 2015 Oct 13]. (ASPE Issue Brief). Available from: http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf

3 *Actuarial value* is defined as the percentage of insurer-covered claims that the plan would pay for a standard population. Individuals with incomes below 250 percent of the federal poverty level who purchase a silver plan are eligible for cost-sharing subsidies that increase the actuarial value from 70 percent to 73 percent, 87 percent, or 94 percent.

4 To test the possibility that our results were driven by greater variation in premiums when more insurers entered a market, we replicated our main results by randomly excluding insurers who entered a market for the first time in 2015. We found that any stochastic effects were likely to be small relative to our key estimates.

5 Trish EE, Herring BJ. How do health insurer market concentration and bargaining power with hospitals affect health insurance premiums? J Health Econ. 2015;42:104–14.

6 Stocking A, Baumgardner J, Buntin M, Cook A. Examining the number

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of competitors and the cost of Medicare Part D [Internet]. Washington (DC): Congressional Budget Office; 2014 Jul [cited 2015 Oct 13]. (CBO Working Paper No. 2014-04). Available from: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/workingpaper/45553-PartD_1.pdf

7 Dafny L, Duggan M, Ramanarayanan S. Paying a premium on your premium? Consolidation in the US health insurance industry. Am Econ Rev. 2012;102(2):1161–85.

8 Pauly MV, Hillman AL, Kim MS, Brown DR. Competitive behavior in the HMO marketplace. Health Aff (Millwood). 2002;21(1):194–202.

9 Dafny L, Gruber J, Ody C. More insurers lower premiums: evidence from initial pricing in the Health Insurance Marketplaces. Am J Health Econ. 2015;1(1):53–81.

10 Sheingold S, Nguyen N, Chappel A. Competition and choice in the Health Insurance Marketplaces, 2014–2015: impact on premiums [Internet]. Washington (DC): Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; 2015 Jul 27 [cited 2015 Oct 13]. (ASPE Issue Brief). Available from: http://aspe.hhs.gov/sites/default/files/pdf/108466/rpt_Marketplace Competition.pdf

11 In contrast, we used a nonlinear specification, which better captures the effects of insurer entry, and we present a broader set of results, including for both states with a federally run Marketplace and those with a state-based one, as well as for bronze premiums.

12 Dafny LS. Are health insurance markets competitive? Am Econ Rev. 2010;100(4):1399–431.

13 HealthCare.gov. Health and dental plan datasets for researchers and issuers [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2015 Oct 20]. Available from: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

14 Plan-level enrollment data were not available at time of our analysis. Thus, our county- and rating area–level changes in mean premiums are unweighted.

15 This choice had minimal effect on our estimates. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2015 plan selections by ZIP code in the health insurance Marketplace [Internet]. Washington (DC): HHS; 2015 Jan [cited 2015 Oct 13]. Available from: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/EnrollmentByZip/rpt_Enrollment ByZip.cfm. In addition, we excluded 252 plans (1 percent of all plans) from our analysis that appeared to be anomalies of the Virginia Marketplace. In 2014 Virginia health insurers were required to offer at least one plan covering the treatment of morbid obesity. The average monthly premium in 2014 for these plans was $1,527, compared to $238 for other plans in the state for the same age group. In 2015 morbid obesity rider plans were no longer included in Virginia's Marketplace. Very few enrollees probably chose those plans, and the absence of the plans in 2015 significantly distorted the implied change in Virginia premiums from 2014 to 2015 (a reduction of 51 percent if the plans were included in 2014).

16 Breakaway Policy Strategies. 2014 ACA silver plan dataset [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2014 May [cited 2015 Oct 13]. Available from: http://www.rwjf.org/en/library/research/2014/05/aca-silver-dataset-2014.html

17 Breakaway Policy Strategies. 2015 ACA silver plan dataset [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2015 May [cited 2015 Oct 15]. Available from: http://www.rwjf.org/en/library/research/2015/05/aca-silver-dataset-2015.html

18 Our rating area–level analyses were weighted by estimates of the nonelderly adult population in 2012.

19 In nearly all states, premiums for individuals at other ages were the same multiple of the premium for the twenty-seven-year-old, which made analyses of premiums for other ages unnecessary.

20 All of our results remained robust when we used more parsimonious models that included only a handful of controls.

21 County Health Rankings and Roadmaps. County health rankings 2014: codebook for analytic datasets [Internet]. Madison (WI): University of Wisconsin Population Health Institute; [cited 2015 Oct 13]. Available from: http://www.countyhealthrankings.org/sites/default/files/2014%20CHR%20analytic%20data%20documentation.pdf

22 County-level poverty rates were derived from Department of Agriculture Economic Research Service. Poverty estimates for the U.S., states, and counties, 2013 [Internet]. Washington (DC): USDA; [cited 2015 Oct 13]. Available for download from: http://www.ers.usda.gov/data-products/county-level-data-sets/download-data.aspx

23 Because of small cell sizes, the county health rankings data (see Note 21) were missing for several hundred counties for two variables (the percentage of the population reporting themselves to be in fair or poor health and average number of sick days per month). In these cases, we imputed the mean value of each variable and included an indicator variable.

24 For instance, because actuarial projections of health risk tend to be cautious, first-year profits may have been inflated and thus could have encouraged second-year entry. Public information on the profitability of insurers became available only after insurers set premiums for the 2015 plan year, making this possibility unlikely.

25 To access the Appendix, click on the Appendix link in the box to the right of the article online.

26 Congressional Budget Office. The budget and economic outlook: 2014 to 2024 [Internet]. Washington (DC): CBO; 2014 Feb [cited 2015 Oct 14]. Appendix B: updated estimates of the insurance coverage provisions of the Affordable Care Act. Available from: https://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf

27 California Healthline. Covered Calif. negotiated lower rates by providing data to insurers. California Healthline [serial on the Internet]. 2015 Jun 19 [cited 2015 Oct 14]. Available from: http://www.californiahealthline.org/articles/2015/6/19/covered-calif-negotiated-lower–rates-by-providing-data-to-insurers

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National Health Interview Survey Early Release Program

Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates From the National Health Interview Survey, 2011–June 2015

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Highlights

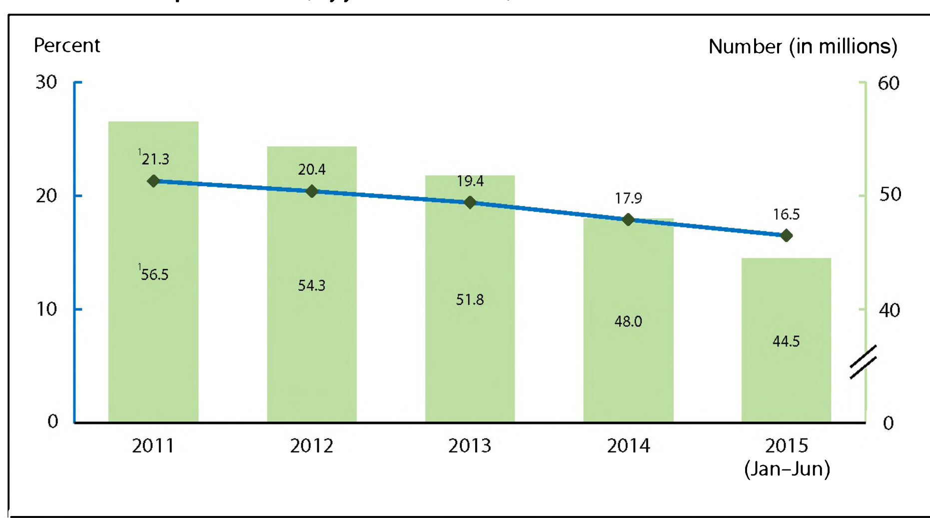
- The percentage of persons under age 65 who were in families having problems paying medical bills decreased from 21.3% (56.5 million) in 2011 to 16.5% (44.5 million) in the first 6 months of 2015.
- Within each year, from 2011 through June 2015, children aged 0–17 years were more likely than adults aged 18–64 to be in families having problems paying medical bills.
- The percentage of children aged 0–17 years who were in families having problems paying medical bills decreased from 23.2% in 2011 to 18.1% in the first 6 months of 2015.
- In the first 6 months of 2015, among persons under age 65, 29.8% of those who were uninsured, 21.8% of those who had public coverage, and 12.7% of those who had private coverage were in families having problems paying medical bills in the past 12 months.
- In the first 6 months of 2015, 24.5% of poor, 27.1% of near-poor, and 12.2% of not-poor persons under age 65 were in families having problems paying medical bills in the past 12 months.

Introduction

In the first half of 2011 through the first half of 2014, approximately one in five persons under age 65 was in a family that had problems paying medical bills in the past 12 months (1–4). The number of persons who were in families having problems paying medical bills decreased from 56.5 million in 2011 to 47.7 million in the first 6 months of 2014 (4). This report provides updated estimates for the percentage of persons under age 65 who were in families having problems paying medical bills, by selected demographic variables, based on data from the National Health Interview Survey (NHIS) for January 2011 through June 2015. Estimates for 2011–2014 were based on full years of data and the 2015 estimates were based on data collected during the first 6 months of 2015. In this report, an NHIS "family" is defined as an individual or a group of two or more related persons living together in the same housing unit. Thus, a family can consist of only one person. In some instances, unrelated persons sharing the same household, such as an unmarried couple living together, may also be considered a family.

This report was produced by the NHIS Early Release (ER) Program, which releases selected preliminary estimates prior to final microdata release. These estimates are available from the NHIS website at http://www.cdc.gov/nchs/nhis.htm. For more information about NHIS and the ER Program, see the Technical Notes and Additional Early Release Program Products sections at the end of this report.

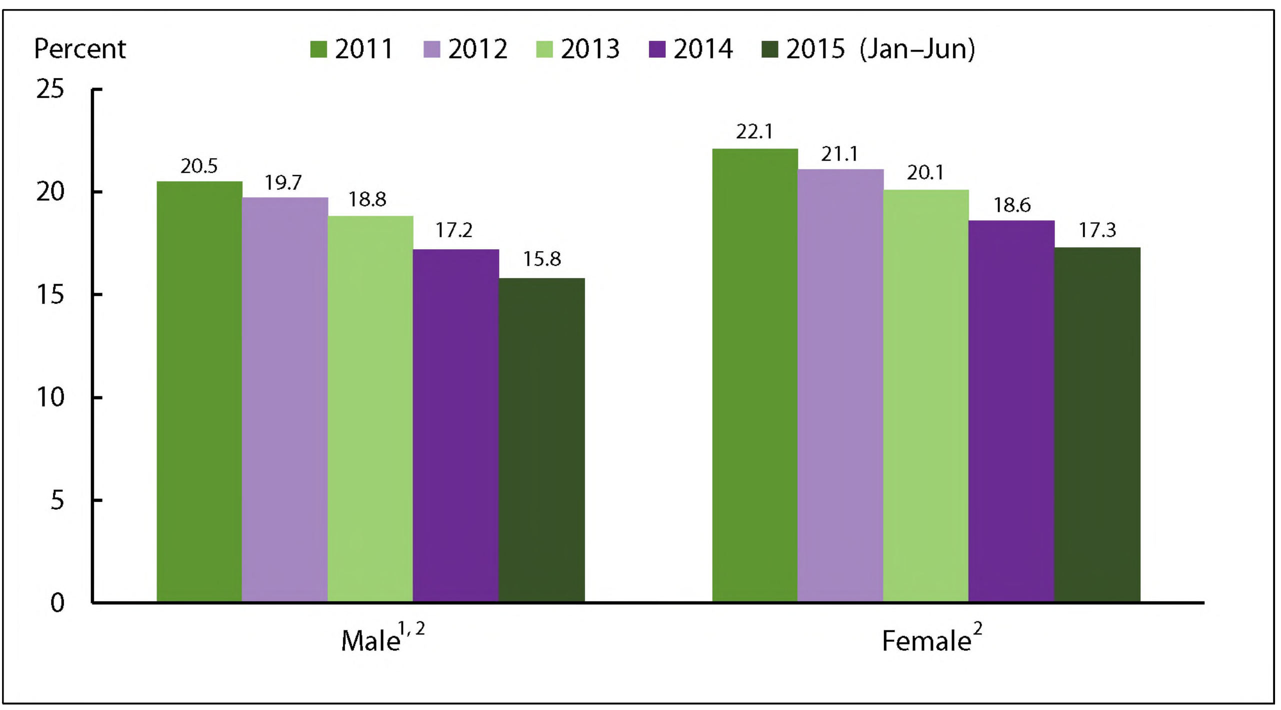
Figure 1. Percentage and number of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by year: United States, 2011–June 2015



[1]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

- Among persons under age 65, 16.5% (44.5 million) were in families having problems paying medical bills in the first 6 months of 2015 (Figure 1 and Table).
- The percentage of persons under age 65 who were in families having problems paying medical bills decreased from 17.9% (48.0 million) in 2014 to 16.5% (44.5 million) in the first 6 months of 2015.
- The percentage of persons under age 65 who were in families having problems paying medical bills decreased from 21.3% (56.5 million) in 2011 to 16.5% in the first 6 months of 2015.

Figure 2. Percentage of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by sex and year: United States, 2011–June 2015



[1]Significantly different from females within each year ($p < 0.05$).
[2]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

- Among persons under age 65, the percentage of males who were in families having problems paying medical bills decreased from 20.5% in 2011 to 15.8% in the first 6 months of 2015 (Figure 2).
- Among persons under age 65, the percentage of females who were in families having problems paying medical bills decreased from 22.1% in 2011 to 17.3% in the first 6 months of 2015.
- Within each year, females were more likely than males to have been in a family having problems paying medical bills.

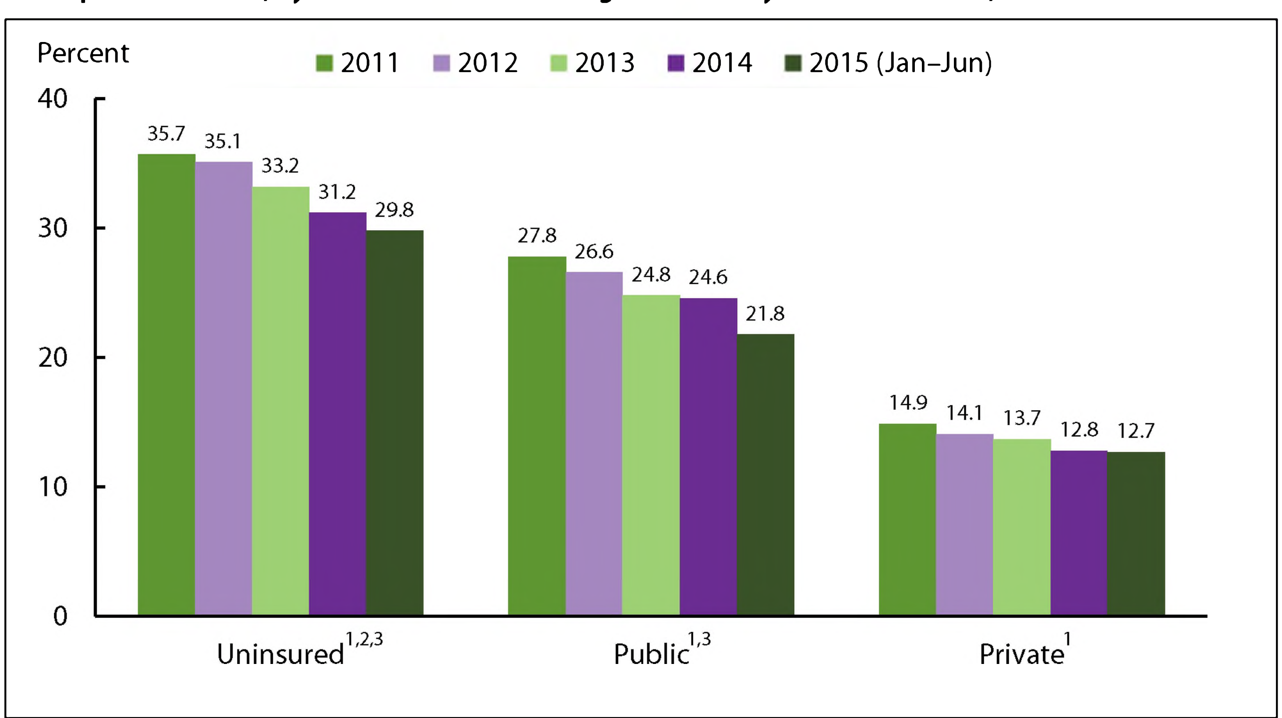
Figure 3. Percentage of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by age group and year: United States, 2011–June 2015

Age group	2011	2012	2013	2014	2015 (Jan–Jun)
0–17 years[1,2]	23.2	22.0	21.0	19.2	18.1
18–64 years[2]	20.6	19.8	18.8	17.4	15.9

[1]Significantly different from age group 18–64 within each year ($p < 0.05$).
[2]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

- Among children aged 0–17 years, the percentage who were in families having problems paying medical bills decreased from 23.2% in 2011 to 18.1% in the first 6 months of 2015 (Figure 3).
- Among adults aged 18–64, the percentage who were in families having problems paying medical bills decreased from 20.6% in 2011 to 15.9% in the first 6 months of 2015.
- Within each year, children were more likely than adults aged 18–64 to be in families having problems paying medical bills.

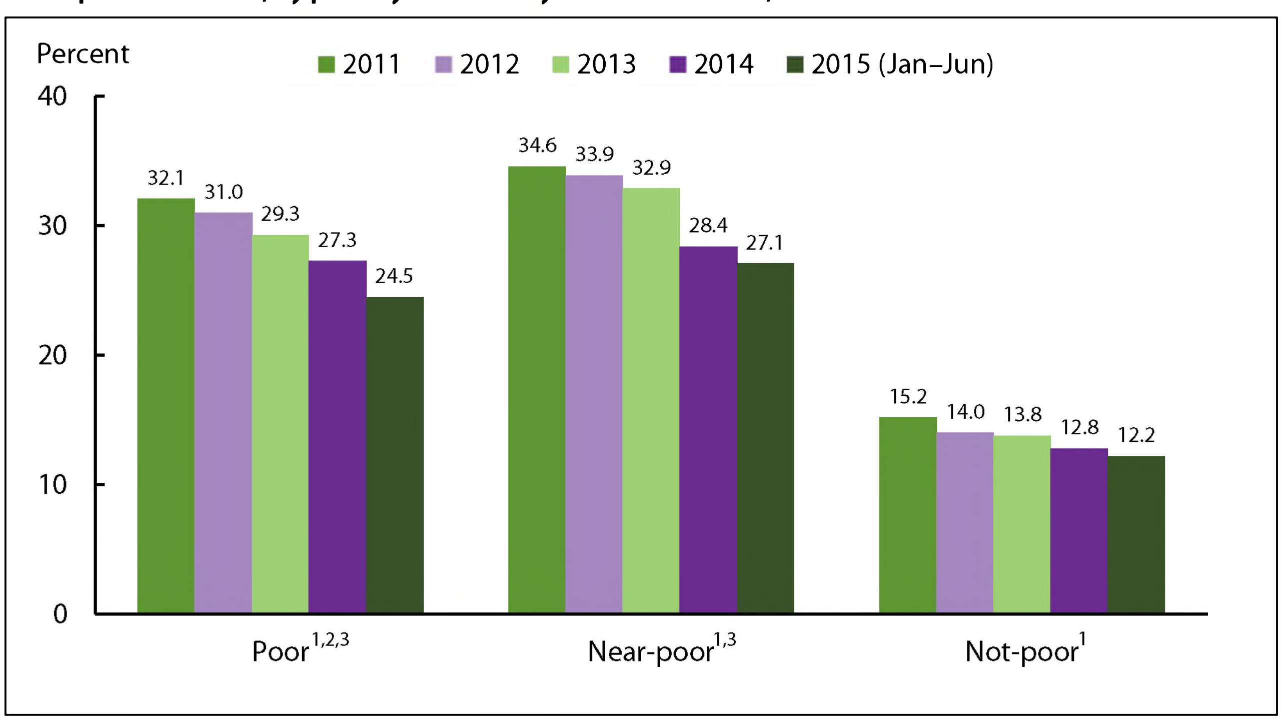
Figure 4. Percentage of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by health insurance coverage status and year: United States, 2011–June 2015



[1]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
[2]Significantly different than Public coverage within each year ($p < 0.05$).
[3]Significantly different than Private coverage within each year ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

- In the first 6 months of 2015, among persons under age 65, 29.8% of those who were uninsured, 21.8% of those with public coverage, and 12.7% of those who had private coverage were in families having problems paying medical bills in the past 12 months (Figure 4)
- Among persons under age 65 who were uninsured, the percentage who were in families having problems paying medical bills decreased from 35.7% in 2011 to 29.8% in the first 6 months of 2015.
- The percentage of persons with public coverage who were in families having problems paying medical bills decreased from 27.8% in 2011 to 21.8% in the first 6 months of 2015.
- The percentage of persons under age 65 with private coverage who were in families having problems paying medical bills decreased from 14.9% in 2011 to 12.7% in the first 6 months of 2015.
- Within each year, persons under age 65 who were uninsured were more than twice as likely as those who had private coverage to be in families having problems paying medical bills.
- Within each year, persons under age 65 who were uninsured were more likely than those who had public coverage to be in families having problems paying medical bills.
- Within each year, persons under age 65 who had public coverage were more likely than those who had private coverage to be in families having problems paying medical bills.

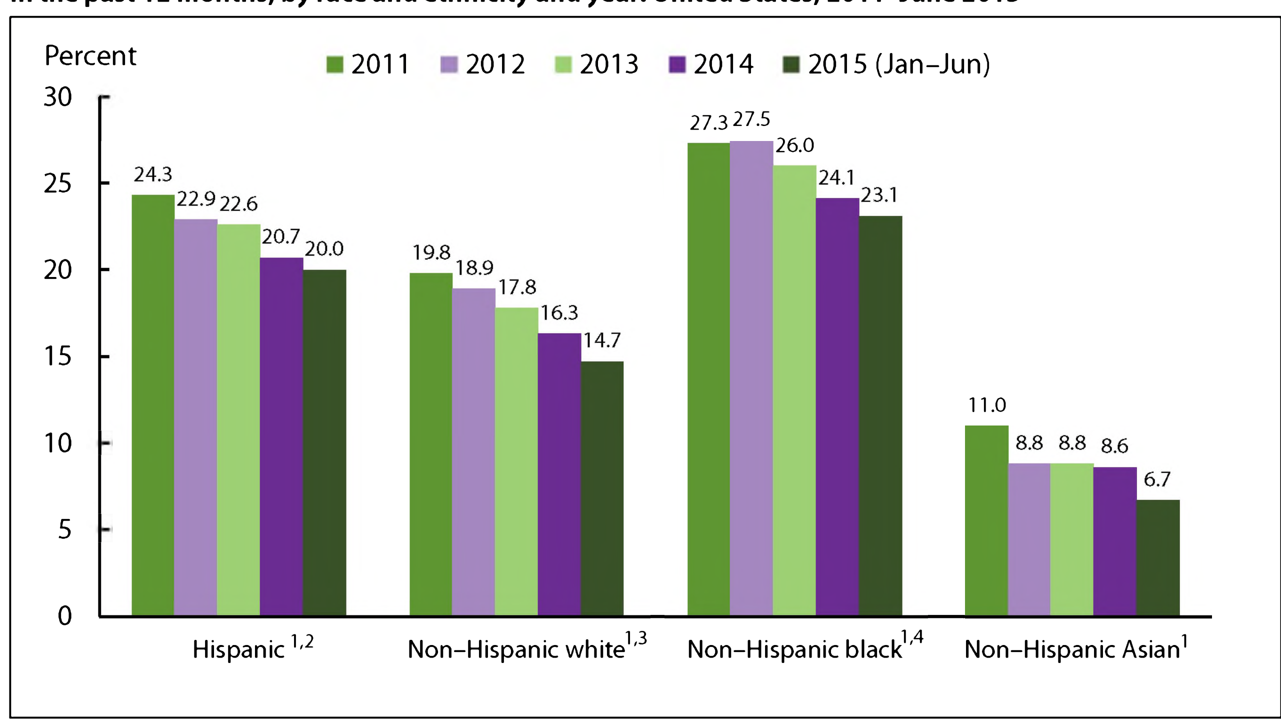
Figure 5. Percentage of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by poverty status and year: United States, 2011–June 2015



[1]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
[2]Significantly different than near-poor within years 2011, 2012, and 2013 ($p < 0.05$).
[3]Significantly different than not-poor within each year ($p < 0.05$).
NOTES: "Poor" persons are defined as those below the poverty threshold; "near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "not-poor" persons have incomes of 200% of the poverty threshold or greater. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

- In the first 6 months of 2015, among persons under age 65, 24.5% of those who were poor, 27.1% of those who were near-poor, and 12.2% of those who were not-poor were in families having problems paying medical bills in the past 12 months (Figure 5).
- The percentage of poor persons under age 65 who were in families having problems paying medical bills decreased from 32.1% in 2011 to 24.5% in the first 6 months of 2015.
- The percentage of near-poor persons under age 65 who were in families having problems paying medical bills decreased from 34.6% in 2011 to 27.1% in the first 6 months of 2015.
- The percentage of not-poor persons under age 65 who were in families having problems paying medical bills decreased from 15.2% in 2011 to 12.2% in the first 6 months of 2015.
- Within each year, persons under age 65 who were poor or near-poor were twice as likely as those who were not-poor to be in families having problems paying medical bills.

Figure 6. Percentage of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by race and ethnicity and year: United States, 2011–June 2015



[1]Significant linear decrease from 2011 through June 2015 ($p < 0.05$).
[2]Hispanic persons were significantly different from Non-Hispanic white, Non-Hispanic black, and Non-Hispanic Asian persons within each year ($p < 0.05$).
[3]Non-Hispanic white persons were significantly different from Non-Hispanic black and Non-Hispanic Asian persons within each year ($p < 0.05$).
[4]Non-Hispanic black persons were significantly different from Non-Hispanic Asian persons within each year ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

- In the first 6 months of 2015, among persons under age 65, 20.0% of Hispanic, 14.7% of non-Hispanic white, 23.1% of non-Hispanic black, and 6.7% of non-Hispanic Asian persons were in families having problems paying medical bills in the past 12 months (Figure 6).
- The percentage of Hispanic persons under age 65 who were in families having problems paying medical bills decreased from 24.3% in 2011 to 20.0% in the first 6 months of 2015.
- The percentage of non-Hispanic white persons under age 65 who were in families having problems paying medical bills decreased from 19.8% in 2011 to 14.7% in the first 6 months of 2015.
- The percentage of non-Hispanic black persons under age 65 who were in families having problems paying medical bills decreased from 27.3% in 2011 to 23.1% in the first 6 months of 2015.
- The percentage of non-Hispanic Asian persons under age 65 who were in families having problems paying medical bills decreased from 11.0% in 2011 to 6.7% in the first 6 months of 2015.
- Within each year and among persons under age 65, Hispanic persons were more likely than non-Hispanic white persons or non-Hispanic Asian persons, and less likely than non-Hispanic black persons, to be in families having problems paying medical bills.
- Within each year and among persons under age 65, non-Hispanic white persons were less likely than non-Hispanic black persons and more likely than non-Hispanic Asian persons to be in families having problems paying medical bills.
- Within each year and among persons under age 65, non-Hispanic black persons were more likely than non-Hispanic Asian persons to be in families having problems paying medical bills.

Table. Percentage and (standard error) of persons under age 65 who were in families having problems paying medical bills in the past 12 months, by selected demographic characteristics and year: United States, 2011–June 2015

Selected characteristic	2011	2012	2013	2014	2015 (Jan–Jun)
Total	21.3 (0.37)	20.4 (0.33)	19.4 (0.38)	17.9 (0.35)	16.5 (0.41)
Sex					
Male	20.5 (0.38)	19.7 (0.34)	18.8 (0.40)	17.2 (0.35)	15.8 (0.46)
Female	22.1 (0.41)	21.1 (0.36)	20.1 (0.40)	18.6 (0.39)	17.3 (0.43)
Age group					
0–17 years	23.2 (0.51)	22.0 (0.49)	21.0 (0.54)	19.2 (0.48)	18.1 (0.59)
18–64 years	20.6 (0.36)	19.8 (0.32)	18.8 (0.37)	17.4 (0.34)	15.9 (0.40)
Race and ethnicity					
Hispanic	24.3 (0.72)	22.9 (0.64)	22.6 (0.64)	20.7 (0.73)	20.0 (0.91)
Non-Hispanic, white only	19.8 (0.47)	18.9 (0.46)	17.8 (0.47)	16.3 (0.44)	14.7 (0.52)
Non-Hispanic, black only	27.3 (0.85)	27.5 (0.73)	26.0 (0.88)	24.1 (0.85)	23.1 (1.18)
Non-Hispanic, Asian only	11.0 (0.87)	8.8 (0.72)	8.8 (0.83)	8.6 (0.76)	6.7 (1.01)
Non-Hispanic other races	26.7 (1.69)	26.2 (1.58)	23.6 (1.73)	23.1 (1.49)	20.5 (2.37)
Health insurance coverage status by age group					
Under 65 years:					
Uninsured[1]	35.7 (0.76)	35.1 (0.63)	33.2 (0.69)	31.2 (0.81)	29.8 (1.19)
Private[2]	14.9 (0.33)	14.1 (0.33)	13.7 (0.42)	12.8 (0.34)	12.7 (0.42)
Public[3]	27.8 (0.62)	26.6 (0.63)	24.8 (0.61)	24.6 (0.61)	21.8 (0.75)
0–17 years:					
Uninsured[1]	37.7 (1.76)	36.7 (1.65)	36.2 (1.73)	32.7 (1.85)	33.9 (3.56)
Private[2]	16.7 (0.52)	15.3 (0.57)	14.7 (0.65)	13.3 (0.54)	14.1 (0.73)
Public[3]	29.3 (0.80)	28.6 (0.81)	26.7 (0.82)	25.6 (0.76)	22.0 (0.95)
18–64 years:					
Uninsured[1]	35.4 (0.74)	34.9 (0.64)	32.8 (0.67)	31.0 0.78)	29.2 (1.12)
Private[2]	14.4 (0.31)	13.8 (0.31)	13.4 (0.40)	12.6 (0.33)	12.3 (0.40)
Public[3]	26.2 (0.64)	24.6 (0.65)	23.0 (0.61)	23.7 (0.67)	21.6 (0.91)
Poverty status,[4] by age group					
Under 65 years:					
Poor	32.1 (0.93)	31.0 (0.84)	29.3 (0.95)	27.3 (0.96)	24.5 (1.23)
Near-poor	34.6 (0.78)	33.9 (0.85)	32.9 (0.86)	28.4 (0.81)	27.1 (1.11)
Not-poor	15.2 (0.39)	14.0 (0.36)	13.8 (0.41)	12.8 (0.37)	12.2 (0.45)
0–17 years:					
Poor	32.7 (1.23)	30.3 (1.13)	28.4 (1.22)	26.7 (1.23)	22.9 (1.48)
Near-poor	34.3 (1.08)	32.7 (1.14)	32.9 (1.20)	27.0 (1.02)	27.3 (1.54)
Not-poor	15.4 (0.59)	14.6 (0.54)	14.2 (0.65)	13.2 (0.56)	13.2 (0.77)
18–64 years:					
Poor	31.8 (0.93)	31.4 (0.87)	29.8 (0.94)	27.7 (0.98)	25.6 (1.28)
Near-poor	34.7 (0.79)	34.5 (0.84)	33.0 (0.83)	29.0 (0.84)	27.0 (1.06)
Not-poor	15.1 (0.38)	13.8 (0.34)	13.7 (0.39)	12.6 (0.36)	11.9 (0.42)
Out-of-pocket medical expenses[5]					
Less than $2,000	17.9 (0.36)	17.2 (0.34)	16.1 (0.36)	15.3 (0.35)	13.3 (0.45)
$2,000 or more	32.7 (0.79)	31.2 (0.78)	30.3 (0.80)	27.2 (0.79)	26.5 (1.06)

[1]Includes persons without private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military health plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[2]Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

[3]Includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare (disability), and military plans. A small number of persons were covered by both public and private plans and were included in both categories

[4]Based on family income and family size, using the U.S. Census Bureau's poverty thresholds. "Poor" persons are defined as those below the poverty threshold, "near-poor" persons have incomes of 100% to less than 200% of the poverty threshold, and "not-poor" persons have incomes of 200% of the poverty threshold or greater. The percentages of respondents with unknown poverty status were 11.5% in 2011, 11.4% in 2012, 10.2% in 2013, 8.8% in 2014 and 8.5% in the first two quarters of 2015. Estimates for persons with unknown poverty status are not shown separately. For more information on the unknown income and poverty status categories, see the Survey Description Document for the 2014 National Health Interview Survey, available from: http://www.cdc.gov/nchs/nhis.htm. The estimates shown in this report may differ from estimates based on both reported and imputed income.

[5]Based on the following survey question: "The next question is about money that [you have/your family has] spent out of pocket on medical care. We do not want you to count health insurance premiums, over-the-counter drugs, or costs that you will be reimbursed for. In the past 12 months, about how much did [you/your family] spend for medical care and dental care?"

NOTES: Having problems paying medical bills in the past 12 months is based on the following survey question: "In the past 12 months did [you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care." Health insurance pertains to the sample person, whereas "problems paying medical bills" refers to the family as reported by the family respondent. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: CDC/NCHS, National Health Interview Survey, 2011–2015.

For additional tabulations on the payment for medical care from 2011–June 2015, two additional tables are available from the ER program. One table presents estimates of the percentage of persons under age 65 who were in families that currently have medical bills that they are unable to pay at all by selected demographics:
(http://www.cdc.gov/nchs/data/nhis/earlyrelease/bills_unable_to_pay_at_all_2011_2015.pdf). Another table presents estimate of the percentage of persons under age 65 who were in families that currently have medical bills that they are paying over time by selected demographics:
(http://www.cdc.gov/nchs/data/nhis/earlyrelease/bills_being_paid_overtime_2011_2015.pdf).

Technical Notes

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) is releasing selected estimates of problems paying medical bills in the past 12 months for the civilian noninstitutionalized U.S. population based on data from the January 2011–June 2015 National Health Interview Survey (NHIS).

The estimates are being released prior to final data editing and final weighting to provide access to the most recent information from NHIS. Differences between estimates calculated using preliminary data files and final data files are typically less than 0.1 percentage point. Estimates for 2011 through June 2015 are stratified by year, sex, age group, race and ethnicity, poverty status, health insurance coverage status, and out-of-pocket medical expenses. All estimates in this report are based on preliminary data files.

Data source

Data used to produce this Early Release (ER) report are derived from the NHIS Family Core and Supplemental components from January 2011 through June 2015. These components collect information on all family members in each household. Data analysis was based on information collected on 417,326 persons in the Family Core and Supplemental components. Visit the NHIS website at http://www.cdc.gov/nchs/nhis.htm for more information about the design, content, and use of NHIS.

Estimation procedures

NCHS creates survey weights for each calendar quarter of the NHIS sample. The NHIS data weighting procedure is described in more detail at http://www.cdc.gov/nchs/data/series/sr_02/sr02_165.pdf. Estimates were calculated using the NHIS survey weights, which are calibrated to census totals for sex, age, and race and ethnicity of the U.S. civilian noninstitutionalized population. Weights for the 2011 NHIS were derived from 2000 census-based population estimates. Weights for the 2012, 2013, 2014 and 2015 NHIS data were derived from 2010 census-based population estimates.

Point estimates, and estimates of their variances, were calculated using SUDAAN software to account for the complex sample design of NHIS. The Taylor series linearization method was chosen for variance estimation.

Unless otherwise noted, all estimates shown meet the NCHS standard of having less than or equal to 30% relative standard error. Differences between percentages or rates were evaluated using two-sided significance tests at the 0.05 level. Terms such as "more likely" and "less likely" indicate a statistically significant difference. Terms such as "similar" and "no difference" indicate that the estimates being compared were not significantly different. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

Definitions of selected terms

Health insurance coverage at interview—The "private health insurance coverage" category includes persons who had any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. The "public health plan coverage" category includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories. A person was defined as uninsured if he or she did not have, at the time of the interview, any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. The analyses excluded persons with unknown health insurance status (about 1% of respondents each year). Data on health insurance status were edited using an automated system based on logic checks and keyword searches. For comparability, the estimates for all years were created using these same procedures. Health insurance information is collected for all persons in a family and is reported on an individual basis.

Family—An individual or a group of two or more related persons who are living together in the same occupied housing unit (i.e., household) in the sample. In some instances, unrelated persons sharing the same household, such as an unmarried couple living together, may also be considered one family.

Poverty status—Based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children) defined by the U.S. Census Bureau for that year (5–9). Persons categorized as "poor" have a poverty ratio less than 100% (i.e., their family income was below the poverty threshold); "near-poor" persons have incomes of 100% to less than 200% of the poverty threshold; and "not-poor" persons have incomes that are 200% of the poverty threshold or greater. The percentage of respondents with unknown poverty status from January 2011 through June 2015 averaged 10.2%. For more information on unknown income and unknown poverty status, see the NHIS Survey Description Document for 2014: http://www.cdc.gov/nchs/nhis.htm.

NCHS provides imputed income files, which are released a few months after the annual release of NHIS microdata and are not available for the ER updates. Therefore, estimates stratified by poverty status in this ER report are based on reported income only and may differ from similar estimates produced later that are based on both reported and imputed income.

Problems paying medical bills in the past 12 months—Based on the following question: "In the past 12 months, did [you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care." This question was answered by the family respondent on behalf of everyone in the family.

Additional Early Release Program Products

Additional reports are published through the ER Program. *Early Release of Selected Estimates Based on Data From the National Health Interview Survey* is published quarterly and provides estimates of 15 selected measures of health. Measures of health include estimates of health insurance, having a usual place to go for medical care, obtaining needed medical care, influenza vaccination, pneumococcal vaccination, obesity, leisure-time physical activity, current smoking, alcohol consumption, HIV testing, general health status, personal care needs, serious psychological distress, diagnosed diabetes, and asthma episodes and current asthma.

Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey is published quarterly and provides detailed estimates of health insurance coverage.

Wireless Substitution: Early Release of Estimates From the National Health Interview Survey is published biannually and provides selected estimates of telephone coverage in the United States.

In addition to these reports, preliminary microdata files containing selected NHIS variables are produced as part of the ER Program. For the 2015 NHIS, these files are made available four times: in August 2015, November 2015, February 2016 and May 2016. NHIS data users can analyze these files through the National Center for Health Statistics Research Data Center without having to wait for the final annual NHIS microdata files to be released.

New measures may be added as work continues and in response to changing data needs. Feedback on these releases is welcome (nhislist@cdc.gov).

Announcements about Early Releases, other new data releases, publications, or corrections related to NHIS will be sent to members of the HISUSERS e-mail list. To join, visit the Centers for Disease Control and Prevention website at http://www.cdc.gov/subscribe.html.

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U.S. Department of Health and Human Services

Rate Review Annual Report

December 2015

U.S. Department of Health and Human Services Rate Review Annual Report for Calendar Years 2014 and 2015

Executive Summary

The Affordable Care Act established the Rate Review and the Rate Review Grants Programs,[1] which became effective in 2011. These programs, coupled with several critical protections for consumers who purchase non-grandfathered health insurance coverage in the individual and small group markets, have brought new levels of scrutiny and transparency to health insurance rates in those markets. Increased review has resulted in some issuers lowering their rates (implemented compared to proposed), while increased transparency allows consumers to view rate information that was not previously available. In 2015, rate review reduced total premiums for renewed single risk pool plans by an estimated $1.1 billion in the individual market and by $418 million in the small group market.

Background

Before the enactment of the Affordable Care Act, annual premium increases in the individual market were highly variable and increases often averaged 10 percent or more at the state-level. From 2008 to 2010, the average annual rates of premium increases in the individual market ranged from 9.9 percent to 11.7 percent. In 2010, many increases were in the range of 9 percent to 15 percent, but a full quarter of issuers increased premiums by 15 percent or more. The average annual state-level increase was 10 percent or higher.[2]

After the enactment of the Affordable Care Act, average rate increases in the individual market moderated to 7.0 percent in 2011 and 7.1 percent in 2012. The average rate increase was 10.3 percent in 2013, but would have been 8.7 percent if the high increases in one outlier state were excluded. This report shows that rate increases have remained moderate since 2013. The average rate increase in the individual market was 2.4 percent in 2014 and 6.9 percent in 2015. In the small group market, the average annual rates of increase were 6.1 percent in 2011, 4.7 percent in 2012 and 7.1 percent in 2013.[3] Small group rate increases have also remained moderate since 2013. In the small group market, the average rate increase was 3.6 percent in 2014 and 4.3 percent in 2015.

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[1] Section 2794 of the Public Health Service Act (PHSA).

[2] HHS (2011), *Rate Review Works: Early Achievements of Health Insurance Rate Review Grants*. See https://www.cms.gov/CCIIO/Resources/Files/Downloads/rate_review_report_092011.pdf.
HHS (2012), *Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011*. See http://www.aspe.hhs.gov/health/reports/2014/Premiums/20121119%20PremTrendsRptFnl.pdf.
Annual Rate Review Reports for prior years are available at:
https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html; http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.pdf; and http://aspe.hhs.gov/pdf-report/rate-review-annual-report-calendar-year-2013.

[3] HHS (2011), *Rate Review Works: Early Achievements of Health Insurance Rate Review Grants*. See https://www.cms.gov/CCIIO/Resources/Files/Downloads/rate_review_report_092011.pdf.
HHS (2012), *Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011*. See http://www.aspe.hhs.gov/health/reports/2014/Premiums/20121119%20PremTrendsRptFnl.pdf.

Increased Review

Since September 1, 2011, all issuers requesting rate increases of 10 percent or more for non-grandfathered products in the individual and small group markets are required to submit a rate filing justification to the Secretary of the Department of Health and Human Services (HHS). States with effective rate review programs review these proposed rate increases to determine whether they are unreasonable in accordance with the federal definition[4] and their review has to incorporate all of the factors listed in 45 CFR 154.301. For states without effective rate review programs,[5] HHS conducts the review of issuers' proposed rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets.

Through the Rate Review Grants Program, HHS provided $250 million in grants to 45 states and the District of Columbia in fiscal years 2010 through 2014 to establish and enhance rate review programs. States have used grant funds for many activities including: hiring and contracting with actuaries to review rates; creating rate filing instructions for issuers; improving state websites to display rate review information; and hiring additional staff to facilitate the rate review process.

Increased Transparency

States with an effective rate review program must post information for proposed increases of 10 percent or more to their state website or provide HHS's web address for such information, and must have a mechanism for receiving public comments on those proposed rate increases. After review, those states must post final increases or provide HHS's web address for such information.

In some states, the insurance regulator has the authority to deny or reduce unreasonable rates. In other states, the regulator cannot prevent an issuer from implementing a rate increase that was deemed unreasonable. However, the issuer must publicly disclose, in a prominent location on its website, that the rate increase was deemed unreasonable by the state, and provide a final justification for implementing the unreasonable rate increase.

2014 Market Reforms

Many additional health insurance market reforms went into effect in 2014. Two of those reforms directly impact the way that issuers are allowed to set rates. Issuers selling non-grandfathered coverage in the individual and small group (or merged) markets are required to adhere to new rating rules that limit permissible rating factors to geographic location, single vs. family coverage, age (within a 3 to 1 band), and tobacco use (within a 1.5 to 1 band).[6] Additionally, issuers are required to set rates based on all enrollees in a single risk pool, on and

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[4] See 45 CFR 154.205(a): "The rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase".

[5] There are currently five states without Effective Rate Review Programs: Alabama, Missouri, Oklahoma, Texas, and Wyoming.

[6] 45 CFR 147.102

off the Health Insurance Marketplace.[7] Grandfathered and transitional plans are not subject to those limited rating factors and risk pool requirements.

Rate Review Annual Reports

This is the fourth Rate Review Annual Report issued by HHS.[8] In prior years, the annual reports generally relied on retrospective data submitted through the Rate Review Grants program. Grantee states report information such as the average initial rate increase requested and final rate increase approved. Results from the 40 grantee states in the individual market and 37 grantee states in the small group market were extrapolated in order to provide national estimates of the premium reductions resulting from the decrease between initial and final rates. Since grantee states reported information retrospectively, prior annual reports contained results from the preceding calendar year (e.g. the 2014 annual report provided estimates using 2013 calendar year data).

Starting with coverage for calendar year 2014, an issuer is required to submit the Unified Rate Review Template (URRT) to HHS if it has any single risk pool plan in the individual or small group market with a rate increase of any size.[9] The URRT, which contains information about rate increases and the issuer's projections for enrollment and utilization for the following calendar year, is submitted by issuers through the Unified Rate Review (URR) module in the Health Insurance Oversight System (HIOS). While the grants data that was used for prior year reports was retrospective, the URRT data is prospective.

This report relies on the self-reported URRT data submitted by issuers in 2013 and 2014 with estimates for single risk pool coverage effective in calendar years (CY) 2014 and 2015.

Report Methodology

Before analyzing the URRT data, we removed records with missing, zero, or duplicate values for projected enrollment, or records that were otherwise labeled by the issuer as terminated or deactivated plans. When estimating total projected premium or enrollment[10], we include records for renewing plans and for new plans. We exclude new plans when calculating weighted average rate changes because issuers cannot measure a rate increase for plans offered for the first time.

To estimate the impact of the Rate Review and Rate Review Grants Programs, we compare the

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[7] 45 CFR 156.80

[8] Prior year reports are available at:
http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html;
http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.pdf; and
http://aspe.hhs.gov/pdf-report/rate-review-annual-report-calendar-year-2013.

[9] Issuers who are not requesting rate increases for their respective non-grandfathered individual or small group coverage must also submit the URRT to HHS if the issuer is offering coverage on the Federally Facilitated or State Partnership Marketplaces or if a state regulator requires issuers to use the URRT for all rate filings.

[10] Enrollment counts in this report are projections provided by issuers in the URRT and do not represent actual enrollment.

issuer's rate increase originally requested in their first URRT submission for a given calendar year to the final revised URRT submission for the same calendar year.[11] For single risk pool products with a proposed rate increase that was reduced before it was finalized, we multiply the projected premium for the product by the difference between the requested rate and the final rate.[12] We then sum the product level savings results to arrive at a national estimate of total reduced premiums for each year.

2014 Individual & Small Group Markets

Single risk pool plans in the individual and small group market had to newly comply with 2014 market reforms such as essential health benefits, actuarial value, maximum out-of-pocket limits, and other required changes to benefit design. As a result, over 80 percent of rate filings for the 2014 calendar year were for new single risk pool products that issuers created in order to comply with those reforms. As mentioned previously, we cannot estimate rate increases or premium reduction for new products because the new products were not offered in the previous year. Thus, the analyses for 2014 are more limited than analyses for prior or future years.

Individual Market

429 issuers submitted 1,130 single risk pool product rate filings for the individual market in 2014. Due to the new insurance market rules discussed above that went into effect in 2014, only 307 of the 1,130 products were renewing (offered in 2013 and in 2014)). Among those filings for renewing products, the average rate increase requested was 2.6 percent and the average implemented was 2.4 percent. We do not provide estimates of individual market premium reductions for CY 2014 because so few filings were for renewing products and such an estimate would only include 20 percent of total filings, which would not accurately reflect the entire individual market.

Small Group Market

366 issuers submitted 1,093 single risk pool product rate filings in the small group market in 2014. 129 of the 1,093 filings were for renewed products. Among those filings for renewed products, the average rate increase requested was 3.7 percent and the average implemented was 3.6 percent. We did not estimate small group market premium reductions for CY 2014 because such an estimate would only include 12 percent of total filings in the entire small group market.

2015 Individual & Small Group Markets

For 2015, most of the rate filings were for existing single risk pool products with rate changes. Products with rate changes include plans with increases and decreases. This provided a larger

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[11] Some issuers refiled the URRT several times before submitting the final version of the URRT. In this case, we define the requested rate increase as the highest value of the proposed rate increase from all submissions prior to the final submission.

[12] For rate increases that were subject to review, some state regulators manually enter the final modified rate increase in HIOS and do not require issuers submit a revised URRT. If the regulator enters a lower rate increase than the rate increase in the issuer's most recent URRT, we treat the regulator-reported value as the final rate increase.

basis for analysis of estimates of premium reductions.

2015 Key Findings

- Rate review reduced total premiums for renewed single risk pool plans by an estimated $1.1 billion in the individual market and by $418 million in the small group market, for a total of $1.5 billion.
- The weighted average rate increase implemented for single risk pool coverage was 6.9 percent in the individual market (8.7 percent initially requested) and 4.3 percent in the small group market (5.1 percent initially requested).
- After rate review in the individual market, the number of double digit rate requests dropped by nearly one-quarter.
- In the individual market, 30 percent of covered lives were projected to enroll in single risk pool plans with a rate increase that was reduced or denied. In the small group market, the projection percentage was 19.6. Altogether, an estimated 6.5 million consumers benefited from rate review.
- The number of issuers submitting a URRT in the individual or small group market grew from 795 in 2014 to 1,195 in 2015, and the number of products included on the URRTs nearly doubled.

Individual Market

577 issuers submitted 1,933 single risk pool product rate filings for the individual market in 2015. 683 of the 1,933 products were new (not offered in 2014). 443 of the 1,250 rate filings for renewed products requested a rate increase of 10 percent or more. Among all single risk pool filings with a rate change request of any size, the average rate increase requested was 8.7 percent and the average implemented was 6.9 percent. After the review process was complete, the percentage of filings with a rate increase of 10 percent or more dropped by approximately 24 percent. We estimate premiums were reduced by $1.1 billion in the individual market for single risk pool coverage in CY 2015 based on the difference between the requested and implemented rate changes.

Table 1: Rate Change Requested Versus Rate Change Implemented in the Individual Market in 2015 for Single Risk Pool Coverage

Individual Market, CY 2015	Requested	Implemented
Number of Issuers	577	
Number of Product Rate Filings	1,933	
Number of Rate Filing for New Products	683	
Number of Filings with Rate Changes requested ≥10%	443	337

Individual Market, CY 2015	Requested	Implemented
Average rate change for renewing products:		
All filings with a requested rate change	8.7%	6.9%
When requesting increase ≥10%	17.7%	14.0%
Projected Covered Lives:		
Number of covered lives affected by rate filings	15.1 million	
Covered lives with rate change requested ≥10% (%)	33.4%	28.6%
Covered lives with rate change request reduced or denied (%)	30.0%	
Estimated Reduction in Premium	**$1.1 billion**	
Source: Unified Rate Review Templates, CY 2015		

Small Group Market

618 issuers submitted 2,377 product rate filings in the small group market in 2015. 787 of the 2,377 products were new (not offered in 2014). 251 of the 1,590 rate filings for renewed products requested a rate increase of 10 percent or more. Among products with a rate change of any size, the average rate increase requested was 5.1 percent and the average implemented was 4.3 percent. We estimate premiums were reduced by $418 million in the small group market for single risk pool coverage in CY 2015 based on the difference between the requested and implemented rate changes.

Table 2: Rate Change Requested Versus Rate Change Implemented in the Small Group Market in 2015 for Single Risk Pool Coverage

Small Group Market, CY 2015	Requested	Implemented
Number of Issuer	618	
Number of Product Rate Filings	2,377	
Number of Rate Filing for New Products	787	
Number of Filings with Rate Changes requested ≥10%	251	220
Average rate change for renewing products:		
All filings with a requested rate change	5.1%	4.3%
When requesting increase ≥10%	15.3%	12.1%
Projected Covered Lives:		

Small Group Market, CY 2015	Requested	Implemented
Number of covered lives affected by rate filings	10.1 million	
Covered lives with rate change requested ≥10% (%)	17.7%	15.5%
Covered lives with rate change request reduced or denied (%)	19.6%	
Estimated Reduction in Premium	**$418 million**	
Source: Unified Rate Review Templates, CY 2015		

Conclusion

The rate review provisions of the Affordable Care Act enhance scrutiny and transparency in the health insurance market and hold issuers accountable for rate increases. Rate increases are now public information, and issuers of single risk pool products must provide data on requested increases of any size. We estimate that 6.5 million consumers benefited from $1.5 billion in premium savings in 2015 ($1.1 billion in the individual market and over $400 million in the small group market) for single risk pool coverage as a result of the rate review program.

In addition, the data indicates an increase in competition in the individual market and more product choice for consumers from 2014 to 2015. The number of issuers submitting the URRT in the individual market grew from 429 in 2014 to 577 in 2015. In the small group market, the number of issuers submitting the URRT increased by nearly 70 percent.[13] The number of product filings nearly doubled from 2014 to 2015. The increase in issuers and products was accompanied by an increase in projected covered lives. The number of consumers projected to purchase coverage in the individual market increased by 11 percent (13.5 million in 2014 to 15.1 million in 2015). In the small group market, there are almost 100,000 more projected enrollees in 2015 than in 2014 (10.1 million in 2015 and 10 million in 2014).

Moving forward, issuers will continue to submit data for requested rate increases of any size for single risk pool plans. The accrual of multiple years of data will improve our ability to assess rate impacts on the market as a whole, compare rate increases across states and issuers, and monitor changes over time. Using both historical and new filings, HHS will continue to monitor the long-term trend of requested and implemented rate increases in the individual and small group health insurance markets.

[13] The increase in filings does not necessarily reflect an increase in the number of issuers offering coverage. In several states operating a State-based Marketplace, new issuers (or existing issuers offering only new products) were not required to submit the URRT.

Filling the need for trusted information on national health issues…

December 2015 | Issue Brief

The Cost of the Individual Mandate Penalty for the Remaining Uninsured

Matthew Rae, Anthony Damico, Cynthia Cox, Gary Claxton, Larry Levitt

The Affordable Care Act (ACA) expands health insurance coverage by offering both penalties and incentives. Low and middle income households who earn too much to qualify for Medicaid can purchase subsidized coverage on the health insurance marketplaces using premium assistance tax credits. Individuals who do not obtain coverage, through any source, are subject to a tax penalty unless they meet certain exemptions. The penalties under the so-called individual mandate were phased in over a three-year period starting in 2014 and are scheduled to increase substantially in 2016. A key area of uncertainty for 2016 is how much the increased penalties will encourage uninsured people – particularly those who are healthy – to obtain coverage, boosting enrollment in the marketplaces and improving the insurance risk pool. This analysis provides estimates of the share of uninsured people eligible to enroll in the marketplaces who will be subject to the penalty, and how those penalties are increasing for 2016.

How the Individual Mandate Works

People are generally required to be covered by a health insurance policy which meets minimum standards or pay a tax penalty.

Some individuals are exempt from the penalty, including undocumented immigrants, those whose incomes are so low that they are not required to file taxes, people with incomes below 138% of poverty in the "Medicaid gap" in states that have not expanded eligibility for Medicaid under the ACA, people who have to pay more than 8.13% of household income for insurance (taking into account any employer contributions or subsidies) and certain individuals who have membership in certain groups or face a particular hardship.

For those who are uninsured and do not meet one of the exemptions, the penalty for 2016 is calculated as the greater of two amounts:

1. A flat dollar amount equal to $695 per adult plus $347.50 per child, up to a maximum of $2,085 for the family.

2. 2.5% of family income in excess of the 2015 income tax filing thresholds ($10,300 for a single person and $20,600 for a family).

The penalty can be no more than the national average premium for a bronze plan (the minimum coverage available in the individual insurance market under the ACA), which was $2,484 in 2015 for single coverage and

$12,420 for a family of three or more children. The penalty is pro-rated for people who are uninsured for a portion of the year and waived for people who have a period without insurance of less than three months.

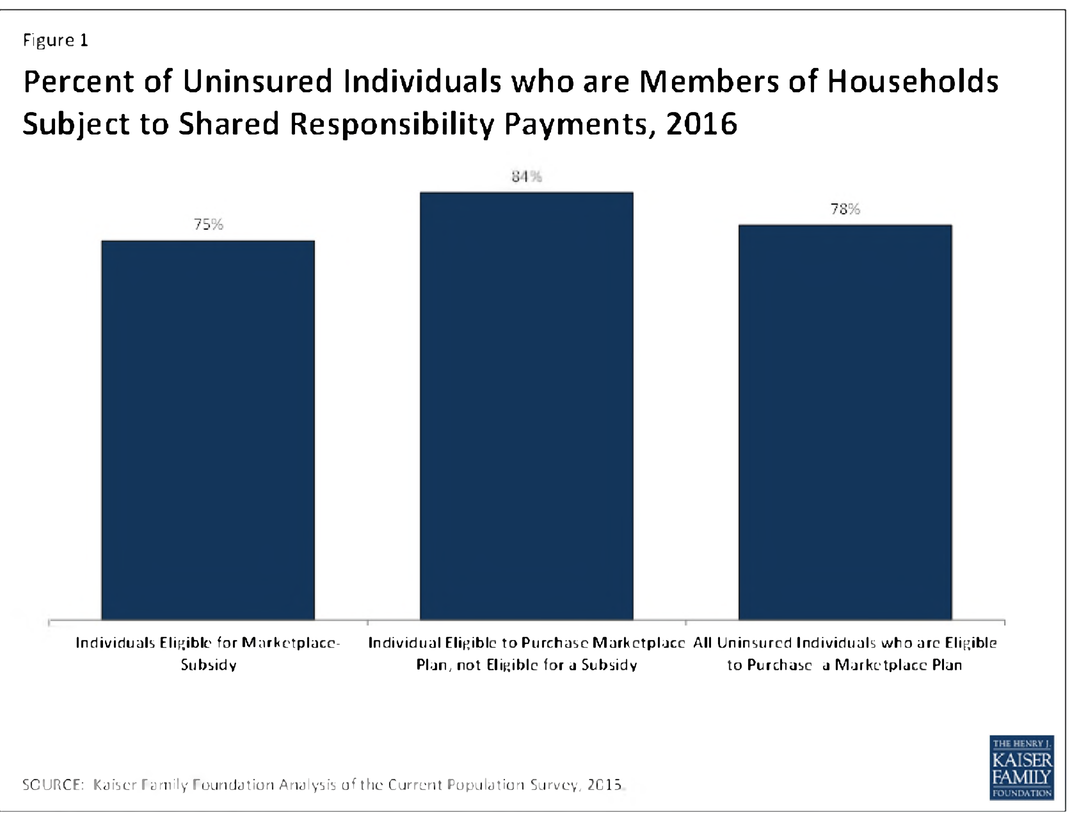
As the table below shows, the penalty amounts have increased substantially since 2014.

Table 1: Penalties Under the Individual Mandate

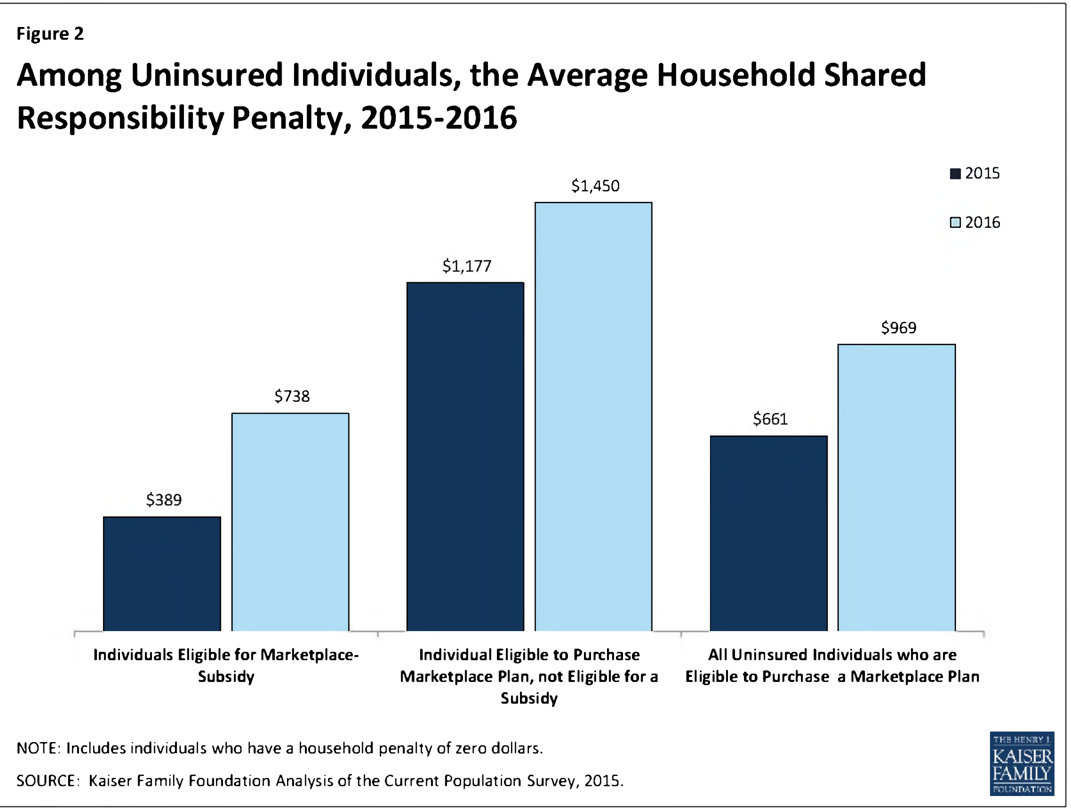
Year	Percent of Income (%)	Per Adult Penalty ($)	Household Penalty ($)	Prior Tax Year Filing Threshold Individual under 65 ($)	Prior Tax Year Filing Threshold – Married filing jointly under 65 ($)	Affordability Standard (%)
2014	1	95	285	10,000	20,000	8
2015	2	325	975	10,150	20,300	8.05
2016	2.5	695	2,085	10,300	20,600	8.13

Estimates of the Actual Penalties People Will Face

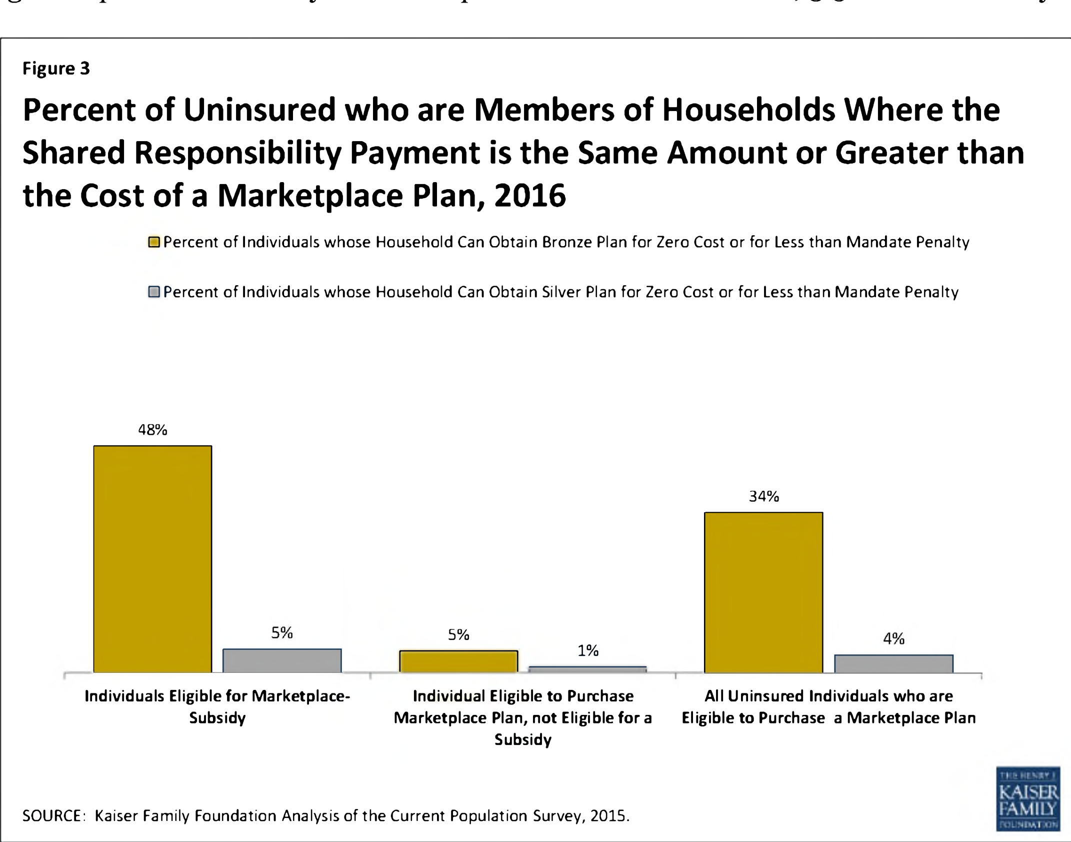
To assess how effective the individual mandate may be in increasing marketplace enrollment, we looked at how penalties are increasing for people who were uninsured in early 2015 and are "marketplace eligible." This includes non-elderly people eligible for marketplace subsidies as well as those who are not because their incomes are too high, but excludes people who are Medicaid-eligible, in the "Medicaid gap," or eligible for employer coverage. [1] We estimate that 78% of people who are uninsured and marketplace eligible would be subject to the individual mandate penalty if they remain uninsured in 2016, including 75% of people who are eligible for premium subsidies and 84% of people who are not.



Among individuals who were uninsured in early 2015 and eligible to enroll in the marketplace, the average household penalty in 2016 is $969. This is up 47% from the average estimated penalty this year of $661. Those who are eligible for premium subsidies will face an average household penalty of $738 in 2016, while the average household penalty totals $1,450 for uninsured individuals not eligible for any financial assistance.



About 7 million uninsured people are eligible for marketplace premium subsidies and are a key target group for increasing marketplace enrollment. Almost half (48%) of them could, in fact, buy a bronze plan for a zero premium contribution or for less than the penalty they would owe for remaining uninsured, including 28% who could buy a bronze plan using their premium subsidy for a zero premium. In other words, 3.5 million subsidy-eligible uninsured people could either get coverage for free or end up paying less by enrolling in marketplace coverage than by remaining uninsured and paying the individual mandate penalty. However, bronze plans come with high deductibles and low-income enrollees may be better off financially enrolling in silver plans that have higher premiums but are eligible for cost-sharing subsidies.



In total, out of almost 11 million uninsured people who are eligible to enroll in marketplace coverage either with or without financial assistance, 7.1 million would pay less for any penalty than they would to buy the least expensive insurance available to them.

Discussion

Increasing enrollment in the ACA's health insurance marketplaces would help to reduce the number of people uninsured and keep premium increases down as more healthy people sign up. Premium subsidies are an important "carrot" to attract new enrollees. As penalties grow in 2016, the "stick" of the individual mandate may also become an increasingly significant factor in the household decisions about whether to buy insurance.

However, the effectiveness of the individual mandate as a tool to increase enrollment will depend on how prominent a place it occupies in outreach messaging. And, emphasizing the mandate to obtain coverage presents challenges for ACA advocates since it is the most unpopular part of the law. At the same time, lack of knowledge about the increasing penalties under the mandate could lead to unpleasant surprises when people file their 2016 taxes in early 2017.

Matthew Rae, Cynthia Cox, Gary Claxton, and Larry Levitt are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Methods:

This analysis uses data from the 2015 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes.

The CPS asks respondents about coverage at the time of the interview (for the 2015 CPS, February, March, or April 2015) as well as throughout the preceding calendar year. People who report any type of coverage throughout the preceding calendar year are counted as "insured." Thus, the calendar year measure of the uninsured population captures people who lacked coverage for the entirety of 2014 (and thus were uninsured at the start of 2015). We use this measure of insurance coverage, rather than the measure of coverage at the time of interview, because the latter lacks detail about coverage type that is used in our model. Based on other survey data, as well as administrative data on ACA enrollment, it is likely that a small number of people included in this analysis gained coverage in 2015.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax

credits for each person individually, using the rules for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available here.

Undocumented immigrants are ineligible for Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. al.[2,3] This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available here.

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance are still potentially MAGI-eligible for Medicaid coverage, but they are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since CPS data do not directly indicate whether workers have access to ESI, we draw on the methods comparable to our imputation of authorization status and use SIPP to develop a model that predicts offer of ESI, then apply the model to CPS. For more detail on the offer imputation used in this analysis, see the technical Appendix C available here.

The household contribution for a marketplace plan includes the cost of covering all subsidy-eligible individuals in the tax filing unit, including those who might currently be purchasing non-group coverage outside of the exchange. Individuals who are eligible for a Basic Health Plan in New York or Minnesota are included as subsidy-eligibles in this analysis. The penalty for each uninsured non-elderly individual is based on the number of uninsured people in the household. The cost of the average bronze plans in 2016 is estimated by inflating the 2015 average by the growth between 2014 and 2015. In this analysis, households with incomes below the relevant tax filing threshold, in the Medicaid gap, or where the cost of the cheapest available (subsidized) bronze plan exceeds the affordability standard are considered to not have a penalty. Individuals ineligible to purchase marketplace coverage, such as undocumented immigrants, are excluded from the analysis. There may be additional exemptions which individuals are eligible for, including particular hardships such as medical debt or domestic violence and membership in groups such as a health care sharing ministry or a recognized Indian tribe. Individuals 65 or above are excluded from the analysis.

Endnotes

[1] Individuals who are eligible for a Basic Health Plan in New York and Minnesota, and who would otherwise be eligible for subsidized coverage, are considered marketplace-subsidy eligible in this analysis.

[2] State Health Access Data Assistance Center. 2013. "State Estimates of the Low-income Uninsured Not Eligible for the ACA Medicaid Expansion." Issue Brief #35. Minneapolis, MN: University of Minnesota. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825

[3] Van Hook, J., Bachmeier, J., Coffman, D., and Harel, O. 2015. "Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches" Demography. 52(1):329-54.

REALIZING HEALTH REFORM'S POTENTIAL

DECEMBER 2015

The CBO's Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?

Sherry Glied, Anupama Arora, and Claudia Solís-Román

Abstract The Congressional Budget Office (CBO), a nonpartisan agency of Congress, made official projections of the Affordable Care Act's impact on insurance coverage rates and the costs of providing subsidies to consumers purchasing health plans in the insurance marketplaces. This analysis finds that the CBO overestimated marketplace enrollment by 30 percent and marketplace costs by 28 percent, while it underestimated Medicaid enrollment by about 14 percent. Nonetheless, the CBO's projections were closer to realized experience than were those of many other prominent forecasters. Moreover, had the CBO correctly anticipated income levels and health care prices in 2014, its estimate of marketplace enrollment would have been within 18 percent of actual experience. Given the likelihood of additional reforms to national health policy in future years, it is reassuring that, despite the many unforeseen factors surrounding the law's rollout and participation in its reforms, the CBO's forecast was reasonably accurate.

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INTRODUCTION

Forecasts of the impacts of health care legislation under consideration, particularly those conducted by the nonpartisan Congressional Budget Office (CBO), are a critical element of the policymaking process. This makes their accuracy vitally important. In practice, however, the complexity of policies and their changes over time make it extremely difficult to assess the accuracy of the forecasts or the underlying models they rely upon. The passage and implementation of the Affordable Care Act (ACA), which created new pathways to health insurance coverage, provides an exceptional opportunity to conduct such an assessment.

The accuracy of forecasts of the effects of new legislation depends on two key elements. First, because there is generally a lag between enactment of a policy and its implementation, accuracy depends on how well the forecasting entity predicts the conditions—particularly income levels and

health care costs—at the time of implementation. Second, accuracy depends on how well the model assumptions and parameters predict the effects of the legislation itself.

In this brief, we examine the accuracy of the CBO's March 2010 estimates of the effects of the ACA's health insurance marketplaces and of its July 2012 estimates of the Medicaid coverage provisions in the year 2014 on: 1) the number of insured through the marketplaces and Medicaid and 2) spending on marketplace subsidies. We also compare the CBO estimates with those made by four other forecasters—the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS), the RAND Corporation, the Urban Institute; and the Lewin Group. (See Appendix A for a comparison of these five forecasting models.) Assessing the accuracy of these forecasts is simplified by the fact that no significant health reform legislation passed between enactment of the ACA in 2010 and implementation of the coverage expansions in 2014. The Supreme Court's decision in *NFIB v. Sebelius* in 2012 making Medicaid expansion optional, however, led many states to reject Medicaid expansion. In the wake of that decision, the CBO revised its forecasts of ACA costs and coverage.[1] We make adjustments to Medicaid estimates from all modelers to reflect what their models were likely to forecast for 2014 under post–Supreme Court rules, using the CBO's July 2012 revised estimates.

KEY FEATURES OF THE FORECASTING MODELS

Health insurance expansions under the ACA occur through the marketplaces, where eligible individuals can obtain coverage subsidized through tax credits, and through expansions of Medicaid eligibility. All the modelers considered here treat these two paths to coverage differently.

Health insurance subsidies in the marketplace are designed to ensure that health plan premiums and out-of-pocket costs are affordable. The amount of a subsidy is determined by applicants' income. For example, for those in households earning between 300 percent and 400 percent of the federal poverty level in 2014, monthly health plan costs for the benchmark plan (the second-lowest silver plan sold in a marketplace) were to be no more than 9.5 percent of income. If they were greater, the subsidy would have paid the difference. To predict take-up of subsidized coverage, all of the models consider how people might react to the difference between the pre-subsidy and post-subsidy

HOW WE EVALUATED THE ACCURACY OF ACA FORECASTING MODELS

To assess the accuracy of predictions of marketplace coverage, we examined both total and subsidized marketplace enrollment, focusing on the latter.[2] To assess the accuracy of predictions of marketplace costs, we examined: 1) estimates of premiums for the second-lowest silver plan premium, which is the "benchmark" for determining subsidies; 2) the average subsidy across the entire population of marketplace enrollees (including both premium tax credits and cost-sharing reductions) per enrollee; 3) the average subsidy per subsidized enrollee; 4) total outlays for premium tax credits; and 5) total outlays for cost-sharing reductions.

For Medicaid coverage, we focused on new Medicaid enrollment only, as we cannot separate the actual costs of the Medicaid expansion population from those of the continuing Medicaid population. In comparing estimates of marketplace enrollment and costs and Medicaid enrollment across models, we adjusted the Lewin and Urban Institute enrollment estimates, which were made based on the assumption that the law was fully implemented in 2010, to construct estimates for 2014, using the CBO's phase-in assumptions. In addition, we further adjusted Urban's premium and subsidy estimates to 2014 using assumptions about cost inflation.

To distinguish the contributions of the effects of changes in baseline conditions from those of the CBO model's parameters, we simulate how the CBO's model might have forecast enrollment had the agency known the actual income levels and health insurance premiums in 2014.

prices. Increases in health insurance premiums make more people eligible for subsidies (because the price of the benchmark plan exceeds the specified percentage of income for more people) and raise the participation rate among those eligible, because the subsidy is larger relative to the pre-subsidy price. Variation among models in predicted marketplace participation may differ because of differences in assumptions about: the baseline conditions (i.e., premium levels before the ACA, income levels, and number of uninsured); future conditions (e.g., benchmark plan premiums); or model parameters (e.g., related to price responsiveness).

Modelers forecast Medicaid enrollment by assuming that a fixed share of those who are eligible will take up coverage. The variation among models in predicted Medicaid enrollment levels may be the result of differences in estimates of the size of the Medicaid-eligible population or because of differences in these assumed take-up rates.

FINDINGS

Marketplace Enrollment

In 2010 CBO projected that average marketplace enrollment over the 2014 calendar year would be 8 million, with 7 million receiving subsidies (Exhibit 1). Other modelers generally anticipated higher participation. CMS projected enrollment at 17 million, with 13 million receiving subsidies,[3] while RAND forecast 16 million, with 9 million receiving subsidies.[4] Estimates from the Lewin Group[5] and the Urban Institute,[6] adjusted for phase-in using the CBO assumptions, projected 10 million and 9 million enrollees, with 8 million and 4 million receiving subsidies, respectively.

Actual enrollment in the marketplaces was lower than any of these forecasts, in part because it ramped up relatively slowly, with a surge at the end. While total enrollment reached 8 million by the end of the open-enrollment period, only about 6 million,[7] on average, were covered through the marketplaces over the course of the calendar year. About 5 million people,[8] 87 percent of those enrolled in marketplaces, received subsidies.

Medicaid Enrollment

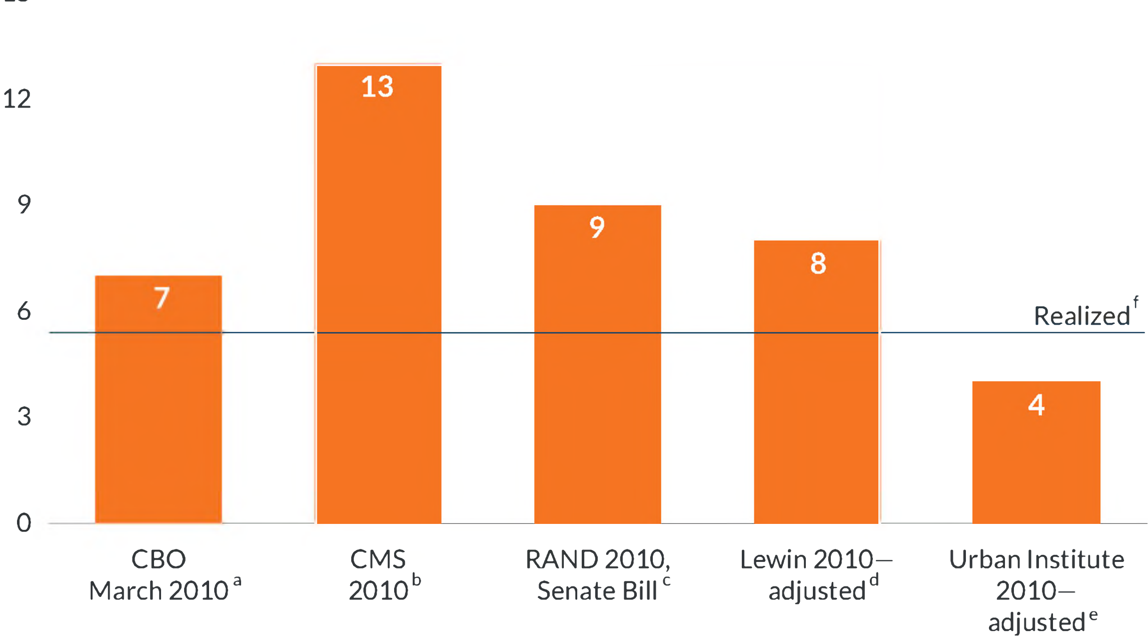
The CBO's original projection in 2010 was that 10 million people would enroll in the Medicaid expansion in 2014. The agency reduced this figure by about 30 percent, to 7 million, after the Supreme Court ruling (Exhibit 2). We adjusted projections made by CMS, the Urban Institute, Lewin, and RAND, all made prior to the Supreme Court ruling, using the ratio between the CBO's 2010 and 2012 estimates. After adjustment, the CMS projection suggests that, in 2014, 16 million people would enroll in Medicaid, while the RAND projection suggests that just 3 million would do so. After adjustments for the law's implementation in 2014 (rather than 2010) and the Supreme Court ruling, the Lewin and Urban forecasts for Medicaid enrollment were 6 and 7 million, respectively. The actual increase in Medicaid enrollment because of the ACA was about 8 million on average through 2014.

Uninsured Population

The effect of the ACA on the number of uninsured depends on the expected baseline number of uninsured people and the number who enroll in the marketplaces and in Medicaid. In its March 2010 projection, the CBO projected that the ACA would reduce the number of uninsured in 2014 by 19 million, from the nearly 51 million otherwise anticipated to 31 million.[9] In its revised

Exhibit 1. Marketplace Subsidized Enrollment Estimates for 2014

Average enrollment, calendar year (millions)



Notes:
All enrollment figures reflect average monthly enrollment figures through the calendar year. Figures for Lewin and Urban are recalibrated to 2014 based on the CBO's August 2010 baseline projections for 2014 vs. 2017, the assumed date of full implementation. The difference between the CBO 2014 and 2017 projections implies that 38% of total enrollment at full implementation and 40% of subsidized enrollment at full implementation would be achieved by 2014.

[a] Congressional Budget Office (March 2010). Cost Estimate for H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation): Table 4, https://www.cbo.gov/sites/default/files/amendreconprop.pdf.

[b] Centers for Medicare and Medicaid Services (April 2010). Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf. We compute the share receiving subsidies based on the estimate in this report that 79% of all enrollees for 2010–2019 will receive subsidies.

[c] RAND (2010). Analysis of the Patient Protection and Affordable Care Act (H.R. 3590), Table 1, http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9514.pdf. Note that the RAND estimates refer to the Senate bill only—the estimate does not incorporate the effects of the Reconciliation bill. In another analysis, http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9515.pdf, RAND compared the House and Senate bills and concluded that marketplace coverage would be higher under the Senate bill. We compute the share receiving subsidies in 2014 based on the projection in this report that 15 million of 28 million people (54% of enrollees) forecast to enroll in a marketplace in 2019 will be receiving subsidies.

[d] Lewin estimates assume full implementation of the Act. Lewin (June 2010). Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers, Figure 9, http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[e] Urban Institute estimates assume full implementation of the Act. Urban Institute (December 2010). America Under the Affordable Care Act, Table 1, http://www.rwjf.org/en/library/research/2010/12/america-under-the-affordable-care-act.html.

[f] Congressional Budget Office (January 2015). The Budget and Economic Outlook: 2015 to 2025, https://www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf.

projection after the Supreme Court decision making Medicaid expansion optional, the CBO assumed a higher baseline number of uninsured (nearly 56 million) and a smaller reduction in the number of uninsured of 14 million, leaving 41 million uninsured (Exhibit 2). After adjustment for the Supreme Court effect, CMS projected a much larger reduction in the uninsured population (20 million) and a lower number of remaining uninsured (32 million). Lewin and Urban estimates (after adjustment) were roughly comparable with the CBO's, while RAND projected a much smaller reduction in the number of uninsured, based on an assumption of much slower phase-in of Medicaid coverage.

In 2015, the CBO estimated that the ACA's insurance expansions had reduced the number of uninsured by 12 million, from a (slightly lower) baseline of 54 million to 42 million.[10] The CBO's 2015 estimate of the reduction in the uninsured population was about 86 percent as great as the

Exhibit 2. Medicaid Enrollment and Uninsured in 2014
(average enrollment calendar year in millions)

Source and date of projection	CMS 2010–adjusted[a]	RAND 2010, Senate Bill–adjusted[b]	Lewin 2010–adjusted[c]	Urban Institute 2010–adjusted[d]	CBO July 2012[e]	Realized 2014[f]
Medicaid enrollment	16	3	6	7	7	8
Medicaid take-up[g]	95%	82%	74%	57%	55%–70%	
Uninsured change	–20	–6	–14	–13	–14	–12
Uninsured total	32	59	37	43	41	42

Notes: Figures for Lewin and Urban are recalibrated to 2014 based on the CBO's August 2010 baseline projections for 2014 vs. 2017, the assumed date of full implementation. The difference between the CBO 2014 and 2017 projections implies that 38% of total enrollment at full implementation, 40% of subsidized enrollment at full implementation, and 18% of unsubsidized enrollment at full implementation would be achieved by 2014.

All figures from CMS, RAND, Lewin, and Urban are adjusted based on the CBO's estimate of the effect of the Supreme Court decision on Medicaid enrollment and uninsurance rates. The CBO estimated that because of the Supreme Court decision, Medicaid enrollment would be 70% as high as initially predicted, the decline in the number uninsured would be about three-quarters as high as initially predicted, and the remaining number of uninsured would be about one-third higher than initially predicted.

[a] Centers for Medicare and Medicaid Services (April 2010), Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended: Table 2, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

[b] RAND (2010). Analysis of the Patient Protection and Affordable Care Act (H.R. 3590): Table 1, http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9514.pdf.

[c] Lewin estimates assume full implementation of the Act. Lewin (June 2010). Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers: Figure 9, http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[d] Urban Institute estimates assume full implementation of the Act. Urban Institute, (December 2010). America Under the Affordable Care Act: Table 1, http://www.rwjf.org/en/library/research/2010/12/america-under-the-affordable-care-act.html.

[e] Congressional Budget Office (July 2012). Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision: Table 3, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[f] Congressional Budget Office (January 205). The Budget and Economic Outlook: 2015 to 2025, https://www.cbo.gov/sites/default/files/cbofiles/attachments/49892-Outlook2015.pdf.

[g] Assistant Secretary for Planning and Evaluation (March, 2012). Understanding Participation Rates in Medicaid: Implications for The Affordable Care Act, http://aspe.hhs.gov/health/reports/2012/medicaidtakeup/ib.shtml. Take-up rates estimated based on CPS estimate of number of citizens not enrolled in Medicaid or Medicare, ages 0–64, with incomes <133% FPL and Sommers et al., 2012.

CBO's 2012 estimate of 14 million, but the remaining uninsured population matches the CBO figure nearly exactly. This apparent anomaly occurred because slower health care cost growth meant that there were fewer uninsured in the baseline (no-ACA) world than the CBO had originally expected (a difference of 2 million people). The latest estimate from the National Health Interview Survey, which uses a somewhat different metric from the CBO's, suggests that about 36 million people remain without health insurance.[11]

Spending on Marketplace Subsidies

Health care cost growth between 2010 and 2014 was much slower than any of the estimators had anticipated. Moreover, competition in marketplaces, combined with ACA mechanisms to reduce risk, appear to have kept premium increases associated with the ACA itself in check. The 2014 benchmark premium (the average premium for the second-lowest-cost silver plan) averaged $3,800,[12] about $900 below the CBO's estimate (Exhibit 3).

Exhibit 3. Benchmark Premium and Average Subsidy for 2014

Source and date of projection	CBO August 2010[a]	CMS 2010[b]	RAND 2010[c]	Lewin 2010–adjusted[d]	Urban Institute 2010–adjusted[e]	Realized 2014[f]
Average subsidy per subsidized enrollee	$3,817	$4,366	$4,651	$4,362	$3,341	$4,425
Benchmark premium	$4,700[g]	–	–	–	$4,618[h]	$3,800

[a] Congressional Budget Office (August 2010). Health Insurance Exchange Projections, http://www.cbo.gov/sites/default/files/ExchangesAugust2010FactSheet.pdf. We estimated the CBO fiscal year average subsidies on the assumption that 2014 fiscal year average enrollment would be three-fourth of calendar year enrollment.

[b] Centers for Medicare and Medicaid Services (April 2010), Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended: Table 1, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

[c] RAND (2010). Analysis of the Patient Protection and Affordable Care Act (H.R. 3590): Table 1, http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9514.pdf.

[d] Lewin estimates assume full implementation of the Act. Lewin (June 2010). Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers: Figure 9. Calculated by dividing total subsidy payments by number of subsidized enrollees, http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[e] Urban Institute, (December 2010). America under the Affordable Care Act: Table 2, http://www.rwjf.org/en/library/research/2010/12/america-under-the-affordable-care-act.html.

[f] Congressional Budget Office (April 2014). Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

[g] Assistant Secretary for Planning and Evaluation (August 2013). Market Competition Works: Silver Premiums in the 2014 Individual Market Are Substantially Lower than Expected, http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.pdf.

[h] Urban Institute estimates assume full implementation. Urban Institute (December 2010). Why the Individual Mandate Matters: Timely Analysis of Immediate Health Policy Issues, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412280-Why-the-Individual-Mandate-Matters.PDF. Urban estimates are adjusted to 2014 premiums by multiplying all figures upward by 12.5%, assuming projected 2010–2014 premium increases of 3% per year, consistent with the 2007–2010 period.

The sharp reduction in the premium for the benchmark plan had very little effect on the average subsidy amount per subsidized enrollee though it did affect the number of people eligible for subsidies, as discussed below. The smaller number of people receiving subsidies (both because of lower eligibility and lower enrollment) reduced total expenditures for marketplace subsidies relative to the estimate[13] to $15 billion, about 79 percent of the original CBO projection (Exhibit 4).

Accuracy of the CBO Model

We examined the accuracy of the CBO's model by mimicking how accurately it would have predicted actual marketplace enrollment if the CBO had known the income levels, insurance coverage rates, and premium rates that existed in 2014 (see Appendix Exhibit B1). The much lower than anticipated benchmark premiums reduced the number of people who might have been expected to qualify for any subsidy by more than 2 million people (about 7%). Differences in the distribution of income reduced the number of people who might have qualified by about 1 million (about 3%). After applying the actual income levels, insurance coverage rates, and benchmark premiums, we conclude that the CBO model's prediction would have been just over 6 million subsidized enrollees. Actual marketplace enrollment in 2014—5 million—is about 18 percent below this revised forecast. This difference is, in part, attributable to the slower-than-expected rollout of the marketplaces.

Exhibit 4. Projected Estimates and Realized Expenditures for Government Outlays on Marketplace Subsidies in 2014 (in billions)

Source and date of projection	CBO August 2010 Baseline[a]	CMS 2010[b]	RAND 2010[c]	Lewin 2010[d]	Urban Institute 2010[e]	Realized 2014[f]
Premium credits (fiscal year)	$16	$38	$38	–	$14	$11
Cost-sharing reductions outlays (fiscal year)	$3	$6	$2	–	$3	$2
APTC+CSR outlays (fiscal year)	$19	$44	$40	$35	$17	$15

Note: The CBO reported figures for total outlays include related spending of $1 billion for marketplace grants. We subtract this figure from the CBO forecasts and realized estimates.

[a] Congressional Budget Office (August 2010). Health Insurance Exchange Projections, http://www.cbo.gov/sites/default/files/ExchangesAugust2010FactSheet.pdf.

[b] Centers for Medicare and Medicaid Services (April 2010), Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended: Table 1, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf.

[c] RAND (2010). Analysis of the Patient Protection and Affordable Care Act (H.R. 3590): Table 1, http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR189/RAND_RR189.pdf. We assume the fiscal year estimate for RAND is three-quarters of the calendar year estimate. We compute the share receiving premium subsidies in 2014 based on the projection in this report that premium subsidies would account for 96% of subsidy expenditures by 2019.

[d] Lewin (June 2010). Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers: Figure 9. Lewin reports total figures for 2014; we calculate subsidies per subsidized person by dividing this figure by our adjusted enrollment estimate. http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[e] Urban Institute, (December 2010). America Under the Affordable Care Act: Table 2, http://www.rwjf.org/en/library/research/2010/12/america-under-the-affordable-care-act.html. We adjust the Urban figures for health care cost inflation between 2010 and 2014 (12.5%) and for the phase-in of coverage, using the CBO's phase-in estimate.

[f] Congressional Budget Office, Insurance Coverage Provisions of the Affordable Care Act– CBO's April 2014 Baseline, https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf.

IMPLICATIONS FOR FUTURE POLICY REFORM

There have been very few efforts to gauge the accuracy of models that project the effects of health reforms.[14] In an earlier review, the CBO's estimates were usually found to fall within 30 percent above or below actual experience, as they did here.[15] In the case of the ACA, about half of the CBO's prediction error was because of its forecast of what conditions in 2014 would be before taking into account the effects of the ACA. The CBO had projected that health care prices would be much higher and that incomes would be lower than what turned out to be the case. After adjusting for these differences in baseline assumptions, the CBO estimate came within 18 percent of actual experience.

Simulations of the effects of health insurance reforms have received considerable attention over the past two decades, leading to substantial improvements in modeling. The CBO, and several private forecasters, were fairly accurate in their predictions of the likely coverage and cost implications of the ACA. A few forecasters—notably the CMS—assumed much higher rates of responsiveness to subsidies and coverage expansions, and these models generated the least accurate predictions. CMS estimates of participation in subsidized coverage, Medicaid enrollment, and total marketplace spending were 2.7, 2.0, and 2.9 times, respectively, higher than actual figures.

The Affordable Care Act was a critical step in expanding health insurance coverage, but it is unlikely to be the last national health policy reform considered by Congress. It is therefore reassuring that despite many factors that could not have been foreseen in 2010—such as the ACA's troubled rollout and the lack of state support—the CBO model proved to be reasonably accurate compared with actual experience and the estimates of other modelers. This should allay concerns of some critics that its forecasts were biased in favor of the Administration.

Appendix A. Comparison of Models

	CBO 2010	CMS	RAND	Urban Institute	Lewin
	CBO Model	OACT	COMPARE	HIPSM	HBSM
Simulation assumption	Simulation of multiyear spending and revenue effects with assumption of full implementation by 2017	No documentation available	Simulation based on assumption that the effects of legislation would be phased in evenly over three years with full implementation by 2015	Single-year simulation assuming the coverage provisions of the ACA are fully implemented in 2010	Single-year simulation assuming the act is fully implemented and that enrollment has fully matured in 2011
Source of population data	2002 Survey of Income and Program Participation (SIPP)		2008 Survey of Income and Program Participation (SIPP)	2009/2010 Current Population Survey (CPS) ASEC Massachusetts Health Insurance Survey to inform the behavioral effects of individuals under a mandate	2002–05 Medical Expenditures Panel Survey (MEPS) used together with the March 2007 Current Population Survey (CPS)
Behavioral assumptions	Elasticity-based approach		Utility-based approach	Utility-based approach Benchmarked behavioral responses consistent with historical ranges indicated by Glied et al. (2002)	Elasticity-based approach * Assumes elasticity declines with age and income.
Private coverage through marketplace	Assumes private coverage take-up among those eligible for public programs would be low		Assumes that the people who enroll initially tend to be sicker than the general uninsured population, on average	Assumes slightly more than half would gain public coverage through the Medicaid expansion; the rest would purchase private insurance	
Subsidized enrollment	Assumes 82.5% of marketplace enrollees receive subsidies		Assumes 79% of all enrollees will receive subsidies from 2010–19	Assumes 45% of the marketplace enrollees are subsidized.	Assumes 74% of marketplace enrollees receive subsidies.
Medicaid take-up rates[a]	Assumes moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible (55%–70%)	95%	Assumes that people's understanding and perception of the Medicaid program are unchanged by the reform, which means that the rates at which newly and currently eligible persons enroll in Medicaid would be similar to what is observed today (82%)	Assumes a take-up rate of about 73 percent for the uninsured who are newly eligible, higher rate of Medicaid take-up than CBO. Medicaid and Children's Health Insurance Program would cover 29 percent.	Simulates enrollment among newly eligible people based upon estimates of the percentage of people who are eligible for the current program who actually enroll; also simulates the lags in enrollment during the early years of the program (74%)

[a] Take-up rates from Assistant Secretary for Planning and Evaluation (March 2012). Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act, http://aspe.hhs.gov/health/reports/2012/medicaidtakeup/ib.shtml.

Appendix B. Simulating How CBO's Model Would Have Performed If Income and Benchmark Premium Were Known

Since we do not have access to the CBO model, we use information from published documentation to assess how the CBO related marketplace insurance subsidy levels to projected participation rates by income.

We estimate the difference between the CBO's 2014 predicted marketplace premiums—using their 2010 forecast and actual premiums in 2014, as well as the 2009 distribution of income and coverage—compared with the actual income distribution in 2013. We compare subsidy participation by relating the subsidy levels to nonsubsidized benchmark premiums. We use information from the CBO's methodology description to estimate subsidized take-up rates.[16] This comparison yields an estimate of the baseline participation rates associated with varying subsidy percentages in the CBO model.

Our baseline participation estimates modeled in this way are not directly comparable to the CBO's 2010 estimates. Many features of the CBO's model are not described in their published methodology, and some parameter assumptions may have changed subsequent to publication of the methodology report. We do not know their baseline assumptions about incomes, coverage, or premiums, and we make no adjustment for citizenship or residency. Most important, to estimate the effects of the ACA, the agency used an estimate of what nongroup premiums would be in the absence of the ACA in calculating participation. By contrast, in our simulation we assume that nongroup market premiums without reform would be equal to benchmark plan premiums. Benchmark plan premiums, however, incorporate all ACA changes, including benefit plans, rating changes, and loss ratios. To address these various differences, we calibrate our baseline participation estimates to match the published CBO estimate of 7.1 million subsidized enrollees in 2014. That is, we generate take-up rates for income/subsidy cells based on published information and further adjust them to generate the 7.1 million estimate.

We then repeat our estimates, and use the same calibration adjustment, to project how much enrollment forecasts would have varied if premiums, income levels, and coverage distributions were known.

We first use the projected premium price of $3,100 for a 21-year-old male—derived from the $4,700 average benchmark premium that the Assistant Secretary for Planning and Evaluation (ASPE) infers based on the CBO's 2010 report—to estimate enrollment. We then estimate enrollment with the actual premium price of $2,508 for a 21-year-old male (derived from the $3,800 premium reported in the CBO's April 2014 report[17]). We assign age-rating factors to benchmark premiums using the Rating Factor Limitations report by Coventry Health Care and an ASPE report on premiums released June 18 2014.[18] Data from the Current Population Survey for survey years 2009 and 2012 were used to construct the share of individuals under age 65 who would qualify for any subsidy and to predict enrollment under forecast and actual conditions.

The CPS measure of insurance coverage changed in 2014. To avoid this problem, we next applied the simulated take-up rates to data on the distribution of uninsured individuals and individuals with individual insurance plans under age 65 by household income from the American Community Survey one-year estimates, 2009 and 2013, available on American FactFinder.

Appendix Exhibit B1. Effect of Changes in Income Distribution and in Benchmark Premiums on Eligibility for and Participation in Subsidies in the CBO Estimates for 2014
(all figures in thousands)

	2010			2014			Difference as a result of income change (holding premium constant)	
	Uninsured and nongroup population 100%–400% FPL	Population qualifying for any subsidy	Population predicted to take up subsidy	Uninsured and nongroup population 100%–400% FPL	Population qualifying for any subsidy	Population predicted to take up subsidy	Population qualifying for any subsidy	Population predicted to take up subsidy
Forecast benchmark premium	38,738	34,506	7,100	36,917	33,175	7,008	–1,331	–92
Realized benchmark premium	38,738	32,147	6,122	36,917	31,126	6,069	–1,022	–53
Difference as a result of premium change (holding income constant)		–2,359	–978		–2,049	–938		
Combined effect							3,380	1,031

Notes

[1] CBO concluded that only 70 percent as many people would gain eligibility for Medicaid as had previously been assumed and that some people with incomes between 100 percent and 138 percent of the federal poverty level residing in states that would not expand Medicaid would obtain insurance offered through the marketplaces. It also assumed that greater take-up of marketplace subsidies among this lower-income, sicker group would lead to a higher average subsidy for enrollees.

[2] Under the ACA, premium subsidies are available for purchases in the marketplaces only, but unsubsidized enrollees could obtain coverage outside the marketplace. While modelers differed in their assumptions about how many unsubsidized enrollees would choose off-marketplace enrollment, we do not have estimates of the actual off-marketplace enrollment with which to make comparisons.

[3] R. S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Darby, Pa.: Diane Publishing Company, 2010).

[4] RAND COMPARE, *Analysis of the Patient Protection and Affordable Care Act (H.R. 3590)* (Santa Monica, Calif.: RAND, 2010), http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9514.pdf.

[5] Lewin estimates assume full implementation of the Affordable Care Act. Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* (Falls Church, Va.: Lewin Group, June 8, 2010), Figure 9, http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[6] M. Buettgens, B. Garrett, and J. Holahan, *America Under the Affordable Care Act* (Princeton, N.J., and Washington, D.C.: Robert Wood Johnson Foundation and Urban Institute, Dec. 2010), http://www.rwjf.org/en/library/research/2010/12/america-under-the-affordable-care-act.html.

[7] Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* (Falls Church, Va.: Lewin Group, June 8, 2010), Figure 9, http://www.lewin.com/content/dam/Lewin/Resources/Site_Sections/Publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

[8] Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (Washington, D.C.: CBO, Jan. 2015), https://www.cbo.gov/publication/49892.

[9] Congressional Budget Office, *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation) Cost Estimate* (Washington, D.C.: CBO, March 2010), https://www.cbo.gov/publication/21351.

[10] Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (Washington, D.C.: CBO, Jan. 2015), https://www.cbo.gov/publication/49892.

[11] R. A. Cohen and M. E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2014* (Washington, D.C.: National Center for Health Statistics, Division of Health Interview Statistics, June 2015), http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf.

[12] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Washington, D.C.: CBO, April 2014), https://www.cbo.gov/publication/45231.

[13] Total marketplace subsidies include premium credit outlays, reductions in revenues from premium credits, and outlays for cost-sharing subsidies.

[14] The CBO recently presented findings comparing its original marketplace enrollment projections with those realized. J. Banthin, "Forecasting Enrollment and Subsidies in the ACA Exchanges," Roundtable presentation for the Association for Public Policy Analysis and Management, Miami, Fla., Nov. 14, 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/presentation/51003-acaexchanges.pdf.

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[17] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Washington, D.C.: CBO, April 2014), https://www.cbo.gov/publication/45231.

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ISSUE BRIEF
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The Changing Landscape of Health Care Coverage and Access: Comparing States' Progress in the ACA's First Year

Susan L. Hayes, Sara R. Collins, David C. Radley, Douglas McCarthy, Sophie Beutel, and Jordan Kiszla

Abstract This analysis compares access to affordable health care across U.S. states after the first year of the Affordable Care Act's major coverage expansions. It finds that in 2014, uninsured rates for working-age adults declined in nearly every state compared with 2013. There was at least a three-percentage-point decline in 39 states. For children, uninsured rates declined by at least two percentage points in 16 states. The share of adults who said they went without care because of costs decreased by at least two points in 21 states, while the share of at-risk adults who had not had a recent checkup declined by that same amount in 11 states. Yet there was little progress in expanding access to dental care for adults, which is not a required insurance benefit under the ACA. Wide variation in insurance coverage and access to care persists, highlighting many opportunities for states to improve.

INTRODUCTION

On January 1, 2014, the major health insurance reforms of the Affordable Care Act (ACA) took effect. They represented the most significant expansion of health coverage in the United States since Medicare and Medicaid were enacted more than 50 years ago. By the end of 2014, the uninsured rate for the U.S. population under age 65 had declined to 13 percent from 17 percent a year earlier, and a dramatic shift in the landscape of coverage had taken place across the country, according to data recently released by the U.S. Census Bureau (Exhibit 1, Appendix Table 1).

This analysis takes a closer look at this shift by comparing states' performance on six indicators of access to care and affordability from The Commonwealth Fund's *State Scorecard on Health System Performance, 2015 Edition*. The scorecard is intended to help policymakers, health system leaders, and the public identify opportunities, and set targets, for improvement. The indicators include uninsured rates for working-age adults and for children, and three others that assess adults' access to care (Exhibit 2).[1] To gauge the affordability of care, we examine the percentage of individuals under age 65 in each state who have high out-of-pocket medical costs relative to their incomes.[2]

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

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Exhibit 1. Percent of Population Under Age 65 Uninsured, 2013 vs. 2014

2013

D.C.

<10% (4 states plus D.C.)
10%–14% (18 states)
15%–19% (18 states)
≥20% (10 states)

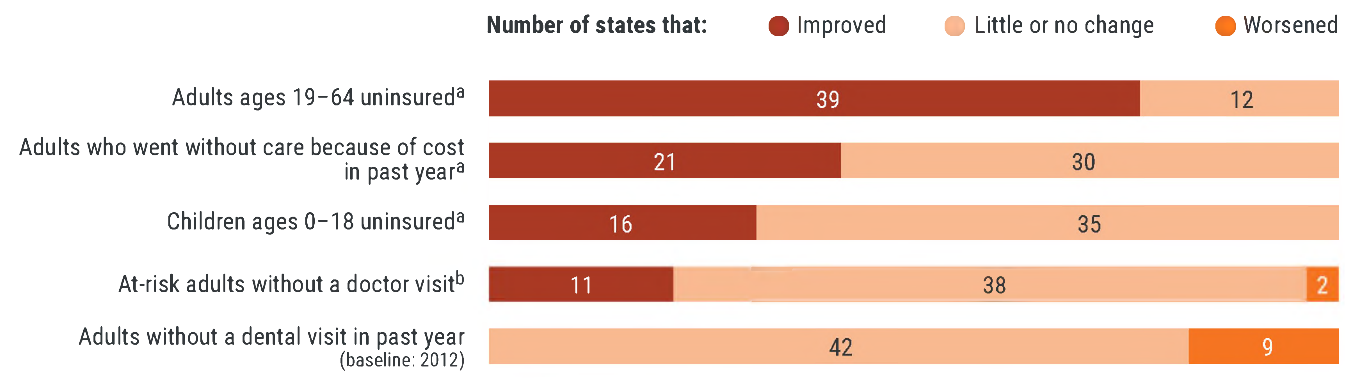
2014

D.C.

<10% (11 states plus D.C.)
10%–14% (25 states)
15%–19% (12 states)
≥20% (2 states)
Expanded Medicaid as of 1/1/14

Data source: U.S. Census Bureau, 2013 and 2014 1-Year American Community Surveys, Public Use Microdata Sample (PUMS).

Exhibit 2. Change in Health System Performance by Access Indicator, 2014 Compared with Baseline



Notes: The exhibit measures change over the two most recent years of data available. The current data year for each indicator is 2014; baseline is 2013 unless otherwise noted. Improvement or worsening refers to change between baseline and current time period of at least 0.5 standard deviations. The "little or no change" category includes the number of states with changes of less than 0.5 standard deviations, as well as states with no change or without sufficient data to assess change over time. Adult uninsured rates declined in all states and D.C. from 2013 to 2014 except for Massachusetts where the rate did not change; in the remaining 11 states, the decline was less than 0.5 standard deviations. See discussion of individual indicators for the minimum percentage point decline or increase needed to meet our definition of change. High out-of-pocket spending indicator is not included because data are not comparable to prior years.

[a] Improvement also occurred at the national level.

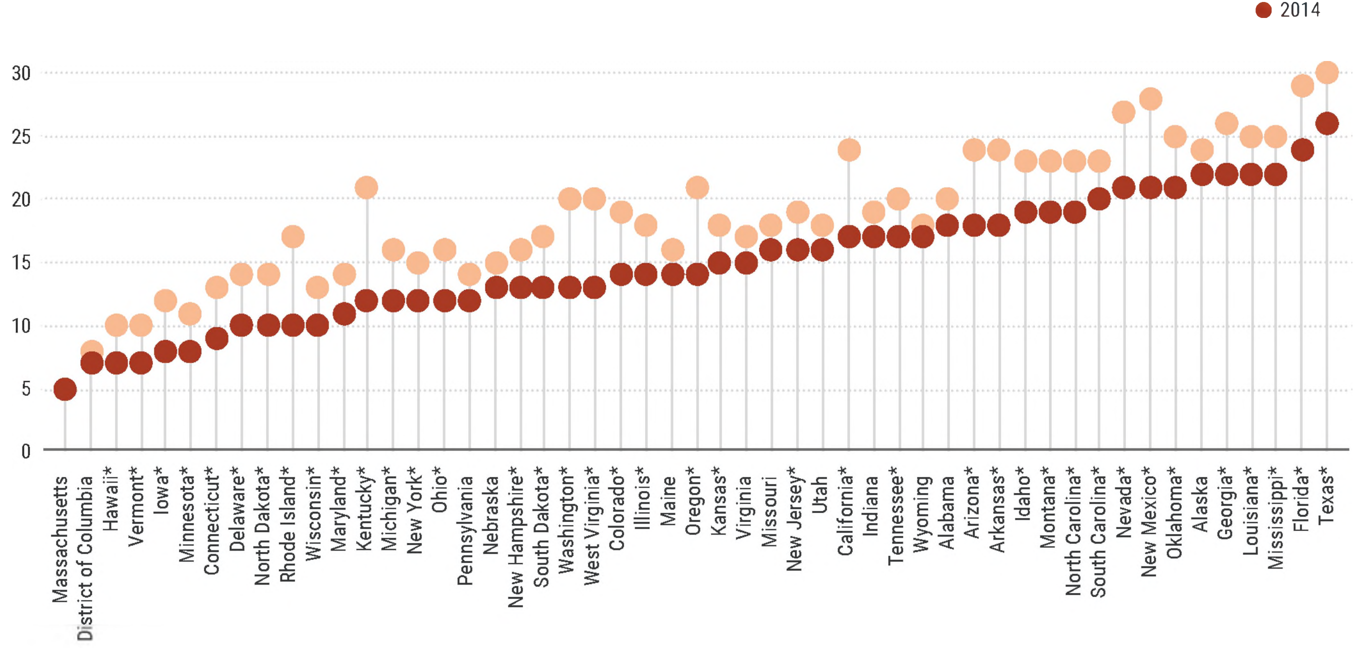
[b] At-risk adults defined as all adults age 50 or older, and adults ages 18 to 49 in fair or poor health, or ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma.

Data source: Commonwealth Fund Scorecard on State Health System Performance, 2015 Edition.

FINDINGS

Substantial Gains in Health Coverage for Adults

Uninsured rates for adults ages 19 to 64 declined in nearly all states from 2013 to 2014—dropping by three or more percentage points in 39 states.[3] The largest declines were in states that had expanded their Medicaid programs as of January 2014: Kentucky (decline of nine points); California, New Mexico, Oregon, Rhode Island, Washington, and West Virginia (seven points); and Arizona, Arkansas, and Nevada (six points). Even some states that did not expand Medicaid by January had four- to five-point declines, including Florida, Georgia, Idaho, Michigan,[4] Montana,[5] North Carolina, Oklahoma, South Dakota, and Texas. Still, widespread variation in uninsured rates persisted, ranging from a low of 5 percent in Massachusetts to a high of 26 percent in Texas. Nevertheless, only 10 states had adult uninsured rates of 20 percent or higher in 2014, compared with 22 states in 2013 (Exhibit 3, Appendix Table 1).



Note: States are arranged in rank order based on their current data year (2014) value.
* Denotes states with at least -.5 standard deviation change (3 percentage point decline) between 2013 and 2014.
Data source: U.S. Census Bureau, 2013 and 2014 1-Year American Community Surveys, Public Use Microdata Sample (PUMS).

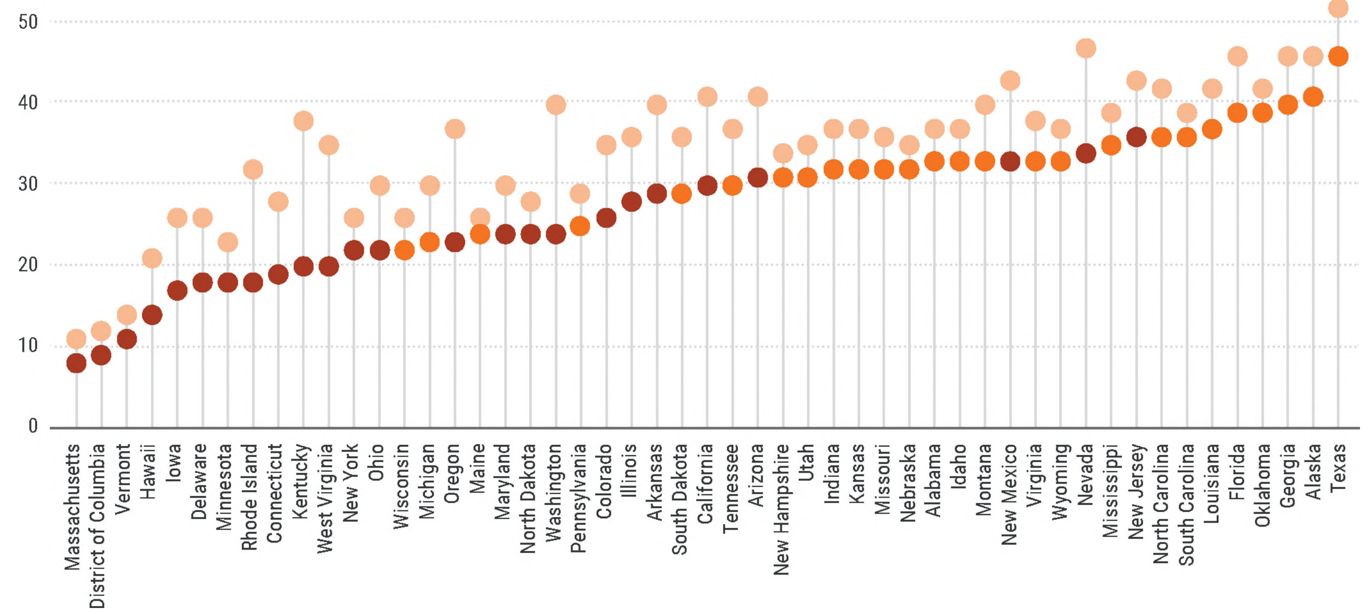
Uninsured Rates Among Low-Income Adults Decline in Every State

Historically, the overwhelming majority of the uninsured have lived in households with low incomes (below 200 percent of the federal poverty level).[6] From 2013 to 2014, the share of low-income adults who were uninsured dropped three percentage points or more in every state except Maine, which had a two-point decline (Exhibit 4, Appendix Table 2). The largest declines were in Kentucky (18 points), Washington (16 points), West Virginia (15 points), Oregon and Rhode Island (14 points) and Nevada (13 points)—all states that had chosen to expand Medicaid eligibility by January 2014. And in 2014, most expansion states had lower rates of uninsured low-income adults than did nonexpanding states.

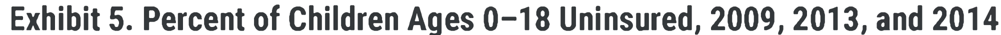
There remained nearly sixfold variation across states in uninsured rates among low-income adults, however, ranging from 8 percent in Massachusetts to 46 percent in Texas. But there was notable improvement in many states with high rates of uninsured residents: by 2014, only three states had uninsured rates of adults with low incomes that were 40 percent or more (Georgia, Alaska, and Texas), compared with 15 states in 2013.

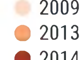
Exhibit 4. Percent of Low-Income Adults Ages 19–64 Uninsured, 2013 vs. 2014

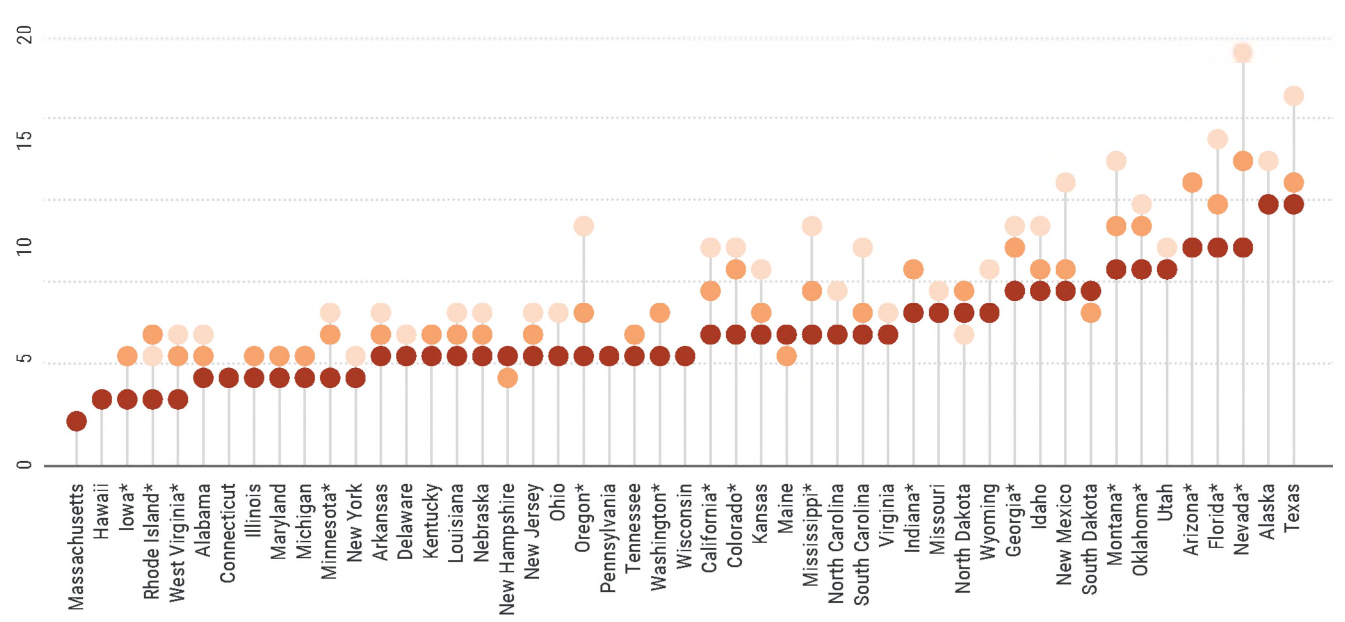
- 2013
- 2014, states that had not expanded Medicaid as of January 1, 2014
- 2014, states that had expanded Medicaid as of January 1, 2014



Notes: Low-income defined as living in a household with income <200% of the federal poverty level. States are arranged in rank order based on their current data year (2014) value.
Data source: U.S. Census Bureau, 2013 and 2014 1-Year American Community Surveys, Public Use Microdata Sample (PUMS).







Note: States are arranged in rank order based on their current data year (2014) value.
* States with at least -.5 standard deviation change (2 percentage point decline) between 2013 and 2014. Data for 2013 and 2014 not available for the District of Columbia or Vermont.
Data source: U.S. Census Bureau, 2009, 2013, and 2014 1-Year American Community Surveys, Public Use Microdata Sample (PUMS).

Further Gains in Covering Children Across States

Even before the ACA's passage, uninsured rates among children were much lower than for working-age adults in every state because of action taken over two decades by federal and state policymakers to expand public health insurance programs for children.[7] In 2014, the percentage of uninsured children 18 years and younger declined still further in a majority of states, and by at least two points in 16 states. Only two states (Alaska and Texas) had children's uninsured rates above 10 percent, compared with seven states in 2013 (Exhibit 5, Appendix Table 1).

As was the case with coverage gains among adults, coverage gains among children reflect both the ACA's new expanded coverage options and the so-called "woodwork effect," in which people who were previously eligible for the program but not enrolled "came out of the woodwork" and signed up for Medicaid, as a result of increased outreach efforts, awareness of the law and its coverage options, and the requirement that everyone have health insurance.[8]

Fewer Adults Face Cost-Related Barriers to Care

Many people with no or inadequate insurance coverage skip needed care or struggle to pay medical bills.[9] One of the central aims of the ACA is to improve access to care by removing financial barriers. From 2013 to 2014, the share of adults (age 18 and older) who said they went without care because of costs declined by at least two percentage points in 21 states. This is likely a result of expanded insurance coverage as well as improvements in the economy.

The percentage of adults reporting cost barriers to care was lowest (7%–10%) in North Dakota, Massachusetts, Hawaii, Iowa, Minnesota, Vermont, and South Dakota, in both 2014 and 2013. From 2013 to 2014, such rates declined by three points in four states in the lowest performance quartile on this indicator: Louisiana, Arkansas, Florida, and Mississippi (Exhibit 6, Appendix Table 1). Fewer low-income adults reported that cost was a barrier to care in 2014, with the greatest declines in Oregon (12 points); Arizona, Kentucky, and New Hampshire (seven points); and Washington (six points) (Appendix Table 2).

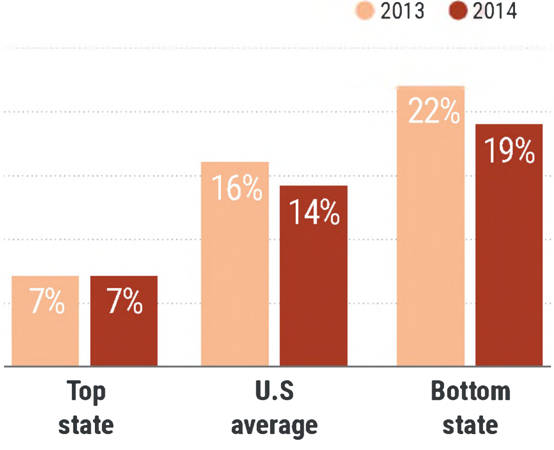
Many Still Face High Out-of-Pockets Costs

Many of those with no health coverage must pay the full amount of medical bills.[11] But even many insured patients are paying an increasing share of their medical care costs.[12] We examined the share of individuals under age 65 who, regardless of insurance status, lived in households that spent a high share of annual income on medical care. We used two thresholds to identify such individuals: People living in households in which 10 percent or more of annual income went toward medical care; or 5 percent or more, if annual income was below 200 percent of the federal poverty level.

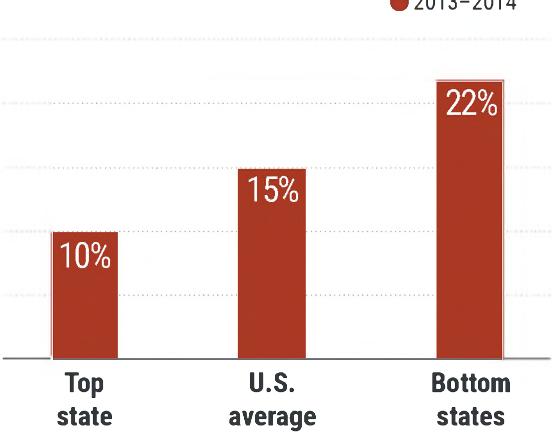
During 2013–14,[13] at least one of 10 people under age 65 in every state lived in households where out-of-pocket spending on medical care was high relative to annual income. In five states this was true for at least one of every five nonelderly individuals: Mississippi and Oregon (20%), Arkansas (21%), and Idaho and Tennessee (22%) (Exhibit 6, Appendix Table 1).

Exhibit 6. State Variation: Cost-Related Access Indicators, 2013 and 2014

▶ Percent of adults age 18 and older who went without care because of costs in past year



▶ Percent of individuals under age 65 with high out-of-pocket spending[a]



[a] Defined as out-of-pocket medical expenses equaling 10 percent or more of annual household income, or 5 percent or more of income if low income (below 200% of the federal poverty level). To ensure adequate sample size, state-level estimates are an average of the two years. Trend data not available because of methodological changes.

Data sources: Behavioral Risk Factor Surveillance System, 2013 and 2014 (going without care) and U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement, March 2014 and March 2015 (spending).

KYNECT: CONNECTING KENTUCKIANS TO COVERAGE

From 2013 to 2014, the uninsured rate among Kentucky's working-age adults fell by almost half, from 21 percent to 12 percent—the largest percentage-point drop in any state. Kentucky also led the country in absolute gains in coverage among low-income working-age adults and saw a decline in the share of adult residents who went without care because of cost (19% to 16%).

Much of Kentucky's success can be attributed to its health insurance marketplace, Kynect, and its outreach efforts. During the ACA's first open-enrollment period, which ended in spring 2014, an estimated 440,000 Kentuckians selected individual health insurance plans or were determined to be eligible for Medicaid or the Children's Health Insurance Program through Kynect.[10] To help consumers enroll in coverage during the ACA's second open enrollment, Kynect opened a retail store in Lexington's Fayette Mall, enabling visitors to shop for and purchase a plan with the assistance of trained navigators. Over the three-month period, more than 7,500 people visited the store and nearly 6,000 submitted applications; the state opened a second store, in Louisville, during the third open enrollment.

To further reduce the number of uninsured Kentuckians, Kynect is targeting marketing efforts at high-risk populations. To reach people recently released from incarceration, for example, Kynect produced an informational video with former inmates about the importance of health care coverage and how to enroll. Kynect also is helping new and returning enrollees make informed purchasing decisions. For Kynect website visitors who are eligible for cost-sharing reductions, silver-level plans appear first, along with an explanation that cost-sharing subsidies are available only with silver-level plans.

Kentucky's individual insurance market has become more competitive since the ACA's market reforms took effect. Previously there were only two insurance companies operating in the market; for 2016, consumers are able to choose from plans offered by seven different insurers.*

* Kentucky Governor-elect Matt Bevin has expressed a desire to adopt a federal marketplace in lieu of Kynect.

Better Access to Care for At-Risk Adults

We also assessed access to routine care for adults who could be at greater risk for adverse health outcomes if they do not receive care. This at-risk group includes everyone age 50 and older, since many have chronic conditions and need preventive care, as well as the subset of younger adults who report having chronic illnesses or being in fair or poor health.

From 2013 to 2014, 11 states experienced at least a two-percentage-point reduction in the share of at-risk adults who did not visit a doctor for a routine checkup in a two-year period. The greatest improvement (four points) was seen in Oregon and Rhode Island. Yet in 2014, greater than twofold variation in performance between eastern and western states persisted. Rates were less than 10 percent in Rhode Island, Maryland, Massachusetts, the District of Columbia, New Jersey, and West Virginia. In contrast, 19 percent to 22 percent of at-risk adults had not seen a doctor for two years for a checkup in Oklahoma, Utah, Idaho, Wyoming, and Alaska (Exhibit 7, Appendix Table 1).

Improvements in access to routine care for these adults may be the result in part of the ACA's insurance expansions and market reforms, as well as the law's Medicare provisions, including the introduction of free annual wellness visits and the closing of the "doughnut hole," or gap in coverage, for prescription drugs.

No Gains in Access to Dental Care for Adults

Many experts, including a former U.S. Surgeon General, have noted that oral health is integral to overall health and well-being.[14] In the U.S., however, dental care traditionally has been covered under a separate policy than medical coverage. Under the ACA, health plans in the marketplaces must offer dental coverage for children, but are not required to do so for adults. Similarly, Medicaid and the Children's Health Insurance Program are required to provide dental benefits for children, but states can choose whether to extend dental coverage to adults.

In 2014, in all states, at least one of nine adults age 18 and older (11%) had gone a year or more without visiting a dentist, dental hygienist, or dental clinic. This is essentially unchanged from 2012 (the most recent year with

comparable data). In the worst-performing states on this indicator in 2014 (Louisiana, Mississippi, Texas, and West Virginia), one of five adults went without dental care for a year or more (Exhibit 7, Appendix Table 1). According to the *State Scorecard on Health System Performance, 2015 Edition,* West Virginia and Mississippi had among the highest rates of adults under age 65 missing six or more teeth because of tooth decay, infection, or gum disease (22% and 19%, respectively, in 2014).[15]

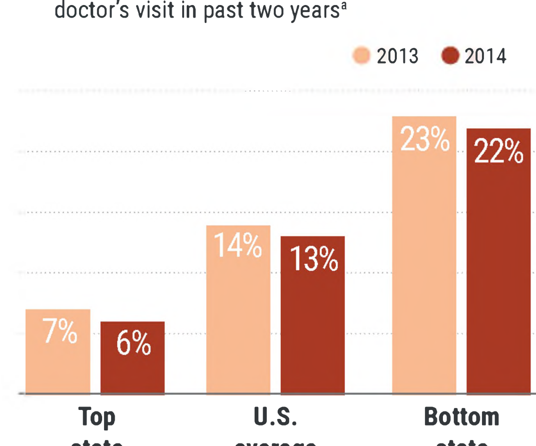
How States Stack Up

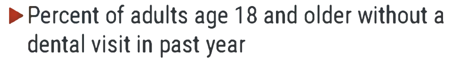
In the area of health care access and affordability, the top-ranked states in the 2015 scorecard (Massachusetts, Vermont, Minnesota, Rhode Island, and Connecticut) have also all been leaders in one or more previous scorecard editions (2014, 2009, 2007). Maryland moved into the top quartile of performance in access for the first time this year. However, even the leading states did not perform consistently well or improve across all indicators (Exhibit 8).

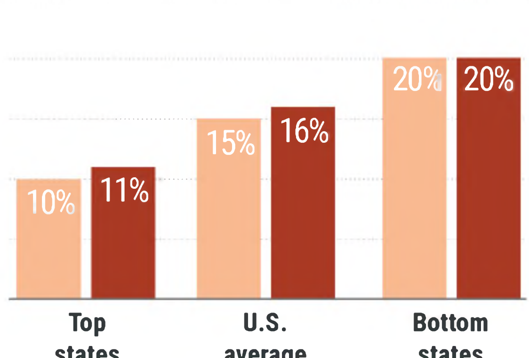
Several states in the bottom quartile of performance showed the greatest absolute improvement on some indicators. For example, New Mexico, Arizona, Arkansas, and Nevada were among the states with the largest percentage-point declines in the uninsured rate for working-age adults (six to seven points), and Nevada and Arizona had among the greatest reductions in uninsured rates for children age 18 and younger (four- and three-point declines, respectively). In addition, Arkansas, Florida, and Mississippi (along with Louisiana, ranked at the bottom of the third quartile) were among only a handful of states that saw declines of three points in the share of adults who went without care because of costs.

Exhibit 7. State Variation: Receipt-of-Care Access Indicators, 2014 vs. 2013 or 2012

▶ Percent of at-risk adults without a routine doctor's visit in past two years[a]







[a] At-risk adults defined as all adults age 50 or older, and adults ages 18 to 49 in fair or poor health, or ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma.

[b] Most recent comparable data year.

Data source: Behavioral Risk Factor Surveillance System, 2012, 2013, and 2014.

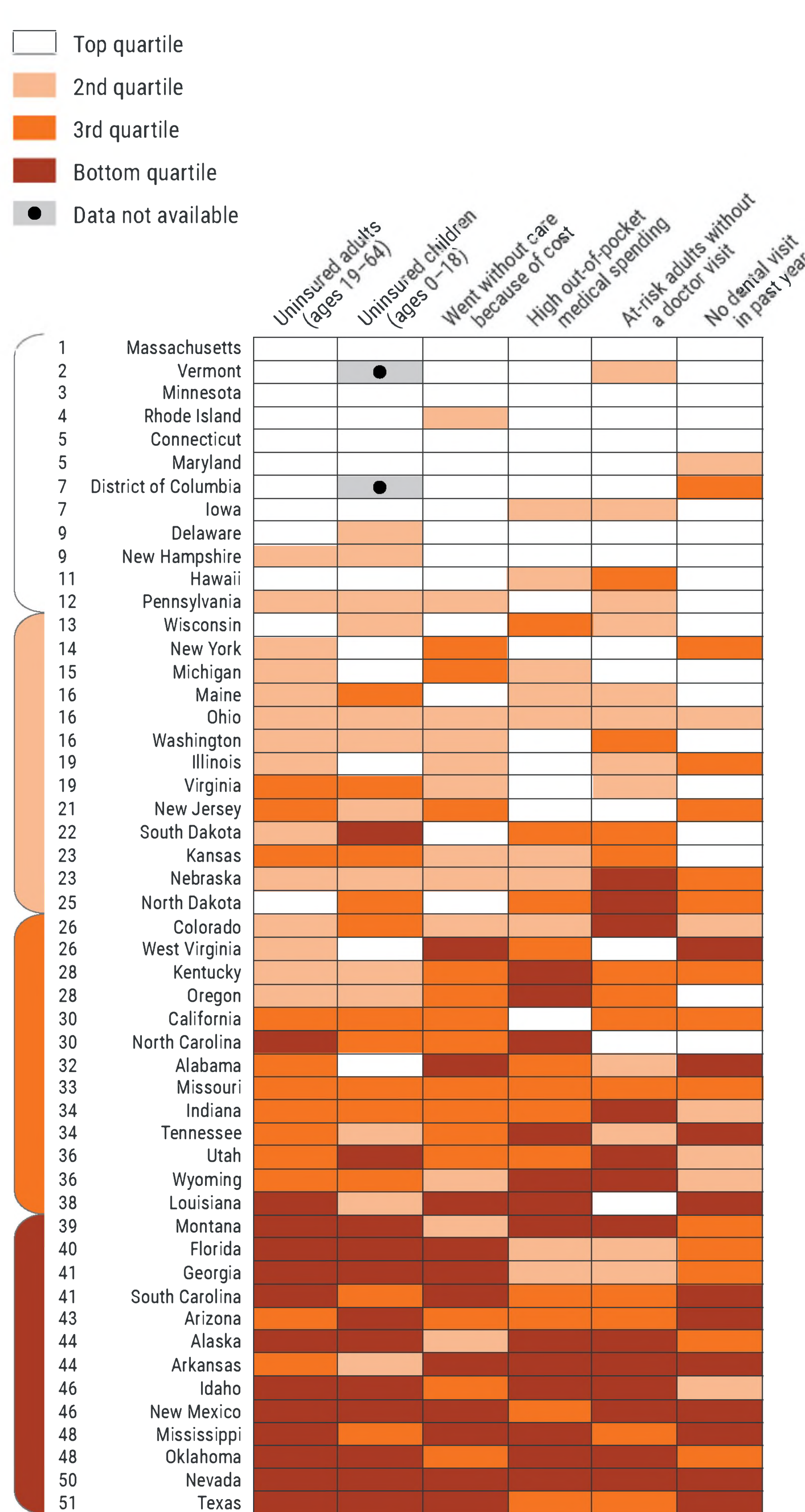
CONCLUSION

During the ACA's first year of health coverage expansions, an estimated 8.8 million Americans gained health coverage.[16] The largest absolute gains were in states that chose to expand eligibility for their Medicaid programs by January 2014. While more states have done so since, several populous states have not—leaving them with some of the nation's highest uninsured rates. If the 20 states that have still not expanded their Medicaid programs were to do so, an estimated 3.1 million fewer people would be uninsured in 2016.[17]

Despite the coverage gains in 2014 and the reduction in the number of adults who reported they went without care because of costs, there remains wide variation among states in residents' access to affordable care. If all states were to achieve the benchmarks set by top-performing states, we estimate that an additional 24 million people under age 65 would gain coverage and nearly 17 million fewer adults would forgo care because of costs.[18]

Continued monitoring of state trends in health care access and affordability will be necessary to determine whether the ACA is achieving its goals of near-universal coverage and lower financial barriers to care.

Exhibit 8. State Scorecard Summary of Health System Performance Across the Access Dimension



Data source: Commonwealth Fund Scorecard on State Health System Performance, 2015 Edition.

Notes

[1] Throughout this brief, we report the number of states in which we found a change in performance from 2013 to 2014 (or 2012 to 2014, for the dental care indicator). We count changes that are at least one-half of a standard deviation larger than the difference in rates across all states over the two years being compared. In addition, we treat the District of Columbia as a state, unless indicated otherwise.

[2] Trend data for our measure of health care affordability—the percentage of individuals under age 65 living in households that spent a high share of their annual income on out-of-pocket medical costs—are not available because of recent changes in the federal survey questions from which this rate is derived.

[3] The exception was Massachusetts, where the uninsured rate for adults ages 19–64 remained at 5 percent, already the lowest in the country owing to insurance reforms enacted by the state in 2006.

[4] Michigan implemented Medicaid expansion on April 1, 2014.

[5] Montana's Medicaid expansion waiver was approved in November 2015, with coverage under the expansion effective January 1, 2016.

[6] C. Schoen, S. L. Hayes, S. R. Collins, J. Lippa, and D. Radley, *America's Underinsured: A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions* (New York: The Commonwealth Fund, March 2014).

[7] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Information Products and Data Analytics, *2013 CMS Statistics,* CMS Pub. No. 03504 (Washington, D.C.: CMS, Aug. 2013).

[8] D. Blumenthal and D. Squires, "Residents in the ACA's Non-Participating States Still Benefiting," *The Commonwealth Fund Blog,* May 28, 2014.

[9] 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* (New York: The Commonwealth Fund, Jan. 2015).

[10] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief, *Health Insurance Marketplace: Summary Enrollment Report for The Initial Annual Open Enrollment Period* (Washington, D.C.: ASPE, May 1, 2014). See Appendix E.

[11] 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* (New York: The Commonwealth Fund, Jan. 2015).

[12] S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, May 2015).

[13] To ensure adequate sample size, the state-level estimates are an average of rates found in 2013 and 2014. This two-year span includes the year before and the first year of the ACA's major coverage expansions. This measure includes both insured and uninsured individuals.

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

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[16] S. R. Collins, M. Gunja, and S. Beutel, "New U.S. Census Data Show the Number of Uninsured Americans Dropped by 8.8 Million," *The Commonwealth Fund Blog,* Sept. 16, 2015.

[17] R. Garfield and A. Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid – An Update* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 23, 2015).

[18] See Appendix A3 in the 2015 state scorecard.

[19] B. Middel and E. van Sonderen, "Statistical Significant Change Versus Relevant or Important Change in (Quasi) Experimental Design: Some Conceptual and Methodological Problems in Estimating Magnitude of Intervention-Related Change in Health Services Research," *International Journal of Integrated Care*, published online Dec. 17, 2002.

METHODS

The Commonwealth Fund's *State Scorecard on Health System Performance, 2015 Edition*, evaluates 42 indicators grouped into four dimensions. It also includes a fifth dimension that assesses equity in states' health systems, using some of these indicators. The scorecard's access and affordability dimension, the focus of this brief, includes the six indicators described below.

Indicators and Data Sources

1. *Percent of uninsured adults ages 19–64.* Source: Authors' analysis of U.S. Census Bureau, 2013 and 2014 1-Year American Community Survey Public Use Microdata Sample.
2. *Percent of uninsured children ages 0–18.* Source: Authors' analysis of U.S. Census Bureau, 2013 and 2014 1-Year American Community Survey Public Use Microdata Sample.
3. *Percent of adults age 18 and older who went without care because of cost during past year.* Source: Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System.
4. *Percent of at-risk adults (all adults age 50 and older and adults ages 18–49 who are in fair or poor health or who were ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma) without a routine doctor visit in past two years.* Source: Authors' analysis of 2013 and 2014 Behavioral Risk Factor Surveillance System.
5. *Percent of adults age 18 and older without a dental visit in the past year.* Source: Authors' analysis of 2012 and 2014 Behavioral Risk Factor Surveillance System.
6. *Percent of individuals under age 65 with high out-of-pocket medical spending relative to their annual income.* Source: C. Solis-Roman, Robert F. Wagner School of Public Service, New York University, analysis of 2014, 2015 Current Population Survey, Annual Social and Economic Supplement.

Measuring Change over Time

We considered an indicator's value to have changed if it was at least one-half (0.5) of a standard deviation larger than the difference in rates across all states over the two years being compared–a common approach in social science research.[19] For purposes of this analysis, we treat the District of Columbia as a state.

Scoring and Ranking

We averaged state rankings for the six indicators within the scorecard's access and affordability dimension to determine a state's dimension rank.

For more information on scorecard methodology and indicator descriptions and source notes, see *Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition*.

Appendix Table 1. Access and Affordability: Dimension Ranking and Indicator Rates

	Adults ages 19–64 uninsured			Children ages 0–18 uninsured			Uninsured ages 0–64			Adults age 18 or older who went without care because of costs in past year			Individuals under age 65 with high out-of-pocket medical spending	At-risk adults[a] without a routine doctor visit in past two years			Adults age 18 or older without a dental visit in past year		
	2013	2014		2013	2014		2013	2014		2013	2014		2013–14	2013	2014		2012	2014	
United States	20%	16%	*	8%	6%	*	17%	13%	*	16%	14%	*	15%	14%	13%		15%	16%	
Alabama	20	18		5	4		16	14	*	16	17		16	12	12		18	18	
Alaska	24	22		12	12		20	19		14	12	*	18	23	22		14	16	*
Arizona	24	18	**	13	10	**	20	16	*	17	16		16	19	16	*	17	18	
Arkansas	24	18	**	6	5		19	14	**	21	18	*	21	18	18		19	18	
California	24	17	**	8	6	*	19	14	**	16	14	*	13	17	15	*	16	17	
Colorado	19	14	*	9	6	**	16	12	*	15	13	*	15	18	17		16	15	
Connecticut	13	9	*	4	4		11	8	*	12	11		13	10	11		11	12	
Delaware	14	10	*	5	5		12	9	*	12	11		13	9	10		12	14	*
District of Columbia	8	7		–	–		7	6		11	11		11	9	8		16	16	
Florida	29	24	*	12	10	*	24	20	*	21	18	*	15	14	12	*	18	17	
Georgia	26	22	*	10	8	*	21	18	*	20	19		15	14	13		16	17	
Hawaii	10	7	*	3	3		8	6	*	9	9		14	14	15		15	14	
Idaho	23	19	*	9	8		19	15	*	16	16		22	21	20		13	15	*
Illinois	18	14	*	5	4		14	11	*	14	12	*	13	14	13		15	16	
Indiana	19	17		9	7	*	16	14	*	16	15		16	17	17		15	15	
Iowa	12	8	*	5	3	*	10	7	*	10	9		15	14	12	*	12	13	
Kansas	18	15	*	7	6		14	12	*	14	13		15	14	15		13	13	
Kentucky	21	12	**	6	5		17	10	**	19	16	*	18	15	15		16	16	
Louisiana	25	22	*	6	5		19	17	*	20	17	*	19	10	10		20	20	
Maine	16	14		5	6		13	12		10	11		15	12	12		13	13	
Maryland	14	11	*	5	4		11	9	*	13	10	*	10	10	7	*	13	15	*
Massachusetts	5	5		2	2		4	4		9	8		11	7	7		11	12	
Michigan	16	12	*	5	4		13	10	*	15	15		15	13	11	*	14	14	
Minnesota	11	8	*	6	4	*	9	7	*	10	9		12	12	11		11	13	*
Mississippi	25	22	*	8	6	*	20	17	*	22	19	*	20	15	14		19	20	
Missouri	18	16		7	7		15	13	*	16	14	*	17	16	15		15	16	
Montana	23	19	*	11	9	*	20	16	*	14	12	*	19	19	17	*	17	16	
Nebraska	15	13		6	5		12	11		13	12		15	18	17		15	16	
Nevada	27	21	**	14	10	**	23	17	**	17	17		18	15	17	*	20	19	
New Hampshire	16	13	*	4	5		13	11	*	12	11		12	11	11		10	12	*
New Jersey	19	16	*	6	5		15	13	*	15	14		13	10	9		15	16	
New Mexico	28	21	**	9	8		22	17	**	18	17		16	17	18		18	18	
New York	15	12	*	4	4		12	10	*	15	14		12	10	10		15	16	
North Carolina	23	19	*	6	6		18	15	*	18	16	*	18	12	11		15	14	
North Dakota	14	10	*	8	7		12	9	*	7	7		17	17	17		15	16	
Ohio	16	12	*	5	5		13	10	*	15	13	*	15	13	12		14	15	
Oklahoma	25	21	*	11	9	*	20	18	*	17	15	*	19	21	19	*	18	17	
Oregon	21	14	**	7	5	*	17	12	**	18	14	**	20	20	16	**	15	14	
Pennsylvania	14	12		5	5		11	10		12	12		12	12	12		13	14	
Rhode Island	17	10	**	6	3	**	14	8	**	14	12	*	13	10	6	**	12	12	
South Carolina	23	20	*	7	6		18	16	*	19	18		17	16	15		18	18	
South Dakota	17	13	*	7	8		14	12	*	10	10		16	14	16	*	11	11	
Tennessee	20	17	*	6	5		16	14	*	18	16	*	22	11	12		17	18	
Texas	30	26	*	13	12		24	21	*	19	18		17	15	16		18	20	*
Utah	18	16		9	9		15	14		15	14		16	19	19		16	15	
Vermont	10	7	*	–	–		8	5	*	9	9		12	11	12		11	11	
Virginia	17	15		6	6		14	12	*	15	13	*	12	12	12		12	14	*
Washington	20	13	**	7	5	*	16	11	**	15	12	*	13	17	16		14	14	
West Virginia	20	13	**	5	3	*	16	11	**	18	17		17	12	9	*	18	20	*
Wisconsin	13	10	*	5	5		10	9		12	11		16	13	12		12	12	
Wyoming	18	17		7	7		15	14		14	12	*	18	21	21		15	15	
Change		39			16			42			21				13			9	
States Improved		39			16			42			21				11			0	
States Worsened		0			0			0			0				2			9	

Notes: * Denotes a change of at least 0.5 standard deviations; ** denotes a change of 1.0 standard deviation or more.
– Data not available.
[a] At-risk adults defined as all adults age 50 or older, and adults ages 18 to 49 in fair or poor health or ever told they have diabetes or pre-diabetes, acute myocardial infarction, heart disease, stroke, or asthma.
Data source: Commonwealth Fund Scorecard on State Health System Performance, 2015 Edition.

Appendix Table 2. Select Access Indicators by Income and by Race and Ethnicity

	Adults ages 19–64 uninsured								Adults age 18 or older who went without care because of costs in past year							
	Low-income (<200% FPL)		Black, non-Hispanic		White, non-Hispanic		Hispanic		Low-income (<200% FPL)		Black, non-Hispanic		White, non-Hispanic		Hispanic	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2012	2014	2013	2014	2013	2014
United States	38%	31%	24%	19%	14%	11%	40%	33%	28%	26%	21%	19%	12%	11%	27%	24%
Alabama	37	33	24	22	17	15	59	47	31	33	21	21	14	16	22	23
Alaska	46	41	–	–	18	15	–	–	23	23	26	24	13	11	26	18
Arizona	41	31	23	15	16	12	38	30	33	26	15	16	13	13	27	23
Arkansas	40	29	28	19	21	15	51	46	32	28	29	23	18	16	39	32
California	41	30	21	13	14	10	38	28	26	24	13	14	11	9	23	19
Colorado	35	26	20	15	14	10	35	29	29	25	24	20	12	10	23	23
Connecticut	28	19	18	11	9	6	29	23	20	16	19	12	9	8	25	26
Delaware	26	18	14	9	12	9	32	25	21	19	18	12	10	9	19	23
District of Columbia	12	9	11	8	4	–	–	21	15	16	14	13	6	8	15	14
Florida	46	39	33	26	22	18	43	35	34	30	25	21	15	14	31	26
Georgia	46	40	28	24	19	16	60	53	35	38	25	25	16	14	31	32
Hawaii	21	14	–	–	12	8	–	10	15	14	–	7	8	9	16	15
Idaho	37	33	–	–	20	15	44	48	30	29	–	–	14	15	23	25
Illinois	36	28	26	18	12	9	39	31	26	21	20	16	9	9	28	25
Indiana	37	32	27	23	17	14	41	36	31	27	23	20	13	14	30	27
Iowa	26	17	21	–	11	7	31	21	20	20	10	18	9	8	25	27
Kansas	37	32	24	22	14	11	42	37	28	26	21	25	11	10	24	26
Kentucky	38	20	26	17	19	11	53	45	34	27	19	17	19	15	23	16
Louisiana	42	37	31	27	19	16	53	48	34	34	26	23	17	15	33	20
Maine	26	24	–	–	16	14	–	–	13	16	–	–	10	10	16	21
Maryland	30	24	15	11	9	7	41	38	26	23	15	12	9	8	36	22
Massachusetts	11	8	10	9	4	4	12	10	17	15	10	11	7	7	21	18
Michigan	30	23	24	16	14	11	30	24	26	25	23	19	14	13	23	30
Minnesota	23	18	21	15	8	6	39	37	20	18	22	21	9	7	21	22
Mississippi	39	35	30	25	20	18	50	48	33	33	29	26	17	16	34	–
Missouri	36	32	27	25	16	14	40	33	30	28	22	18	12	13	28	23
Montana	40	33	–	–	20	16	–	–	24	21	–	–	13	11	22	16
Nebraska	35	32	30	19	11	10	38	38	25	27	29	25	11	10	24	24
Nevada	47	34	31	18	20	14	41	35	27	25	24	21	14	14	23	24
New Hampshire	34	31	–	–	15	12	–	–	28	21	–	–	11	11	31	10
New Jersey	43	36	22	18	11	9	41	35	29	27	20	18	10	9	31	28
New Mexico	43	33	31	–	15	12	35	25	28	25	23	14	13	12	24	23
New York	26	22	17	13	10	7	29	24	24	22	14	19	11	10	28	25
North Carolina	42	36	27	21	17	14	59	53	34	31	24	19	15	14	32	28
North Dakota	28	24	–	–	11	7	–	–	15	14	–	–	7	6	13	23
Ohio	30	22	22	17	14	10	34	25	23	24	21	18	13	12	22	16
Oklahoma	42	39	27	27	19	16	51	42	32	30	23	21	15	13	32	31
Oregon	37	23	20	–	18	12	43	32	35	23	–	–	16	13	32	24
Pennsylvania	29	25	22	18	11	10	28	27	21	22	18	20	10	9	27	25
Rhode Island	32	18	22	–	12	7	43	24	25	20	15	14	11	9	32	27
South Carolina	39	36	27	23	18	16	56	53	32	31	22	22	16	15	28	30
South Dakota	36	29	–	–	13	8	–	–	19	18	–	–	8	9	21	7
Tennessee	37	30	23	19	17	15	60	52	28	23	20	15	17	15	–	29
Texas	52	46	27	22	17	15	47	41	34	32	22	21	13	11	28	26
Utah	35	31	–	–	14	12	42	41	29	29	23	21	13	12	27	25
Vermont	14	11	–	–	10	7	–	–	15	14	–	–	9	9	8	–
Virginia	38	33	22	19	12	10	44	36	28	27	19	16	12	11	34	25
Washington	40	24	23	11	16	10	47	32	31	25	23	11	14	11	30	24
West Virginia	35	20	21	18	20	13	--	--	31	27	31	21	18	16	18	31
Wisconsin	26	22	22	17	10	8	35	32	18	16	31	20	10	9	22	26
Wyoming	37	33	–	–	16	15	28	29	27	24	–	–	12	10	30	26

Note: FPL refers to federal poverty level.
– Data not available.
Data source: Commonwealth Fund Scorecard on State Health System Performance, 2015 Edition.

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2016 HEALTH INSURANCE EXCHANGES

The Good, the Bad, and the Ugly

POLICY RECOMMENDATIONS TO IMPROVE CONSUMER CHOICES

AMIT RAO, JOEL WHITE, AND KATIE ALLEN
DECEMBER 11, 2015

ABOUT

The Clear Choices Campaign

The Clear Choices Campaign is a multi-stakeholder advocacy association, representing patients, providers, insurers, employers, and life science companies that is dedicated to improving health care transparency. We advance solutions that empower consumers to make better health care choices, leading to a more robust, more competitive, and less costly health care system.

WE BELIEVE THERE SHOULD BE

- Better tools for consumers and employers to make informed decisions.
- Better data in the hands of more experts to power consumer tools.
- Better markets in which consumers can use these tools.

2016 HEALTH INSURANCE EXCHANGES

The Good, the Bad, and the Ugly

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FOREWORD

The Clear Choices Campaign is an advocacy effort of the Council for Affordable Health Coverage, which I help lead. We are dedicated to the idea that improved transparency in health care will empower consumers to make better choices that will, in turn, lower costs and improve health outcomes. To this end, we collectively support changing the laws and regulations that inhibit the use of information in health care.

Done well, changes to improve transparency can offer a huge pay-off. According to Don Berwick, the former Administrator of the Centers for Medicare and Medicaid Services, the lack of transparency and competitive pricing was responsible for between $84 billion and $174 billion in wasteful spending last year. While transparency, by itself, will not cure all that ails our uncompetitive health care system, it is a good place to start.

The Affordable Care Act's (ACA) insurance exchanges are tasked with providing consumers with the information and tools they need to maximize the value of their insurance dollars. While the exchanges have made considerable upgrades to their websites since the initial 2014 rollout, there is still substantial room for improvement. Despite the existence and use of private sector technologies like integrated provider network and drug formulary directories, consumer decisions are hampered—needlessly—by websites that do not go far enough to help them make the best possible coverage decisions. Any new program will have its fits and starts, but we should not hobble ourselves by failing to use the best consumer-facing features and tools available.

Politically, both Democrats and Republicans see value in transparency. Republicans want markets to work. Democrats want to level the real and perceived imbalances in the playing field. Both parties seem to want an empowered consumer.

Therefore, our goal in developing this white paper is to offer constructive and practical recommendations to Congress, the Administration, and state governments for the exchange websites to better support consumer welfare. We believe these reforms will also improve the functioning of markets and enhance competition by better providing the necessary information needed for consumers to make optimal health plan choices.

As bigger fights loom over health reform, some in both parties want to identify and work on real problems that are adversely impacting their constituents. We believe improving the exchange websites is an issue both parties can address without creating partisan collateral damage, even in an election year. The Clear Choices Campaign encourages policymakers to do just that.

The paper's primary author, Amit Rao, has done important work and spent countless hours drafting the paper and working on its methodology. For that, I am thankful. I also extend thanks to Paul Hewitt for his editing and methodological assistance, and to Katie Allen for her collaboration in helping to finalize the paper. Finally, many thanks to members of the Clear Choices Campaign for all of their feedback, advice, and counsel in developing this white paper. We all hope it leads to positive change.

Sincerely,
Joel C. White
President, Clear Choices Campaign

INTRODUCTION

Consumerism in health care is rapidly evolving, driven by rising costs, improved data and information technology, new plan designs, and the growing role of online comparison shopping in our everyday lives. The Affordable Care Act's (ACA) online health insurance exchanges, now entering their third year, are intended to offer consumers in themarket for individual coverage a greater ability to view and compare plan choices than before. Yet, how the exchanges present plan information plays a major role in the choices consumers make and, indeed, whether they purchase coverage at all.

Although nine in ten privately insured Americans still obtain coverage through the workplace, a growing number are purchasing insurance on their own.[1] As of June 30, 2015, 9.9 million individuals were enrolled in health plans available through the ACA's state-based and federally-facilitated exchanges—most of whom receive public subsidies.[2] The Department of Health and Human Services (HHS) projects that this number could reach up to 11.4 million in 2016.[3] Another 7-10 million Americans purchase individual health insurance directly from issuers or through private insurance exchanges.[4]

In recent years, a broadening array of plan benefit designs, featuring complex mixes of premiums, deductibles, consumer cost sharing, formularies, and "narrow" provider networks, have raised the stakes for consumers in choosing plans that fit their unique medical, financial, and geographic circumstances. These designs are intended to help curb wasteful utilization and improve quality by incentivizing consumers to utilize high-value, in-network health care services and providers. However, they also carry risks, particularly if consumers are not properly equipped.

In this context, HealthCare.gov (the federally-facilitated exchange website, which operates in 38 states) and the 13 state-based exchange websites are tasked with providing consumers with the information and tools they need to make informed health plan choices.

WHAT DEFINES A SUCCESSFUL
Online Plan Enrollment Experience?

Research suggests that consumers typically need four primary features to best inform their online enrollment choices.[6,7]
Consumers need to:

1. Easily view, compare, and understand their health plan options.
2. Identify their expected total plan costs and determine eligibility for financial assistance.
3. Confirm whether a plan covers their preferred doctors and/or prescribed medications.
4. Navigate the website smoothly and complete the enrollment process quickly.

With these core consumer goals in mind, this paper outlines the Clear Choices Campaign's assessment of the insurance exchanges, provides a scorecard to grade the 2016 exchange websites (see Appendices), and offers suggestions for improving exchange websites to facilitate better plan choices. The recommendations for exchange websites to better serve the consumer decision-making process and online plan enrollment experience are based on current research and literature, as well as input from an array of consumer-industry stakeholders, including health care consumers, providers, payers, life sciences companies, and employer groups.

SUMMARY OF

POLICY RECOMMENDATIONS

To Improve Consumer Choices

1 CUSTOMIZED WINDOW-SHOPPING TOOL

Allow consumers to preview and compare customized plan choice information based on their personal circumstances prior to creating a user account.

2 SMART, COMPARATIVE PLAN DISPLAY PAGE

Display health plan choices optimized to the consumer's personal circumstances, considering factors such as the type of health plan, total out-of-pocket costs (premiums, deductibles, and cost sharing), eligibility for financial assistance and tax benefits, preferred providers, and prescribed medications.

3 ACCESS TO DETAILED PLAN INFORMATION

Provide direct links to plan summaries of benefits and coverage, in-depth information on plan deductibles and cost sharing for health care services, and direct links to plan provider networks and drug formularies that allow consumers to easily toggle back and forth without leaving the window-shopping experience.

4 OUT-OF-POCKET COST CALCULATOR

Include a tool that provides an estimate of total annual out-of-pocket costs (premiums, deductibles, and cost sharing) customized to the consumer's health condition, anticipated health care usage, and prescribed medications.

5 INTEGRATED PROVIDER AND DRUG DIRECTORY TOOLS

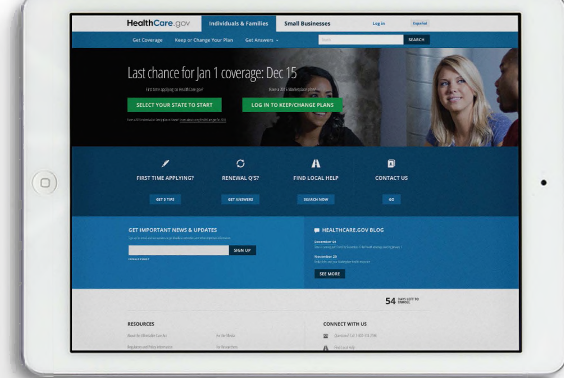
Utilize integrated provider and drug directories that allow consumers to easily determine which plans cover their preferred doctors and to assess the coverage tier and cost sharing for their prescribed medications under each plan.

6 USER-FRIENDLY WEBSITE LANGUAGE AND NAVIGATION

Provide a user-friendly, intuitive website layout that uses clear language that is free of jargon, requires a small number of steps to access key information, and simplifies consumer decision-making.

7 ACCURATE PLAN INFORMATION

Information on benefits, cost sharing, provider networks, and drug formularies should be as accurate, current, and consistent as possible, updated no less frequently than on a monthly basis.



CUSTOMIZED
Window-Shopping Tool

Allow consumers to preview and compare customized plan choice information based on their personal circumstances prior to creating a user account.

Much like shopping for plane tickets or other services, consumers value the opportunity to easily browse their choices before creating a user account that requires significant personal information. During the first open enrollment period, many consumers expressed frustration at having to create user accounts before being able to view health plans. Such front-end requirements may deter individuals from shopping for coverage. To mitigate this problem, 13 of the 14 exchange websites (including HealthCare.gov) have adopted tools designed to allow consumers to "window-shop" available plan choices.

Window-shopping tools, however, should allow for customization, so that consumers can quickly identify those plans most appropriate to their unique medical, financial, and geographic circumstances. The exchange websites vary in this regard. HealthCare.gov and nine of the state-based exchanges permit some degree of customization, whereas at least two exchange websites have no capacity for customization.[8]

RECOMMENDATIONS

- All exchange websites should provide a window-shopping tool that allows consumers to preview and compare plan choice information prior to creating a user account.
- The window-shopping tool should allow consumers to input varying degrees of personal information (e.g., age, household size, and income) to determine their eligibility for premium subsidies and Cost-Sharing Reductions (CSRs), and to view customized plan choice information that reflects this financial determination.[9]
- Exchange websites should clearly indicate that entering more personal information will enable the window-shopping tool to display increasingly customized plan options that better reflect their health care needs and eligibility for financial assistance.

2

SMART, COMPARATIVE
Plan Display Page

Display health plan choices optimized to the consumer's personal circumstances, considering factors such as the type of health plan, total out-of-pocket costs (premiums, deductibles, and cost sharing),eligibility for financial assistance and tax benefits, preferred providers, and prescribed medications.

The default order in which plans are displayed and the sorting tools available to consumers can play an important role in shaping choices. The default displays of seven exchange websites (including HealthCare.gov) are ordered by premium cost. This default display encourages consumers to choose plans based on premiums alone and, hence, undervalue key factors that affect total costs, such as deductibles, cost sharing, and coverage networks. For example, plans with the lowest premiums will not always be the least costly option for consumers with significant medical needs. In addition, website sort options typically are limited to only on a few basic criteria beyond cost, such as plan metal tiers, types (e.g., Health Maintenance Organizations) and issuer. Finally, HealthCare.gov and eight state exchanges automatically steer those eligible for CSRs to the Silver plans that offer those benefits, while five states do not. Without such guidance, consumers may be less likely to choose the most affordable options, or even to enroll in the first place. [10]

Exchange websites should implement a smarter strategy for displaying plan options and offering tools to help consumers choose a health plan that works best for them. Evidence suggests navigating through all potential health plan options can be confusing and overwhelming for consumers, anmost exchange websites do not offer sufficient support on the plan display page to help consumers quickly identify high-value options that may best meet their needs. In contrast, best-in-class private insurers and exchanges[i] use "smart tools" that walk consumers through the tradeoffs among different types of plans and organize the display of options according to best-fit. Many of these private websites have been in operation for years prior to the launch of the ACA insurance exchanges and have extensive data showing which tools and designs best support consumer preferences and plan selection needs. The federally-facilitated and state-based exchange websites can draw from the private sector's substantial experience in this area.

[i] Examples of best-in-class private exchange websites include eHealth, GetInsured, GoHealth, HealthCare.com, HoneyInsured, and Stride Health.

[ii] Details on the appropriate level of patient information needed for exchange websites to provide accurate out-of-pocket cost estimates are specified in the Out-of-Pocket Cost Calculator section.

2

SMART, COMPARATIVE
Plan Display Page

RECOMMENDATIONS

- The default plan order should be based on a "Smart Sort" that incorporates a number of factors, including consumer preferences and the total annual out-of-pocket (premiums, deductibles, and cost sharing) cost estimate[ii] for each plan.[11]

- Allow consumers to sort and filter plans based on an expanded set of factors, including plan deductibles, eligibility for CSRs, and consumer preferences for providers and prescription drugs.[12]

- Allow consumers to easily select several plans and compare premiums, deductibles, cost sharing, total annual out-of-pocket cost estimates, plan benefits, quality ratings, and coverage of preferred providers and prescribed medications in a side-by-side format.[13]

- Clearly flag plans with tax benefits—premium subsidies, CSRs, and HSAs—for consumers eligible to receive financial assistance.[14]
    - In particular, automatically prioritize Silver plans for consumers determined eligible for CSRs.

- Utilize "smart tools" that walk consumers through the tradeoffs of different types of plans and prioritize the display of health plans based on the consumer's input to quickly highlight best-fit options.[15]
    - Some consumers may be overwhelmed by too many plan choices, in which case a smart interactive tool can help in identifying high-value plan options.[16]
    - Exchange websites should consider adopting or building from numerous smart tools already in use by the private sector.[iii]

- Plan quality ratings should be provided alongside cost information for each plan to facilitate appropriate plan comparisons.[17,18]

[iii] See this article for more information: "What Expedia, Kayak could teach the ACA exchanges." FierceHealthPayer, 4 Nov 15. http://www.fiercehealthpayer.com/story/what-expedia-kayak-could-teach-aca-exchanges/2015-11-04.

3

ACCESS TO
Detailed Plan Cost and Benefit Information

Provide direct links to plan summaries of benefits and coverage, in-depth information on plan deductibles and cost sharing for health care services, and direct links to plan provider networks and drug formularies that allow consumers to easily toggle back and forth without leaving the window-shopping experience.

To help consumers better understand their health plan options, exchange websites should directly provide detailed information on each plan's cost and benefit structures. While all exchange websites now include links to insurer-provided summary of benefits and coverage documents, the overview of cost and benefit information on the exchange websites themselves still need significant improvement.

Notably, the detailed plan information does not always clearly specify which products and services are subject to the plan's deductible. When consumers do not understand how a plan deductible may affect their cost sharing—especially for common benefits such as physician visits and prescription drugs—the result is unnecessary confusion and unexpected costs. In addition, the federally-facilitated and state-based exchange websites offer consumers only limited flexibility to customize the cost-sharing information based on their expected levels of health care utilization. Another common weakness is that the websites do not always indicate the financial implications of seeking health care services out-of-network, which, in most cases, is significant.[19]

Exchange websites should present easy-to-understand plan information directly following the exchange's main display page. Consumers should be able to quickly find comprehensive plan information on the exchange website or from the issuer directly as needed.

RECOMMENDATIONS

- Provide direct links on the plan display page to summaries of benefits and coverage, detailed information on deductibles and cost sharing, provider networks, and prescription drug formularies.[20]
- Clearly highlight all specific services subject to or exempt from a plan deductible to ensure that consumers accurately perceive their expected cost sharing.[21]
  - If a plan has a separate medical and drug deductibles, clearly specify which deductible applies for which services and how the deductibles relate to each other.
  - Clearly specify how deductibles differ in application for individuals or a family enrolled in a plan, if applicable (e.g., total plan deductible versus a per-person deductible for family coverage).
- Clearly identify preventive services as requiring no cost sharing for the consumer.[22]
- Alert consumers to the risk of higher cost sharing for health care services accessed out-of-network.[23]
  - The detailed plan information should clarify the benefit structure that applies for the type of out-of-network care (e.g., 20% coinsurance) and indicate whether consumer payments for such care would count towards the plan deductible and out-of-pocket maximum.
- Provide direct links to the specific plan page on insurer websites for consumers that wish to obtain more information about certain plans.[24]

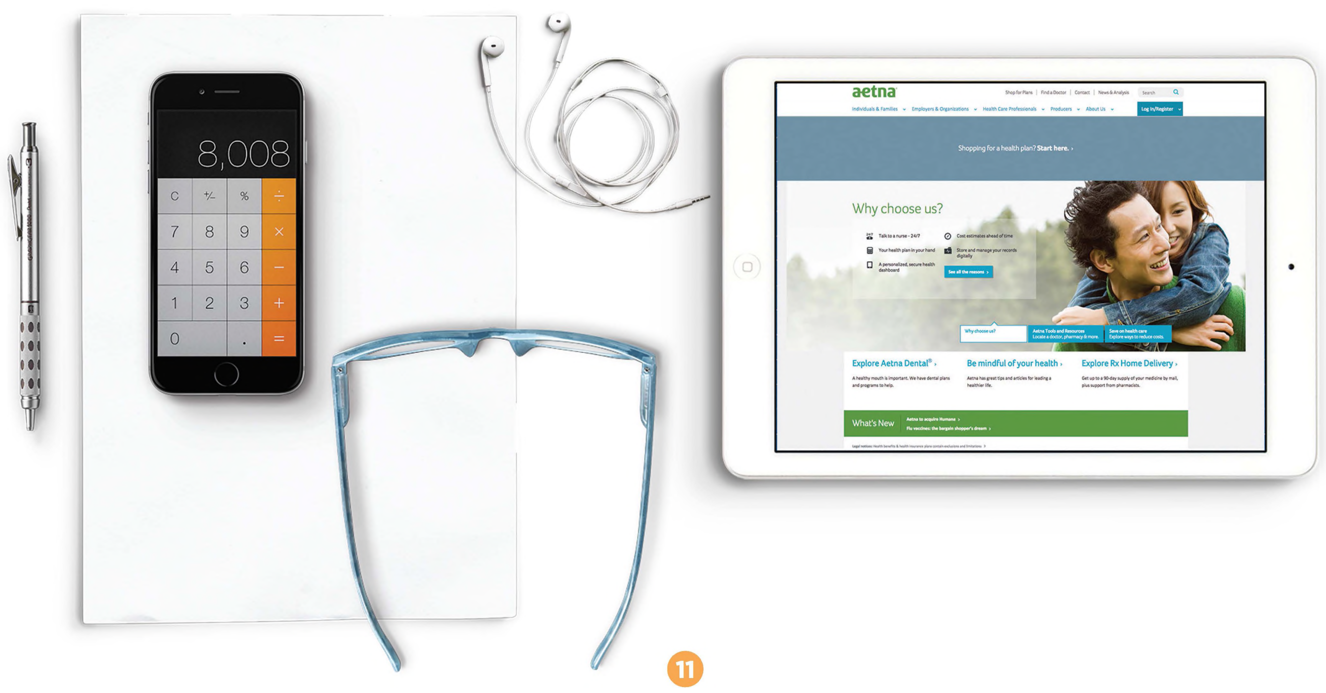
OUT-OF-POCKET

Cost Calculator

Include a tool that provides an estimate of total annual out-of-pocket costs (premiums, deductibles, and cost sharing) customized to the consumer's health condition, anticipated health care usage, and prescribed medications.

When displaying plan options, exchange websites should help consumers calculate their expected out-of-pocket costs and assess the cost tradeoffs of different health plan options. At present, most exchange websites (eight of 13, excluding Vermont Health Connect) do not include a tool that helps consumers calculate or compare estimates of their total annual out-of-pocket costs, including remiums, deductibles, and cost sharing. Currently, these websites generally allow consumers to view cost-sharing policies for various categories of care, and to make eyeball comparisons between several plans, but these features provide little detail as to how each plan's benefit structure would affect a consumer's expected annual costs.

For the 2016 Open Enrollment period, five exchange websites (including HealthCare.gov) have added a new Out-of-Pocket Cost Calculator designed to help consumers better understand their expected plan costs. In most cases, though, consumers are not given the option to provide the extensive detail needed to make reliablecost estimates. For example, HealthCare.gov only allows consumers to select a general preset range of expected health care utilization (low/medium/high) to be factored into the calculation for each family member applying for coverage. Estimates based on such general levels of detail can significantly understate the plan's expected total out-of-pocket costs. The most accurate calculators, such as the tool used by the Kentucky exchange (Kynect), allows consumers to specify known health conditions, anticipated health care procedures, and prescribed medications. Exchange websites should allow consumers the option of entering specific health information and provide an easy comparison of such customized out-of-pocket cost estimates across all applicable plans.



OUT-OF-POCKET
Cost Calculator

RECOMMENDATIONS

- Include an Out-of-Pocket Cost Calculator tool that provides an estimate of total annual out-of-pocket costs (premiums, deductibles, and cost sharing) customized to the consumer's health and financial status.[25, 26]

- Specify that the total annual out-of-pocket cost estimate provided on the exchange website includes premiums, deductibles, and cost sharing. Distinguish this cost estimate from information provided on the plan out-of-pocket maximum, as defined in the ACA statute as the limit consumers can pay towards the plan deductible and cost sharing (premiums excluded).

- Allow consumers to provide input on all of the following factors for each family member applying for coverage: common or known health conditions, anticipated health care procedures/usage, and prescribed medications.
  - Although optional, exchange websites should clearly indicate to consumers that entering more health information will enable the tool to provide increasingly customized and accurate out-of-pocket cost estimates.

- The tool should support consumers on the plan display page in more easily comparing the estimate of total annual out-of-pocket costs between health plan options to better assess the potential tradeoffs between premiums, deductibles, cost sharing, and benefits.

- Provide the Out-of-Pocket Cost Calculator tool methodology as open-source for stakeholders to review and suggest improvements for the accuracy of cost estimates.

- Exchange websites may also consider including an Individual Mandate Penalty Calculator that accurately estimates the fee consumers may face if they choose not to purchase qualified coverage.

5

INTEGRATED PROVIDER
And Drug Directory Tools

Utilize integrated provider and drug directories that allow consumers to easily determine which plans cover their preferred doctors and to assess the coverage tier and cost sharing for their prescribed medications under each plan.

A chief concern for consumers when evaluating plan options is determining whether their doctor or preferred hospital participates in their plan. They also want to know if their prescribed medications are covered and what their cost-sharing obligations might be on the plan formulary. In most cases, exchange websites provide direct links to plan provider networks and formulary directories hosted on the insurer's website, a method that limits consumers' ability to quickly search for and compare all plan options that include their particular providers or prescription drugs.[27]

For the 2016 Open Enrollment period, three exchange websites include integrated provider search tools, while six include integrated drug search tools. These tools allow consumers to quickly determine whether plans cover their preferred providers and prescribed medications.[27] In most cases, however, they do not include filters designed to highlight all of the plans being offered that cover the consumer's preferred providers and prescribed medications. In addition, the integrated drug directories generally do not includeessential information on coverage tier and cost sharing for the consumer's prescribed medications.

Exchanges should include integrated provider and drug directory tools that help consumers easily search for, filter, and compare plans that cover their preferred providers and prescribed medications, as well as access coverage tier and cost-sharing information for prescription drugs.

RECOMMENDATIONS

- Include built-in tools (i.e., non-external site) that provide a standardized, user-friendly means for consumers to easily search for and compare health plans that cover their preferred providers and prescribed medications. [29]
- The tools should allow consumers to enter multiple providers and/or drugs into one search, indicate coverage on the plan display page while window-shopping, and provide a filter to highlight plans which cover the consumer's preferred providers and/or prescribed medications.[30, 31]
- Consumers should have several options to vary, sort, and filter their search results, including, but not necessarily limited to:[32]
  - Provider networks: provider type (e.g., primary care, specialist), facility type (e.g., physician office, hospital), and distance (e.g., based on the consumer's location); and
  - Drug formularies: Medication dosage level (if desired, but not required), generic drug availability, coverage tier, and utilization management restrictions, if applicable.
- Integrated drug directories should indicate prescription drug coverage with coverage tier and cost-sharing information (similar to the Medicare Drug Finder).
- Consumers should be able to access the integrated provider and drug directory tools from the plan display page.[33]
- State-based exchange websites should make their integrated irectory data available for public use in a machine-readable format, similar to the availability of the Application Program Interface (API) for HealthCare.gov.

6

USER-FRIENDLY

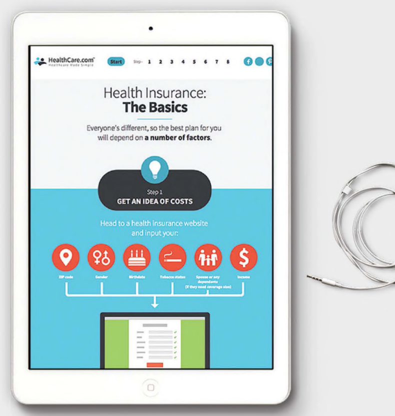
Website Language and Navigation

Provide a user-friendly, intuitive website layout that uses clear language that is free of jargon, requires a small number of steps to access key information, and simplifies consumer decision-making.

When using exchange websites, consumers seek to easily navigate website platforms, understand the information presented, and quickly complete the enrollment process. Website language and layout should make the often complicated choices involved as easy as possible.[34] Some exchange websites provide cluttered layouts, require too many clicks to obtain needed enrollment information, and rely too heavily on complicated text when visuals might better accomplish the same purpose. In addition, while HealthCare.gov offers a mobile phone layout option, not all state-based exchange websites support mobile accessibility, which may create barriers for consumers who primarily utilize smartphones to access the Internet.[35]

User-friendly website navigation should also include accessibility for multiple major languages. Two of the 13 state-based exchanges do not offer any non-English language assistance, while seven exchange websites (including HealthCare.gov) support only Spanish. In addition to Spanish, the major languages commonly supported in the private sector include Chinese, Russian, Tagalog, French, German, and Hindi. The lack of accessibility on exchange websites needlessly limits enrollment by consumers with limited English proficiency.

Currently, exchange websites vary significantly in how user-friendly they are across platforms and all may benefit from improvements to comprehension, layout, accessibility, and consumer support.



6

USER-FRIENDLY

Website Language and Navigation

RECOMMENDATIONS

- Have an intuitive design and layout. Consumers may have more difficulty following content if the words are difficult to read (due to font size, spacing, or color) or if the layout is too cluttered.[36]

- Require minimal clicks from the homepage to access the window-shopping tool and other key plan and enrollment information.[37]

- Use plain and concise language that is free of academic, bureaucratic, or legalistic jargon.[38] A "living room" conversational tone will reach consumers more effectively than a technical tone. Include tutorials when use of insurance jargon in required that helps provide a clear definition of the term.

- Break up and highlight important content by using bolds, italics, underlines, section headers, checklists, numbers, bullets, and arrows. [39]

- Utilize a progress bar to guide the consumer through multiple steps and indicate which stage of the plan selection process they are in screen-by-screen.[40, 41]

- Use visuals (images, graphs, tables) to help clarify plan information.[42] Generally, the less text and more visuals, the better for consumer viewing comprehension.

- Provide easy-to-follow (walkthrough or hover-over) definitions of key plan display page features and terms. If consumers need additional help, provide supporting links, interactive tutorials, and connections to insurance brokers.[43]

- Provide language accessibility support across multiple languages to help non-English consumers to enroll in coverage.[44] Websites should prominently flag how consumers can obtain assistance in other languages on the website homepage.[45]

7

ACCURATE

Plan Information

Provide a user-friendly, intuitive website layout that uses clear language that is free of jargon, requires a small number of steps to access key information, and simplifies consumer decision-making.

At their core, delivering accurate plan information is a primary function for all exchange websites. Information that is inaccurate or inconsistent across plans may erode trust or do actual harm by facilitating decisions at odds with a consumer's best medical or financial interests. In this regard, consumers and navigators have raised concerns about the reliability of certain health plan information presented on the exchange websites.[46]

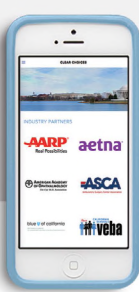
Inconsistencies between a website's plan overview page and a plan's summary of benefits and coverage—particularly with respect to the application of a plan deductible and cost sharing for health care services—are a well-documented problem. In addition, there are sometimes discrepancies between plan names on the exchange websites and on an insurer's website, which may complicate consumer efforts to obtain assistance with a particular plan. Consumers generally look at the plan overview page found on the exchange website, whereas plans strictly adhere to plan contracts, whose information is summarized in detail for consumers in the summary of benefits and coverage document. Such inconsistencies have the potential to negatively impact consumer decision-making.[47]

Consumers also have reported issues with the accuracy of information on plan provider networks and drug formularies presented on exchange websites. In these cases, consumers typically select a plan believing their preferred provider is in-network, only to later discover that the provider no longer contracts with the plan. Similar problems arise less frequently with prescription drug formularies, though they remain a concern. Inaccurate or outdated information regarding provider or prescription drug coverage can be particularly disruptive for consumers.[48] Accurate directories require information to be shared both ways among all entities involved.

Exchange websites should take further measures, in conjunction with plans, providers, and regulators, to ensure that the plan informationpresented to consumers is accurate, consistent across multiple sources, and updated on at least a monthly basis.[49]

RECOMMENDATIONS

- Ensure that plans provide consistent information across the website plan overview page, the underlying plan summary of benefits and coverage document, and plan contracts.[50]
- Regularly spot check the accuracy of plan information, particularly for data on benefits, cost sharing, provider networks, and drug formularies.[51]
- Provide an easy means for consumers to report potential inconsistencies they observe with plan information for review.[52]
- Require plan provider networks and drug formularies to have accurate and consistent data, updated no less frequently than on a monthly basis.[53]
- Include "last modified" timestamps on the plan display page to indicate to consumers when the plan information available was last updated by the insurer.



CONCLUSION

Going into the 2016 Open Enrollment period, HHS has identified approximately 10.5 million uninsured Americans who were eligible for exchange plan coverage in 2015 but did not enroll.[54] To help reach this untapped market and better match consumers with plans that meet their health care needs and financial circumstances, exchange websites should work towards best practices in providing the kinds of information and tools consumers need in order to effectively comparison shop and enroll in coverage.[55]

To this end, exchange websites should provide customized window-shopping tools and utilize smart, comparative plan display pages. Exchange websites should incorporate Out-of-Pocket Cost Calculator tools that provide a customized estimate of total annual out-of-pocket costs—including premiums, deductibles, and cost sharing—to help consumers clearly identify their expected plan costs and eligibility for financial assistance. Exchange websites should also utilize integrated plan provider and drug directories, to allow consumers to easily search for and compare plans that provide the best coverage for their preferred doctors and/or prescribed medications. Finally, to provide consumers with an efficient and effective overall enrollment experience, exchange websites should encourage accessibility through user-friendly language and website navigation and ensure validity through accurate plan information across all pages. Given that many of these features have already been developed and utilized on private exchange websites, HHS should consider incorporating or contracting out certain consumer-facing features to the private sector.

Empowering consumers to effectively evaluate and compare health plan choices is critical to ensuring they have the best chance to select a plan that meets their needs. Better information on coverage options can help reduce costs and improve health outcomes. By adopting the recommendations outlined in this paper, exchange websites can reduce costs for consumers and taxpayers alike.

APPENDICES

2016 INSURANCE EXCHANGE

Websites Scorecard

INSURANCE EXCHANGE WEBSITE	WINDOW-SHOPPING TOOL		SMART, COMPARATIVE PLAN DISPLAY PAGE				OUT-OF-POCKET COST CALCULATOR	INTEGRATED PROVIDER DIRECTORY	INTEGRATED DRUG DIRECTORY	USER-FRIENDLY NAVIAGTION		INDEXED SCORE**
	ANONYMOUS BROWSING	CUSTOMIZED PLAN INFO	DEFAULT ORDER	SIDE-BY-SIDE COMPARISONS	SMART PLAN FINDER	HIGHLIGHTS CSR PLANS				LAYOUT	LANGUAGE ACCESSIBILITY	
KYNECT	YES	A	YEARLY COST ESTIMATE	YES	NO	YES	A	A	B	B	A	84
WASHINGTON HEALTHPLANFINDER	YES	A	PREMIUMS	YES	YES	YES	F	A	F	A	B	74
ACCESS HEALTH CT	YES	A	SMART SORT	YES	YES	YES	B	F	F	B	B	71
COVERED CALIFORNIA	YES	A	SMART SORT	YES	YES	YES	F	F	F	B	A	64
HEALTHCARE.GOV	YES	A	PREMIUMS	YES	NO	NO	C	B	C	A	B	63
DC HEALTH LINK	YES	A	YEARLY COST ESTIMATE	YES	NO	NO	B	A	F	A	F	63
MARYLAND HEALTH CONNECTION	YES	A	SMART SORT	YES	YES	YES	F	F	F	B	F	63
HEALTHSOURCE RI	YES	A	PREMIUMS	YES	YES	YES	C	F	F	C	B	63
MNSURE	YES	A	YEARLY COST ESTIMATE	YES	NO	YES	B	F	F	A	F	61
YOUR HEALTH IDAHO	YES	A	PREMIUMS	YES	NO	YES	D	F	F	B	B	59
CONNECT FOR HEALTH COLORADO	YES	F	PREMIUMS	YES	NO	NO	F	A	A	A	B	55
MASSACHUSETTS HEALTH CONNECTOR	YES	F	PREMIUMS	YES	NO	NO	F	C	F	C	A	35
NEW YORK STATE OF HEALTH	YES	B	PREMIUMS	YES	NO	NO	F	F	F	C	A	30
VERMONT HEALTH CONNECTION	NO	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	N/A*	F	N/A*

*N/A: Indicates that the exchange website features were not accessible for evaluation because the website did not offer a window-shopping tool. **Indexed Weighted Composite Score
IV Your Health Idaho's Out-of-Pocket Cost Calculator only provides a "Low," "Medium," or "High" cost estimate for each plan, which offers lower utility than a specific dollar amount for consumers.

SCORECARD
Methodology

The exchange website analysis for the scorecard was conducted between November 17-25, 2015, using window-shopping tools as available.

OVERVIEW

SCORING SYSTEM

Each column is scored based on one of the following metrics, depending on the column's particular criteria as outlined below.

Yes/No: Provides a simple binary classification to indicate whether the question is satisfied.

Categorical Variable: Specifies the type of feature in use by the exchange website out of a defined set of options.

Letter Grade: Indicates the level of proficiency at which the criteria are satisfied. Generally, the letter grades are scored as follows. Underlined text in the criteria description indicate key factors for distinguishing between scoring grades.

- A Meets all criteria for this category.
- B Meets most criteria for this category.
- C Meets some criteria for this category.
- D Meets minimal criteria for this category and provides little utility to the consumer in their current construction.
- F Meets none of the criteria for this category (e.g., the feature is not provided).

CRITERIA

ANONYMOUS BROWSING (YES/NO)

Allow consumers to preview and compare customized plan choice information based on their personal circumstances prior to creating a user account.

CUSTOMIZED PLAN INFO (LETTER GRADE):

Indicates whether the window-shopping tool allows consumers to input their personal information (age, household size, and income) to determine eligibility for financial assistance and access customized plan choice information.

- **A** Determines the consumer's eligibility for premium subsidies and Cost-Sharing Reductions and provides customized plan choice information based on these financial determinations.
- **B** Determines the consumer's eligibility for premium subsidies only and provides customized plan choice information based on this financial determination.
- **C** Determines the consumer's eligibility for premium subsidies and/or Cost-Sharing Reductions but does not provide customized plan choice information based on this financial determination.
- **F** Does not allow consumers to input personal information to determine eligibility for financial assistance and access customized plan choice information within the window-shopping tool.

DEFAULT ORDER (CATEGORICAL VARIABLE):

Specifies the default order in which plan options are displayed. Options include "Premiums," "Yearly Cost Estimate,"

- "Smart Sort" indicates that the default plan order incorporates a number of factors, including consumer preferences and the total estimated annual out-of-pocket costs (premiums, deductibles, and plan cost sharing).

SIDE-BY-SIDE COMPARISONS (YES/NO):

Indicates whether the plan display page allows consumers to select plans and compare benefits and cost-sharing information side-by-side.

SMART PLAN FINDER (YES/NO):

Indicates whether the plan display page includes a "smart tool" that prioritizes the display of health plans based on the consumer's input to quickly highlight best-fit options.

HIGHLIGHTS CSR PLANS (YES/NO):

Indicates whether the plan display page highlights Silver plans by default for consumers eligible for Cost-Sharing Reductions.

OUT-OF-POCKET COST CALCULATOR

Indicates whether the exchange website includes a tool that provides an estimate of total annual out-of-pocket costs (premiums, deductibles, and cost sharing) customized to the consumer's health and financial status.

- **A** Allows consumers to provide input on all of the following factors for each family member applying for coverage: common health conditions, anticipated health care procedures/usage, and prescribed medications.
- **B** Allows consumers to provide input on some of the following factors for each family member applying for coverage: common health conditions, anticipated health care procedures/usage, and prescribed medications.
- **C** Allows consumers to select a general preset range of expected health care utilization (e.g., Low/Medium/High) or general health status (e.g., Poor/Moderate/Good) only for each family member applying for coverage.
- **F** Does not include a tool to provide consumers with a customized estimate of total annual out-of-pocket costs.

INTEGRATED PROVIDER DIRECTORY (LETTER GRADE):

Indicates whether the exchange website includes a built-in tool (non-external site) that allows consumers to search for plans that cover their preferred providers.

- **A** Indicates provider coverage on the plan display page while window-shopping and provides a filter to highlight plans that cover the consumer's preferred providers.
- **B** Indicates provider coverage on the plan display page while window-shopping but does not provide a filter to highlight plans that cover the consumer's preferred providers.
- **C** Allows consumers to search for plans that cover their preferred providers but does not indicate provider coverage on the plan display page while window-shopping and does not provide a filter to highlight plans that cover the consumer's preferred providers.
- **F** Does not include a built-in tool for consumers to search for plans that cover their preferred providers.

INTEGRATED DRUG DIRECTORY (LETTER GRADE):

Indicates whether the exchange website includes a built-in tool (non-external site) that allows consumers to search for plans that cover their prescribed medications.

- **A** Indicates prescription drug coverage, with coverage tier and cost-sharing information, on the plan display page while window-shopping and provides a filter to highlight plans that cover the consumer's prescribed medications.
- **B** Indicates prescription drug coverage, without coverage tier and cost-sharing information, on the plan display page while window-shopping and provides a filter to highlight plans that cover the consumer's prescribed medications.
- **C** Indicates prescription drug coverage, without coverage tier and cost-sharing information, on the plan display page while window-shopping but does not provide a filter to highlight plans that cover the consumer's prescribed medications.
- **F** Does not include a built-in tool for consumers to search for plans that cover their prescribed medications.

LAYOUT (LETTER GRADE):

Indicates whether the exchange website has an intuitive design and provides easy explanations of terms for consumers.

- **A** Requires minimal clicks from homepage to access the window-shopping tool, and includes all of the following items: plain and concise language, a progress bar while entering personal information (if multiple pages), easy-to-follow (walkthrough or hover-over) definitions of key features/terms, and a lack of clutter.
- **B** Requires minimal clicks from homepage to access the window-shopping tool, and includes most of the following items: plain and concise language, a progress bar while entering personal information (if multiple pages), easy-to-follow (walkthrough or hover-over) definitions of key features/terms, and a lack of clutter.
- **C** Requires minimal clicks from homepage to access the window-shopping tool, and includes some of the following items: plain and concise language, a progress bar while entering personal information (if multiple pages), easy-to-follow (walkthrough or hover-over) definitions of key features/terms, and a lack of clutter.
- **F** Does not require minimal clicks from homepage to access the window-shopping tool, and includes few of the following items: plain and concise language, a progress bar while entering personal information (if multiple pages), easy-to-follow (walkthrough or hover-over) definitions of key features/terms and a lack of clutter.

LANGUAGE ACCESSIBILITY (LETTER GRADE):

Indicates whether the exchange website prominently features non-English language assistance.

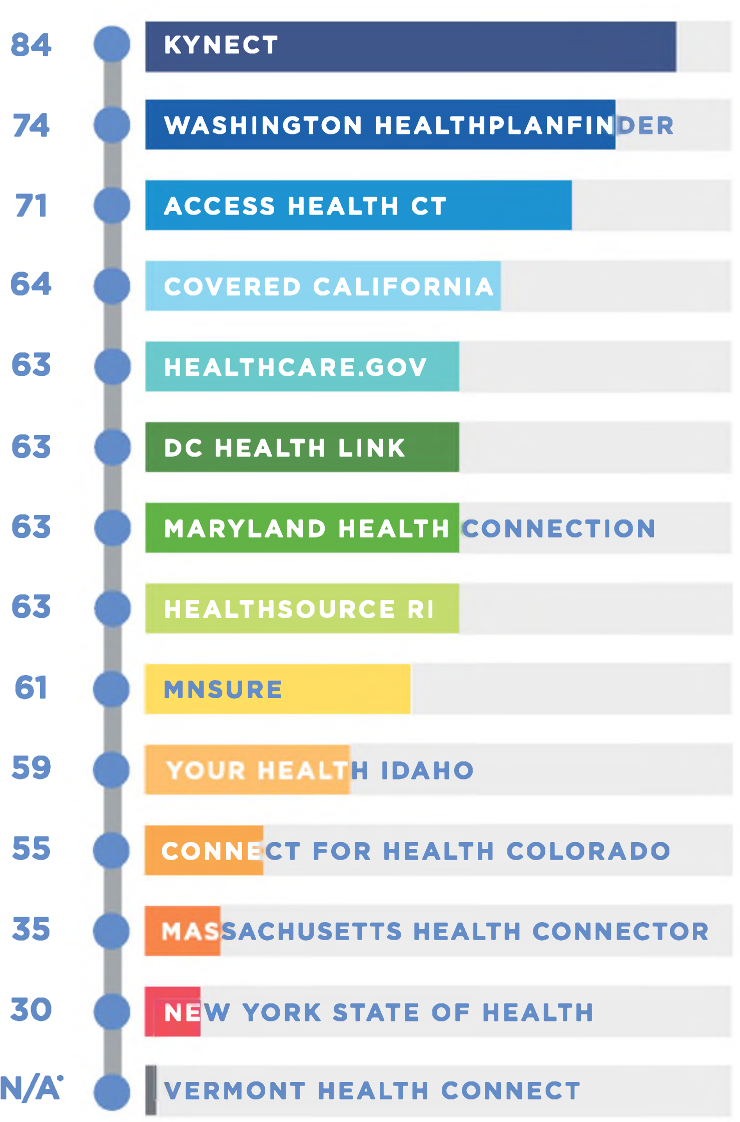
- **A** Displays language support prominently on the homepage for multiple languages.
- **B** Displays language support prominently on the homepage for a single language (usually Spanish).
- **F** Does not display language support on the homepage, does not provide language support through the website, or relies on basic google translation for language support.

INDEXED WEIGHTED COMPOSITE

The central finding of the 2016 Insurance Exchange Websites Scorecard is that the various exchange websites differ widely in their functionality and in how effectively they help consumers identify and select the health plans that best fit their unique circumstances. There is a question as to how meaningful those differences are, however. To help answer this, the final column of the scorecard provides a measure of relative functionality in the form of an *indexed weighted composite*. On this index, the highest possible score is 100.

As shown in Table B-1, most exchange websites are clustered in the middle of the distribution. HealthCare.gov, which operates in 38 states, has a score of 63, which also happens to be the median. Overall, there are clear leaders and laggards among the exchange websites.

TABLE B-1: INDEXED WEIGHTED COMPOSITE SCORES



In developing this composite, we weighted each of the 11 primary features evaluated in this study on a scale of 1 to 10, based on our assessments of their relative importance. We weighted seven of the 11 features as 10. Two features—"Default Order" and "Highlights CSR Plans"—we weighted as 8; while two other features—"Side-by Side Comparisons" and "Language Accessibility"—we rated as 5. For example, most of the websites provide Spanish language accessibility. Therefore, we felt that support for, say, Chinese or Tagalog (the third and fourth most widely spoken languages in the U.S.), was not on par with providing a window-shopping tool or Out-of-Pocket Cost Calculator. Those features with an 8 weighting were relatively less important only because other features could allow consumers to accomplish the same or similar tasks with, perhaps, another step or two. Had we weighted all factors as 10, the ranking would still be essentially the same, with modest differences in the middle of the distribution.

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VIEWPOINT

Choosing a Health Insurance Plan
Complexity and Consequences

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Individuals who dread the annual ritual of choosing a health insurance plan might take solace in learning that they are not alone in feeling overwhelmed by the complexity of plan choice. For many, selecting a health plan is a source of considerable confusion and distress. The complexity of plan choice arises in part from wide variation among plans across the 4 features that determine how health costs are shared between the insurer and enrollee: the deductible, co-payment, co-insurance, and out-of-pocket spending limits. Consumers aspiring to make an informed choice across plans must evaluate the trade-off between each of these cost-sharing features and premiums, after carefully considering their projected health expenses, because paying for greater cost-sharing makes most sense if a person anticipates significant medical costs. Recent research, however, suggests that most consumers do not understand even the basics of health insurance. A 2013 survey of 202 insured US adults found that only 14% could answer 4 simple multiple-choice questions regarding the definition of cost-sharing features. Additionally, when presented with a simplified plan, most respondents were unable to accurately estimate the cost of their medical services.[1] Complicating decisions further, plans typically differ on additional dimensions, such as which physicians are included in the network, the medical services covered, and insurer reputation for the speed and ease of processing claims.

Individuals who dread the annual ritual of choosing a health insurance plan might take solace in learning that they are not alone in feeling overwhelmed by the complexity of plan choice.

This lack of understanding has significant consequences. A recent study investigated the decisions of 23 894 employees at a Fortune 50 firm who "built" their own insurance policy from a menu of 48 plans that differed in cost sharing (eg, employees could choose between 4 available deductibles) and in premiums but were otherwise identical (eg, plans were administered by the same insurer and featured the same physician networks).[2] Because premiums for the plans were set in a manner that made high-deductible plans unambiguously less expensive than other plans, regardless of the employee's health or tolerance for financial risk, this setting provided a clear test of the ability of consumers to make good decisions. Employees failed this test. Sixty-one percent of employees chose plans for which no level or pattern of their health care spending could justify their choice. These mistakes led to overspending by employees equivalent to 42% of the cost of their yearly insurance premiums.

Intuition might point to the large number of available plans as the underlying cause for inefficient plan choice, but a series of follow-up studies found that individuals made nearly identical choices when given a small number of simply presented options. The research concluded that the main barrier to financially efficient choice was not the number of options confronting employees, nor the transparency of their presentation, but rather the same lack of basic understanding of health insurance revealed by survey respondents in the previously discussed study of health insurance literacy.

The consequences of complicated insurance plans extend beyond the choices people make between policies. Much of the complexity of health insurance comes from elaborate incentives designed to discourage inefficient use of medical services. However, such incentives are unlikely to have much influence on the decisions of individuals who do not understand their policies.[3,4]

The architects of the Affordable Care Act (ACA) were not naive to the perils of complicated plan choice. The legislation enacting the ACA funded informational outreach, standardized coverage so that every plan covered a set of basic medical services, and mandated transparent communication of plan details. Perhaps most notably, the ACA organized plans on its exchanges into 4 different cost-sharing "tiers." Within each tier, plans were required to cover a predetermined fraction of essential health expenses for the typical plan enrollee. Tiers were given distinctive metal labels corresponding to their actuarial level of coverage so that bronze plans paid approximately 60% of covered spending across all enrollees, whereas silver (70%), gold (80%), and platinum (90%) plans offered higher levels of financial coverage. However, one investigation of hypothetical plan choices with plan menus designed to mimic those of the exchanges found that metal labels (eg, bronze, silver, gold), rather than facilitating better decisions, worsened choices compared with generic labels (eg, plan A, plan B, plan C) (unpublished data, S. B., G. L., and S. Benartzi, "The Costs of Poor Health Plan Choice and Prescriptions for Reform." Carnegie Mellon University working paper). The same study found that alternative plan labels that encouraged consumers to forecast how much care they anticipated needing did have a modestly beneficial effect, suggesting that participants

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may have misinterpreted metal labels as signals of quality, or the breadth of services covered, rather than the degree of cost sharing.

Although the media and policy makers have devoted considerable attention to how the ACA has influenced the magnitude of plan premiums, the question of whether consumers make sensible choices given the premiums they face has been largely ignored. Despite strict regulations governing how plans are priced, consumers may risk financial loss by choosing a plan incommensurate with their health needs.

To appreciate the financial consequences of choice in the ACA exchanges, consider a childless couple of 40-year-old nonsmokers, with income level exceeding 400% of the Federal Poverty Level and residing in Pittsburgh, Pennsylvania. Based on their demographic characteristics and information about available plans in their area, last year this couple would have a choice of 54 plans ranging in annual premiums from $3648 to $10 584.[5] To simplify the example, suppose that this couple restricted themselves to a choice between the least expensive plans from each of the 4 tiers, which, in this example, happen to be offered by the same insurer. At one extreme, suppose the couple was relatively healthy and ended up needing little or no health services beyond preventive care. If this couple had wisely chosen the bronze plan, they would have spent a total of $3648 (premium + no out-of-pocket spending), which is less than half of the $8748 they would have spent had they chosen the platinum plan. At the opposite extreme, suppose the couple was unhealthy and incurred medical care costs that exceeded the spending limits set by the ACA (eg, an episode involving a short hospitalization). This couple would have spent a minimum of $11 184, had they chosen the gold plan (the best plan for them), and up to $17 292 if they had chosen the silver plan (the worst plan for them). The differences in projected spending are unaffected by the premium tax credit for which most enrollees are eligible, but which can be applied to any tier. These estimates would change for the smaller number of couples whose income qualifies them for a cost-sharing reduction, which requires enrolling in a silver tier plan. The consequences of plan choice are therefore significant. To make a financially efficient choice, enrollees, most of whom lack extensive prior experience with insurance, would have to carefully consider the complicated relationship between plan cost, cost sharing, and their expected health risk.

Given the complexity and consequences of these decisions, what can policy makers do? Behavioral economists have proposed strategies such as providing consumers with decision aids—eg, education through scenario-based examples or personalized recommendations—or, more aggressively, the use of plan "defaults" or restricted menus tailored to each consumer.[6] However, while intelligently designed choice architecture has improved decisions in other domains,[7] a more effective long-term policy would be to encourage substantial simplification of health insurance. Insurance products free of the complex features that consumers are least able to understand, such as deductibles and co-insurance, would more likely help consumers make informed decisions regarding plan choice and utilization. Simpler insurance may also lead to better market outcomes, such as lower-priced and higher-quality plans. Recent research by behavioral economists finds that when consumers are confused about product features—for example, by credit cards with short-lived "teaser" rates—market competition is less likely to benefit consumers in the ways that economists typically predict.[8]

The economic rationale policy makers have offered for the expansion of choice (as exemplified by the 47 plans available to the typical ACA enrollee) is that greater choice will enable consumers to find plans that meet their needs and will stimulate competition among insurers, leading to improvements in plan price and quality. However, these benefits are unlikely to emerge if consumers are incapable of making informed plan comparisons. Taken together, the evidence suggests that policies advancing the fundamental simplification of insurance may offer the greatest promise of improving the quality of enrollee decisions, encouraging advantageous competition between insurers, and alleviating the anxiety that grips consumers every year during open enrollment.

ARTICLE INFORMATION

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ISSUE BRIEF

KEY PROPOSALS TO STRENGTHEN THE AFFORDABLE CARE ACT

Timothy Stoltzfus Jost and Harold Pollack | December 15, 2015

ISSUE BRIEF

KEY PROPOSALS TO STRENGTHEN THE AFFORDABLE CARE ACT

Timothy Stoltzfus Jost and Harold Pollack | December 15 , 2015

Though not yet six years old, the Affordable Care Act (ACA) has accumulated a record of remarkable accomplishments. Despite uncompromising political opposition; widespread public misunderstanding; serious underfunding; numerous lawsuits, three of which have so far made it to the Supreme Court; and major technological failures at launch, the ACA has largely succeeded in its principal task—enrolling tens of millions of people in health insurance coverage. Indeed the period from 2010 to 2015 may be the most successful five years in the modern history of health policy.

The ACA has already achieved many significant accomplishments:

- The ACA has reduced the ranks of the uninsured by an estimated 17.6 million since it was adopted in 2010.[1] This is a striking reduction, especially in light of the refusal of twenty states to implement the ACA's Medicaid expansion, one of the ACA's core coverage strategies.[2] The percentage of Americans under the age of 65 who lack health insurance is now lower than at any point in the past five decades (see Figure 1).

- Hospital expenditures for uncompensated care have plummeted by $7.4 billion, with the decline particularly great in states that embrace the ACA's Medicaid expansion.[3]

- Health care prices have grown at an annual rate of 1.6 percent since the ACA was adopted, roughly in line with overall inflation and the slowest rate for any comparable period for the past half century.[4] Economic conditions have contributed to this favorable trend, but the ACA also played a helpful role.

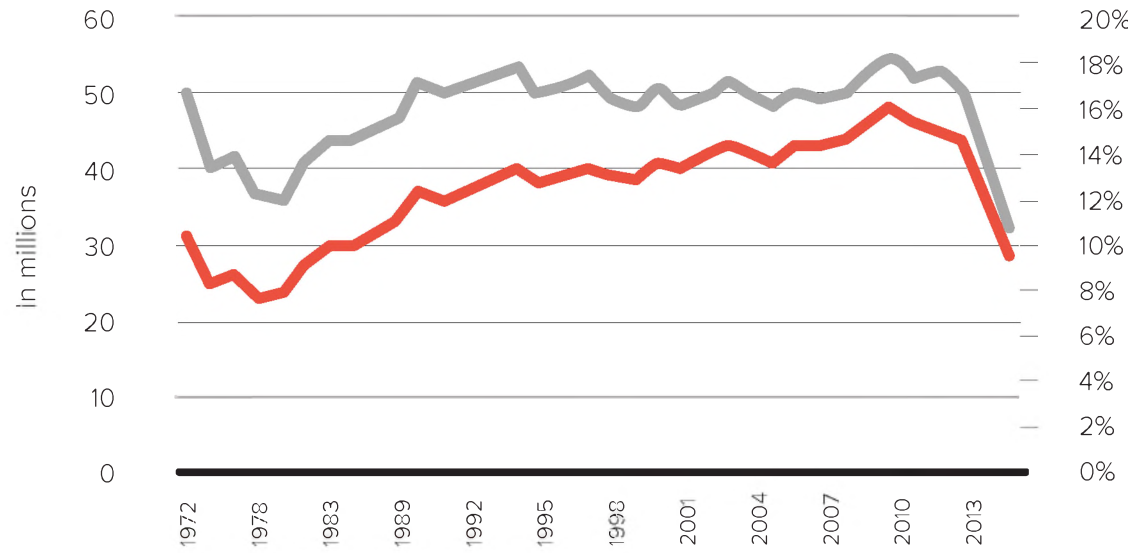
- Public health care expenditure growth has markedly slowed, which suggests the change extends beyond transient economic patterns

This brief can be found online at: http://apps.tcf.org/key-proposals-to-strengthen-the-aca

FIGURE 1

UNINSURED AMERICANS UNDER AGE 65

1972 to 2015



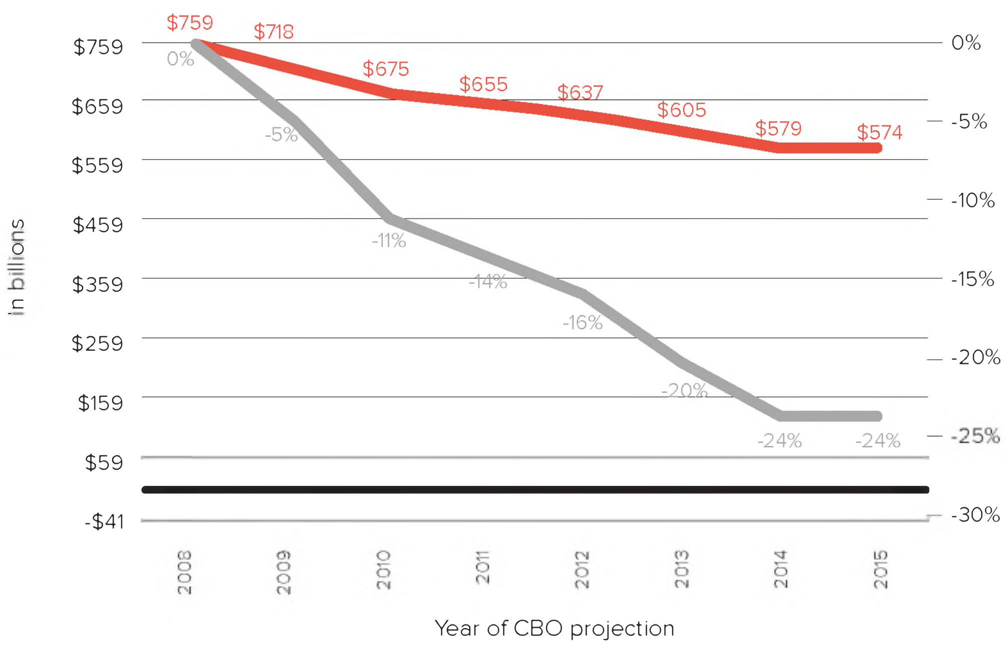
Source: Centers for Disease Control and Prevention, National Health Interview Survey, uninsured status at time of survey, 1972–2015.

associated with the Great Recession. The ACA is now projected to reduce budget deficits far more than was projected at the bill's passage.[5] Between January and March 2015 alone, the Congressional Budget Office (CBO) and the Joint Committee on Taxation reduced their estimated costs of ACA's 2015–2025 coverage provisions by $142 billion.[6] Medicare expenditure growth has fallen markedly below original projections. In 2008, for example, CBO's projected that Medicare's net mandatory outlays would be $759 billion in calendar year 2018. CBO now projects that Medicare will spend only $574 billion in that same year, 24 percent less than predicted before the ACA (see Figure 2). State expenditures associated with the ACA have also been restrained, with lower Medicaid expenditure growth observed within states that embraced the ACA's Medicaid expansion than in their non-expansion counterparts.

- Average monthly premiums on the new marketplaces are proving reasonable, with manageable premium growth in most major markets since the ACA's enactment.[7] Between 2014 and 2015, the population-weighted national average premium increase in the lowest-cost silver plan was 2.9 percent.[8] Although 2015–16 premium growth varies by location and plan, average premium growth for the benchmark second-lowest cost silver plan was 7.2 percent,[9] well below average premium growth in the three years preceding the ACA.[10]

FIGURE 2

PROJECTED NET MANDATORY MEDICARE OUTLAYS FOR 2018



Source: Congressional Budget Office, Updated Budget Projections, individual years, 2008–2015.

- Recent data on hospital infection, preventive care, and avoidable hospital readmission (alongside continued striking progress in age-adjusted survival) suggest that American medical care is better[11] and safer[12] than it has ever been. Incentives and new payment arrangements enacted under the ACA played an important part in these improvements.

Despite these accomplishments, our health care system continues to face serious challenges, some traceable to flaws and weaknesses in the ACA. The ACA undertook from the beginning an ambitious reform agenda, but some of its approaches have turned out to be ineffective, poorly targeted, or not ambitious enough to address deeply rooted problems.

Many of the remaining challenges in health care reform reflect the inherent complexities and path-dependency of the American system and were beyond the reach of any politically feasible reform. Perhaps the most serious problem—which this report will address repeatedly—is the inadequacy of the ACA's subsidies and regulatory structures to address the problems of low-income Americans, for whom merely meeting the costs of day-to-day essentials is a continuing challenge, and for whom even modest monthly insurance premiums and cost-sharing are often serious barriers to health coverage and care.[13]

This report identifies problems and suggests potential solutions. Some solutions would require federal legislation. Others could be implemented by the administration, state law, or by private parties.

Some of our solutions are concrete and practical. Others are intended to provoke further thinking and debate. We have not precisely estimated costs and benefits, something that should be done before implementation. We understand that many of our proposals are not immediately politically viable. We believe it is important to think now about what should be done, and what the most important choices will be when political opportunities present themselves.

The first and second sections of our report describe steps to expand health care coverage and improve its affordability, particularly for low- and moderate-income Americans. The third section deals with improving the health care shopping experience for those who use health insurance marketplaces. The final section recommends improvements in the Medicaid program, which covers the lowest-income Americans.

In all, we propose nineteen steps that could help fix recognized flaws in the ACA as well as build on its accomplishments. Taken together, these proposals would further improve the access and affordability of health care under the ACA, create more robust provider networks, enhance competition among insurers, improve the consumer experience, and strengthen the Medicaid program. We understand that in the current political climate, improvements to the ACA that require congressional action are unlikely. Yet an administration committed to improving access could take some of the actions we recommend without new legislation, while other proposals could be implemented by the states, marketplace, or simply by insurers.

1. Expanding Access to Health Coverage for Moderate-Income Americans

Fix the Family Glitch. Congress should clarify the legislative drafting ambiguity that led to the "family glitch," or the White House should direct the Internal Revenue Service to interpret relevant sections of the Internal Revenue Code, so that working families are not excluded from marketplace tax credits. The result could allow up to 4.7 million people to gain access to subsidized health care coverage.

Reduce Complexity in the Tax Credit Program. The Internal Revenue Service should provide applicants to the ACA's Advanced Premium Tax Credit program with clear and comprehensive explanation of how their credit was calculated as well as regular statements on applicant income so that burdensome tax credit reconciliations can be avoided. The result could help protect more of the approximately 4.8 million eligible taxpayers from receiving overpayments in advance premium tax credits.

Increase Credits for Moderate- and Middle-Income Families. Congress should consider either increasing the size and scope of the Advanced Premium Tax Credit program, or adding fixed-dollar, age-adjusted tax credits to the mix to improve access to affordable health insurance for moderate- to middle-income households. The result could dramatically expand coverage for families who currently receive little assistance under the ACA.

2. Making Health Care Affordable

Reduce Cost-sharing and Out-of-Pocket Limits and Improve Minimum Employer Coverage Requirements. Congress should amend the ACA to expand eligibility for cost-sharing reduction payments and reduce out-of-pocket limits for moderate-income individuals or families. Congress or the administration should also improve minimum essential coverage and minimum value requirements to ensure that employees receive at least a minimum level of protection from employee coverage. These reforms could increase the affordability of coverage for millions of Americans.

Increase Use of Health Savings Accounts for Moderate-Income Americans. Congress should align the requirements of the ACA and of the health savings account program and consider offering subsidies for health savings accounts for moderate-income individuals and families. This could make health care more affordable for millions of moderate-income Americans.

Allow Use of Health Reimbursement Accounts to Purchase Health Insurance. Congress should amend the Internal Revenue Code to allow small employers to use health reimbursement accounts, with appropriate safeguards, to help the employees purchase health insurance. This could make health insurance more affordable for millions of people.

Incorporate Value-based Insurance Design to Support Coverage for High-Value Services. The ACA requires insurers to reimburse clinical preventive services without patient cost-sharing if these services receive an "A" or "B" rating from the U.S. Preventive Services Task Force. In similar fashion, expert bodies could require public and private insurers to cover high-value secondary prevention and disease management services without copayments or deductibles.

Improve State Regulation of Network and Formulary Adequacy. States should adopt legislation or amend existing legislation to ensure that insurer networks and formularies are adequate and nondiscriminatory. Control over networks is a legitimate approach to controlling health care costs and ensuring provider quality, but networks must be regulated to ensure that plan enrollees can access necessary care and are not discriminated against because of their medical conditions.

Improve Protection from Balance Billing. States should adopt legislation to protect network plan enrollees from balance billing when they access care in emergencies or through network providers. This is necessary to ensure that network plan enrollees are not burdened by crippling medical bills when they have not intentionally sought care out of network.

3. Improving the Consumer Marketplace Experience

Actively Guide Consumers in Coverage Selection. The marketplaces should provide better tools, and personal assistance, to consumers to select plans. This could help ensure that consumers enroll in the plans best suited to their needs and 8resources.

Improve Network and Formulary Transparency. The marketplaces and state regulators should demand greater network and formulary transparency from insurers and deploy tools to help consumers better understand the networks and formularies available to them. This could help ensure access to appropriate care and continuity of care for consumers.

Standardize Insurance Products. Marketplaces should standardize products their insurers offer. This would facilitate and improve not only consumer choice but also insurer competition.

4. Improving Medicaid for Low-Income Americans

Have the Federal Government Permanently Assume the Entire Cost of the Medicaid Expansion Population. Congress should make permanent the 100 percent federal match for the adult Medicaid expansion population. This could encourage states to expand Medicaid coverage and protect the expansion population from future state budget-based cutbacks.

Constrain 1115 Waivers. Section 1115 waivers have proven an effective tool to permit the administration to accommodate the concerns of states reluctant

to expand Medicaid. The administration needs to take care, however, that 1115 waivers are not used to undermine basic protections of the Medicaid program or to discourage enrollment.

Eliminate Medicaid Estate Recoveries from the Expansion Population. Congress or the states should prohibit estate recoveries from the expansion population. Individuals should not be discouraged from seeking the medical help they need for fear that, once they die, their beneficiaries may have to pay for the health care they received.

Improve Medicaid Payment Rates. The Department of Health and Human Services and the states should take action to ensure that Medicaid payment rates are sufficient to ensure adequate provider participation. Medicaid beneficiaries need not only a guarantee of coverage but also of actual access to available providers.

Ensure a Judicially Enforceable Right to Adequate Access to Medicaid Providers and to Adequate Medicaid Payment Rates. Recent court decisions have undermined the long-standing right of beneficiaries and providers to sue in federal court to ensure state compliance with federal Medicaid requirements. Congress should clarify continuing rights of access to federal court for Medicaid beneficiaries and providers to ensure that beneficiaries enjoy the access to care guaranteed them by federal law.

Reconsider a "Public Option" Early Medicare Coverage within Health Insurance Marketplaces. Individuals should have the option of purchasing Medicare coverage on state marketplaces. As an initial step, the Centers for Medicare and Medicaid Services should design an actuarially fair benefit package available on the new marketplaces for participants over the age of 60.

Raise or Eliminate Medicaid and Supplemental Security Income Asset Limits for People Living with Disabilities. The ACA does not impose asset limits for the Medicaid expansion population. Stringent asset limits remain, however, for individuals who qualify for Medicaid because of qualifying disabilities. States and the federal government should raise or eliminate these asset limits, which harm individuals with disabilities and their families.

1. EXPANDING ACCESS TO HEALTH COVERAGE FOR MODERATE-INCOME AMERICANS

Before the ACA's passage, the United States had the most complicated health care financing system in the world. The ACA made that system even more complicated, by adding the new health insurance marketplaces, Medicaid expansion, and other innovations.

Employer-sponsored group coverage remains the foundation of our health financing system. Federal and state governments heavily subsidize this form of coverage through exclusions from federal income and payroll taxes and from state income tax of employer and often employee contributions for coverage. Americans have also traditionally obtained coverage through many other channels. The elderly and many people with disabilities, for example, qualify for Medicare, while certain categories of the poor have long qualified for Medicaid and then CHIP. Programs such as the Veterans' Administration and Indian Health Services cover other specific populations. These various forms of health care and coverage are financed through multiple funding streams that are often poorly coordinated. Care and coverage are also regulated by different federal entities and by fifty state governments, whose priorities, political perspectives, administrative structures, and regulatory requirements are often quite different.

TABLE 1

REQUIRED FAMILY COST OF COVERAGE UNDER ACA'S ADVANCED PREMIUM TAX CREDIT

HOUSEHOLD INCOME PERCENTAGE OF FEDERAL POVERTY LINE:	ANNUAL MAGI FOR FAMILY OF THREE	INITIAL MAXIMUM COST OF COVERAGE AS % OF INCOME	FINAL MAXIMUM COST OF COVERAGE AS % OF INCOME
Less than 133%	Less than $26,270	2.03%	2.03%
At least 133% but less than 150%	between $26,720 and $30,1353	.05%	4.07%
At least 150% but less than 200%	between $30,135 and $40,1804	.07%	6.41%
At least 200% but less than 250%	between $40,180 and $50,225	6.41%8	.18%
At least 250% but less than 300%	between $50,225 and $60,270	8.18%9	.66%
At least 300% but not more than 400%	between $60,270 and $80,360	9.66%	9.66%

Source: Internal Revenue Service, "Internal Revenue Bulletin: 2014-50," December 8, 2014, https://www.irs.gov/irb/2014-50_IRB/ar11.h

Although the ACA included reforms aimed at virtually all of the various pieces of our patchwork of coverage, it left most pre-existing programs largely intact. Most Americans continue to get health coverage as they always have, largely unaffected by the ACA. When the ACA did affect individuals' existing health coverage, it primarily expanded coverage, for example by abolishing annual and lifetime limits for employer coverage, allowing coverage for young adults to age 26 under their parents' plans, or closing the drug coverage "donut hole" for Medicare beneficiaries.

The most dramatic effect of the ACA has been to help people who were not previously covered. Before 2014, most working-age adults under age 65 who were not offered health insurance through employment were not eligible for any government assistance or tax subsidies to help them purchase health coverage. Many people were unable to afford health insurance unassisted.

The ACA took two approaches to extending coverage. First, it expanded Medicaid eligibility to cover individuals and families with incomes below 138 percent of the federal poverty level (FPL) who were not otherwise covered. Second, it offered tax credits on a sliding scale to individuals and families with incomes between 100 and 400 percent of the FPL—who were not otherwise offered coverage in government programs or affordable and adequate employer-based coverage—to help them purchase health insurance through state health insurance marketplaces. In 2015, individuals are thus eligible for financial help as long as their annual incomes are below $47,080. A family of four is eligible for some premium assistance at incomes less than about $97,000.

The Medicaid expansion has not reached all Americans. The Supreme Court's 2012 decision in the *National Association of Independent Business* case seriously

weakened the Medicaid expansion by allowing states to opt out. Currently more than three million adults in twenty states are uncovered because of that decision.[14] Even so, the ACA has cut the portion of currently uninsured American residents under age 65 from 18.2 percent in 2010 to 10.7 percent in 2015.[15]

Furthermore, while the tax subsidy approach can claim many successes, it remains cumbersome and it has not been wholly effective. More than half of the 9 million moderate-income Americans currently enrolled through the ACA marketplaces were uninsured before they obtained such coverage.[16] Yet millions of Americans remain uninsured. Over 5 million of the uninsured remain uncovered because Congress deliberately excluded individuals not lawfully present in the United States from federal assistance.[17] Others remain uncovered, or may lose coverage, because the ACA premium tax credit assistance program is so complex, because they do not know that assistance is available, or because the cost of insurance, even with assistance, is still too high for them to afford.[18]

We shall describe strategies for improving Medicaid coverage later in this report. The rest of this section will focus on gaps in and limitations of the tax subsidy approach to making coverage affordable for moderate-income Americans.

Improving the Process for Awarding Advanced Premium Tax Credits

At the time the ACA was enacted, political realities dictated that assistance for moderate-income Americans must be provided through tax credits rather than through a new entitlement program.

Many of ACA's greatest challenges arise from the basic reality that the subsidy structure is poorly suited to financing health coverage for low- and moderate-income Americans.[19] Political and cost constraints also limit the generosity of these tax subsidies, which compounds the challenge for millions of people who require financial assistance to purchase health coverage.

Those with incomes below 400 percent of the federal poverty level (FPL) are eligible for at least some subsidies on the state marketplaces. Low- and moderate-income applicants for Advanced Premium Tax Credits (APTC) must predict their household income (actually, their modified adjusted gross income, or MAGI) for the entire coming year at the time of application (see Box 1). Yet the actual tax credits are based on retrospectively reported income as determined at tax-filing time.

Predicting household finances is especially challenging for individuals with fluctuating incomes. It is also difficult because household income includes not only the income of the applicant, but also the incomes of other household members. Even predicting household composition for an entire year may be challenging, as enrollees marry, divorce, have children, or die.

In relying on tax credits to expand coverage, the ACA follows a familiar strategy. Although America has maintained large health care entitlement programs for the elderly and poor, it has long relied—with bipartisan support—on the tax system to subsidize health coverage for the majority of Americans, who receive employer-sponsored coverage.[20]

The IRS has demonstrated impressive administrative capacity to manage many aspects of this process, and has long operated programs such as the Earned Income Tax Credit (EITC), which rank among the most successful and popular efforts to assist low-income Americans. Moreover, income-based tax credits, as opposed to fixed-dollar tax credits, are a reasonably effective way of ensuring that coverage will be roughly affordable regardless of a family's income.

BOX 1

THE COMPLEXITY OF THE ACA'S ADVANCED PREMIUM TAX CREDIT

The ACA marketplace compares applicants' projected income to income reported on past tax filings and to other available income information. If there is a significant discrepancy, the marketplace may request further verification. The applicant must also meet other eligibility requirements including citizenship or lawful presence status, and the applicant must lack access to a government program or employer coverage deemed affordable and adequate under ACA. If all these conditions are met, the marketplace will deem the individual eligible for a premium tax credit.

The ACA requires individuals eligible for tax credit assistance to pay for a portion of the cost of coverage, up to a certain percentage of gross household income. This percentage increases with applicants' household income.* Marketplace participants with incomes below 150 percent of the federal poverty level (FPL); currently about $36,000 for a family of four) are initially required to pay 2.03 percent of their household income (see Table 1). Households with incomes between 300 and 400 percent of the FPL (between $73,000 and $97,000 for family of four) required to pay up to 9.66 percent. (These percentages will increase as the cost of health insurance increases.)**

Individuals' tax credits are set based upon income, household size, and the premium of the second-lowest cost silver-tier plan available to the household through the marketplace.*** Tax credits are paid on a monthly basis to the insurer that covers the household. If household income or other eligibility factors change during the year, the taxpayer is supposed to report the change to the marketplace, which must recalculate APTC eligibility and the accompanying subsidy.

At the end of the tax year, the marketplace submits to the taxpayer and to the IRS a 1095-A tax form, which indicates the amount of advance tax credits that the individual received during the year. Taxpayers must then file with their annual tax filing a form 8962 recalculating eligibility for premium tax credits based on the taxpayer's modified adjusted gross household income (MAGI) for the past tax year.

If the taxpayer was eligible for a larger premium tax credit given MAGI for the full year than was actually received, the additional amount will be credited against taxes owed or refunded. If a taxpayer received a larger premium tax credit than the taxpayer was eligible to receive, the excess amount is added to the taxes otherwise owed or subtracted from a refund otherwise due. The amount that can be recovered by the IRS through this reconciliation process is capped, with the amount of the cap varying from $300 to $1,500 for individual coverage based on household income. If household income exceeds 400 percent of FPL, however, the taxpayer must pay back the entire premium tax credit, with no accompanying cap.

* In states that enacted ACA's Medicaid expansion, households with incomes below 138 percent FPL are eligible to enroll in Medicaid, with those of higher incomes eligible to receive marketplace assistance. In non-expansion states, individuals with incomes below 100 percent FPL are not eligible for financial assistance. Those with higher incomes may receive marketplace assistance. Lawfully-present immigrants who are not eligible for Medicaid are eligible for marketplace assistance below 100 percent of the federal poverty level.

** J. James, "Premium Tax Credits Low- and Middle-Income Individuals and Families Will Be Eligible for Federal Subsidies to Purchase Insurance Through the New Exchanges," Health Affairs/Robert Wood Johnson Foundation, August 2013, http://www.rwjf.org/en/library/research/2013/08/premium-tax-credits.html.

*** Technically, the benchmark premium is the premium of the second-lowest cost silver plan available to the particular enrollee at the time of enrollment considering only that portion of the premium that covers essential health benefits.

The formulas used for calculating premium tax credits under the ACA also adjust payments to take account of premium variations in different insurance markets, household size, and the age of household members.

Yet the ACA's program of advanceable tax credits is inescapably complex. Tax credits available under the ACA are often insufficiently generous to provide affordable coverage. Gaps in the current law also leave coverage unaffordable for many households. Were it politically possible, we would abandon the tax system as the mechanism of covering low-income Americans and extend Medicaid or Medicare or create a new program to do so. Given the daunting political obstacles to such approaches, we offer instead recommendations for improving the current system. We first address the biggest gap in the current program—the "family glitch"—and then the complexity of the tax credit approach.

FIX THE FAMILY GLITCH

The so-called "family glitch" may be the most glaring defect in the current ACA tax credit system.[21] Fixing the family glitch is essential to providing low-income working families access to affordable health coverage.
Under the ACA, workers are ineligible for marketplace tax credits if their employer offers them health insurance coverage that is deemed to be adequate and affordable. The family glitch arises because of the way in which affordability is actually defined. Current IRS regulations deem employer-sponsored coverage affordable if individual coverage (*covering only the individual worker and not the worker's family*) costs less than 9.56 percent of household income.[22] (Throughout this report, affordability and eligibility levels will be provided in the inflation-adjusted percentages that apply for 2015. These percentages will be higher for 2016 and subsequent years).

This rule is fair for single workers, but not for many workers with families. Workers who need family coverage may be cut off from access to marketplace tax credits, even when the (much higher) cost of family coverage greatly exceeds 9.56 percent of income.[23] Many children in low-income families caught in the family glitch may be eligible for the Children's Health Insurance Program (CHIP). CHIP offers other advantages over marketplace plans, particularly for children experiencing significant health needs. However, half the states set the CHIP eligibility level at 255 percent of poverty or less, leaving many families excluded from marketplace coverage by the family glitch also unable to get CHIP coverage for their children.[24]

Although the family glitch is often described as a legislative drafting error, it results from questionable statutory interpretation by the IRS (see Box 2). Whether this problem is addressed by Congress or administratively, and whether relief is extended to all individuals in affected families or just to dependents, it is important to provide working families the financial help they need to gain practical access to affordable health insurance.

RAND Corporation researchers recently examined two alternatives for fixing the family glitch. The first approach would allow all family members, including employed family members with access to affordable individual coverage, to be eligible for the APTC if employer family coverage were unaffordable; the second approach would give only dependents access to APTC subsidies.[25] (Alternatively, employees who lack access to affordable family coverage could be offered subsidized coverage to child-only policies.[26]) Linda J. Blumberg and John Holahan of the Urban Institute performed similar analyses, and obtained consistent estimates.[27]

The RAND team estimates that granting eligibility to all family members would allow 4.7 million people to gain access to subsidized coverage, reducing the

BOX 2

THE COMPLEXITY OF THE ACA'S ADVANCED PREMIUM TAX CREDIT

Internal Revenue Code section 36B(c)(2)(C), added by section 1401 of the ACA, provides that an employee is eligible for premium tax credits if the employee is offered employer-sponsored coverage and if "(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income." The provision further states: "This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee."

Section 5000A(e)(1)(B) (which governs the applicability of the individual mandate), similarly provides that affordability for purposes of the individual mandate is based on the cost of self-only coverage. Section 5000A(e)(1)(C), however, provides:

- For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

This provision could be interpreted to refer to the "required contribution" for family coverage, and indeed the agencies have interpreted the provision to mean this for application of the individual mandate tax. That is, taxpayers cannot be penalized for failure to purchase available employer coverage for their families if their required contribution for family coverage was not in fact affordable (applying an 8.05 percent rather than a 9.5 percent (now 9.56 percent) standard for mandate exemption purposes).

The tax credit affordability standard is clearly based on the individual mandate affordability exemption coverage, and the agencies should apply the same standard, eliminating the family glitch. Of course, Congress could also amend the ACA to definitively fix the family glitch.*

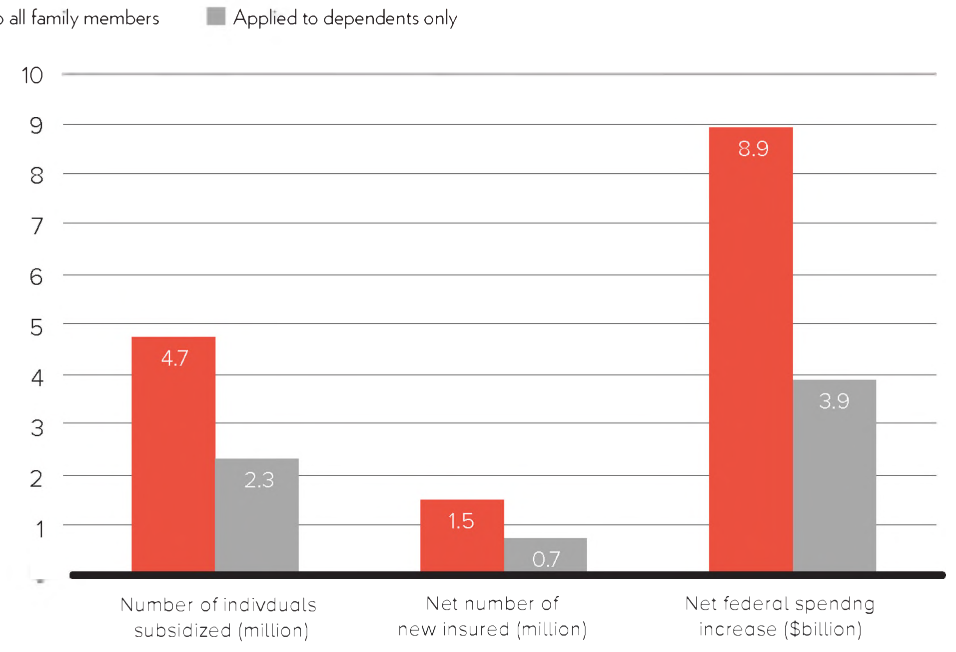
* Brittany La Couture and Connor Ryan, "The Family Glitch," American Action Forum, September 18, 2014, http://americanactionforum.org/research/the-family-glitch.

uninsured population by approximately 1.5 million people, with an accompanying net federal spending increase of $8.9 billion, slightly less than a 9 percent increase over the current baseline of $104 billion. The second approach would allow 2.3 million people to gain access to subsidized coverage, with an accompanying net federal spending increase of $3.9 billion, and a corresponding reduction of about 700,000 in the number of uninsured. (See Figure 3, p. 12.)

Average spending for health care in 2017 for those affected by the change would decrease from a projected average of $6,564 under the current rules to $4,290 under the first option and $4,484 under the second. The proportion of affected working families spending more than 10 percent of their income on health care in 2017 would decrease from 87 percent under current rules to 47 percent under the first option or 58 percent under the second. Fixing the family glitch would come at some cost, but also would bring significant benefits for those who lack access to coverage because of it. It should be the place to start for expanding ACA coverage for families with incomes above the Medicaid eligibility level.

FIGURE 3

ESTIMATED IMPACT AND COST OF FIXING THE "FAMILY GLITCH"



Source: Sarah A. Nowak, Evan Saltzman, and Amado Cordova, "Alternatives to the ACA's Affordability Firewall," RAND Corporation, report RR-1296-RC, 2015, http://www.rand.org/pubs/research_reports/RR1296.html.

REDUCE COMPLEXITY IN THE TAX CREDIT PROGRAM

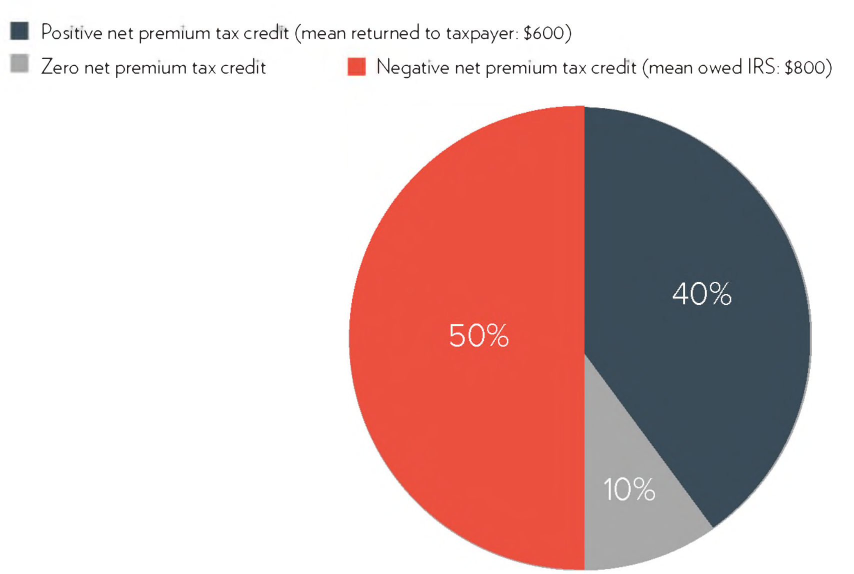
The complexity of the ACA's tax credit program is daunting. To begin, many taxpayers cannot fulfill the ACA's request of accurately projecting their household income a year in advance. Taxpayers earning less than 400 percent of FPL often experience variable work hours. Their incomes may depend upon the generosity of tip income, demand for a product or service, even, in many jobs, on the weather. A taxpayer or household member may gain or lose a job over the year, move from part-time to full-time status, or visa-versa. Moreover, tax credits are based on household size and composition. But household composition and size change, as babies are born, couples marry or divorce, people die, or older children become independent.

Tax year 2014 statistics on the functioning of the tax credit program reflected these uncertainties. In 2014, for only 10 percent of taxpayers eligible for the APTC did the credits paid out in advance equal the credits for which taxpayers were in fact determined to be eligible when they filed their taxes.[28] Fifty percent had to pay back excess APTC. Forty percent received additional tax credit amounts when they filed their taxes because they received too little APTC given their final income. Most (about 65 percent) of those who received excess APTC did not have to make a specific additional payment to the IRS because the excess amount was recovered from a tax refund to which they otherwise have been entitled. (See Figures 4 and 5.)

Yet another issue looms for APTC recipients who are not following through on their tax filing obligations

FIGURE 4

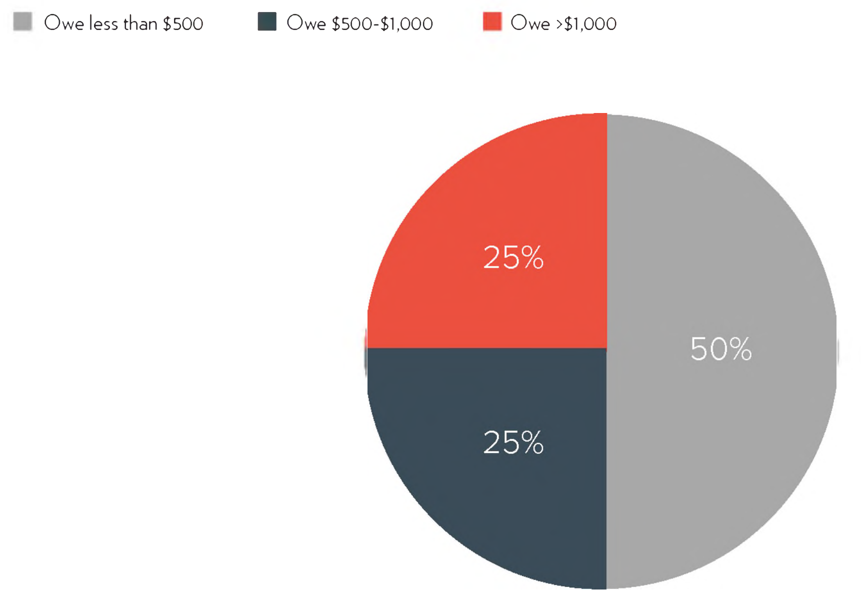
RECONCILING ADVANCED PREMIUM TAX CREDITS



Source: John Koskinen, IRS Commissioner, Letter to Congress, July 17, 2015, https://www.irs.gov/pub/irs-utl/CommissionerLetterlwithcharts.pdf.

FIGURE 5

AMOUNT OWED IN TAXES AMONG RECIPIENTS OF EXCESS ADVANCED PREMIUM TAX CREDITS



Source: John Koskinen, IRS Commissioner, Letter to Congress, July 17, 2015,https://www.irs.gov/pub/irs-utl/CommissionerLetterlwithcharts.pdf

under the ACA. As of June 2015, only 3.2 million of the 4.8 million taxpayers who were required to file a form 8962 to reconcile the APTC they received with the credits to which they were actually entitled had done so.[29] Taxpayers who fail to file these forms by the end of 2015 will not be entitled to reenroll for APTC for 2016.

One simple step to smooth the functioning of the APTC and avoid burdensome reconciliations would be to improve the accuracy of the credits by providing coverage applicants with a clearer and more comprehensive explanation of how their APTC was calculated.

Currently, applicants receive a statement when they become eligible that tells them the amount of their APTC and the amount of income on which APTC were based. Eligibility may be calculated based on the income reported by the applicant or on income drawn from prior tax records or other sources. A more transparent explanation could explain how the income was computed, including what income was considered in calculating the amount. The current notice informs the taxpayer that changes in income, available coverage alternatives, or household composition must be reported and that failure to do so may result in the taxpayer having to pay back overpayments, but the notice could include examples of how changes in household income or size might affect the amount the taxpayer would have to pay back.

Taxpayers could also be sent quarterly notices including the income projections on which their tax credits are calculated and advised to report any changes in income to avoid over- or under-payment of their APTC. Monthly premium statements from insurers could also remind enrollees of their obligation to keep enrollment information current. The issuance of the 1095-A form that enrollees are sent to assist with tax reconciliation could be moved up to mid-January to ensure that taxpayers received early notice of their need to file taxes and the amount of APTC on which their taxes would be calculated.

The reconciliation process could also be adjusted to ease the burden of reconciliation. Under current regulations, applicants' income estimates need no verification if estimated income is no more than 10 percent below the amount found in other data sources, such as tax records.[30] In fact, the federally facilitated marketplace will accept a 20 percent variance based on a taxpayer's income attestation when validating taxpayer income claims.[31] Of the 1.6 million taxpayers who had to repay excess APTC for 2014, half owed less than $500. Of the 1.3 million who were underpaid, 65 percent received less than $500.[32]

Allowing some variance from projected to actual income at the time of reconciliation could reduce administrative complexity and taxpayer burden. Taxpayers could be excused from having to pay back tax credits if their final household income were within a certain percentage (perhaps 10 percent) of their projected income, as long as the taxpayer did not intentionally underreport income. Taxpayers who were determined to have received less in APTC than they were entitled by the same percentage of variation would not receive an additional payment unless they had intentionally foregone advance payment of the full tax credit. The total amount that an individual would have to repay would still be subject to caps, although these should be reduced from the current amounts to amounts closer to those found in the original ACA ($250 for individuals, $400 for families).[33]

Taxpayers should also have the option of the IRS reconciling their APTC and actual premium tax credits rather than having to do it themselves. The IRS has access to most of the information available to taxpayers for determining the credit—most importantly the total amount of APTC received and number of covered family members reported on the 1095-A, and the final

amount of the taxpayer's income, reported on form 1040.[34] Taxpayers should have the option of reconciling the amount of APTC they received and the amount to which they were entitled using the form 8962—the tax reconciliation form--and would have to do so if special circumstances apply, such as a mid-year marriage. If they fail to do so, however, the IRS could simply perform the reconciliation calculation for them, assuming the information on form 1095-A to be correct. Taxpayers could be notified on the form 1095-A that the IRS will perform the reconciliation calculation for them if they fail to file a form 8962. No one should lose access to premium tax credits simply because they fail to file this form.

Assisting Moderate and Middle-Income Uninsured Individuals and Families

Although Medicaid, tax credits, and cost-sharing reduction payments help make insurance affordable, health insurance is still so costly for many moderate- and middle-income Americans that they refuse coverage.[35] An estimated 9 million Americans with incomes exceeding 300 percent of the poverty line are uninsured (see Figure 6, p. 16).

Current tax credits require individuals and families with incomes below 200 percent of FPL to pay too much before tax credits take over. One consequence is that many low-income workers are declining subsidized employer-based and marketplace-based coverage. One employer noted to the New York Times' Robert Pear that persuading hourly workers to buy insurance is "like pulling teeth." Most workers whose weekly take-home pay is about $300 will not spend $30 of that on insurance, particularly on policies with significant deductibles and copayments.[36]

Reducing (or eliminating) premiums for Medicaid-ineligible families below 150 percent of the FPL would greatly improve take-up among those in greatest need. Affordability is also a problem among those with higher incomes. More than 15 million uninsured Americans have incomes in excess of 200 percent of FPL, while 5.7 million uninsured have incomes above 400 percent of the poverty level.[37]

Households with incomes above 400 percent of FPL are not entitled to financial assistance, and few have sought coverage through the marketplaces.[38] The current structure imposes an additional implicit marginal tax rate on enrolled individuals whose incomes increase, with a particularly high "notch" at 400 percent of FPL, where APTC eligibility ends. The full schedule of ACA subsidies could potentially (particularly in combination with income limits of other federal and state anti-poverty programs) create adverse work incentives. They also impose significant burdens on middle-income Americans who lack access to employer-sponsored coverage.

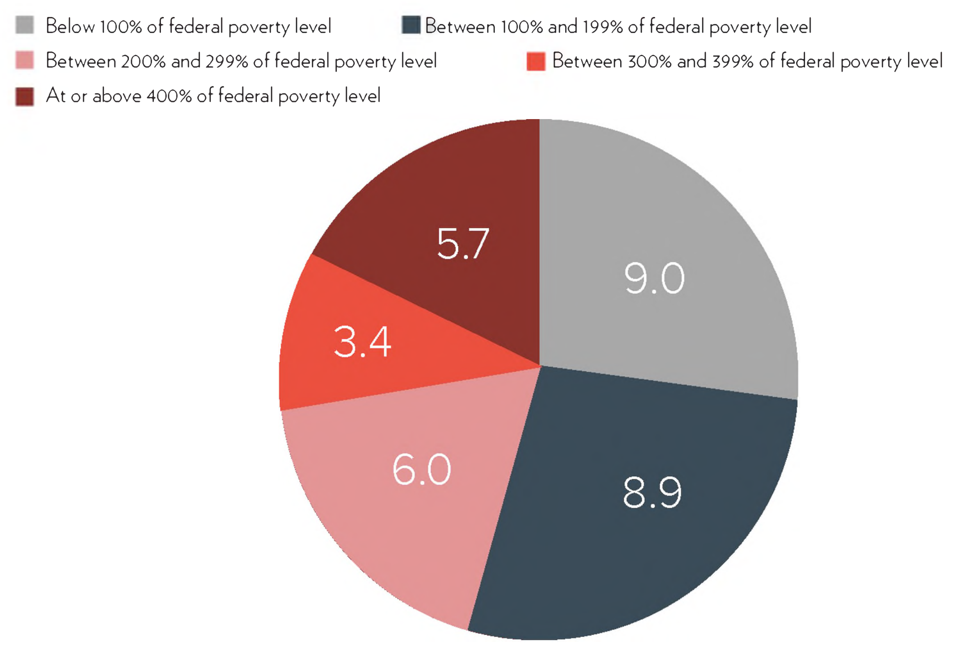
INCREASE CREDITS FOR MODERATE- AND MIDDLE-INCOME FAMILIES

Urban Institute researchers Linda Blumberg and John Holahan have proposed raising the APTC to make health insurance more affordable.[39] Households with incomes at 200 percent of the FPL would see the amount they would have to pay for premiums out of their own pocket reduced from 6.34 percent of income to 4 percent, while those at 300 percent of poverty would see a reduction from 9.56 percent to 7 percent. Blumberg and Holahan also propose allowing individuals with incomes above 400 percent of FPL to gain access to tax credits, as long as the premiums they would have to pay for the second-lowest-cost gold plan cost more than 8.5 percent of household income. Thus assistance would not be linked only to the amount of income but also to the cost of coverage. Adoption of this proposal would improve access to affordable health insurance for moderate- to middle-income households. Yet its cost would not be open ended, as the number of households that would be eligible for coverage would rapidly diminish as income increased.

FIGURE 6

UNINSURED AMERICANS BY POVERTY LEVEL

2014, In millions



Source: Authors' calculations from U.S. Census Bureau, "Health Insurance in the United States: 2014," Table 4, http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2014/Table4.pdf

Another approach would be to combine fixed-dollar, age-adjusted tax credits with ACA's income-based tax credits. Middle-income taxpayers without access to employer coverage would at least be entitled to a fixed-dollar tax credits even if their incomes were too high to qualify for income-based credits.

From both a substantive and a political perspective, such proposals merit consideration. Fixed-dollar tax credits have long been proposed as an alternative to the current employer-sponsored insurance tax exclusion. These proposals have come primarily from conservative or libertarian advocacy groups, but have also been put forward by many economists across the political spectrum.

Under one proposed alternative, taxpayers who do not have employer-sponsored coverage could choose between income-based tax credits, which could continue to phase out at 400 percent of FPL based on the cost of coverage, as described above, and fixed-dollar tax credits, which could be more generous than income-based tax credits at the 400 percent of poverty level. The amount of the credits should be set high enough to have a significant effect on affordability, but would still leave most of the responsibility for the cost of insurance with enrollees at higher income levels. Credits should be age-adjusted to ensure that they reflect age-related premium differences. These could also phase out at higher incomes, for example providing no assistance above the ninetieth percentile for household income ($150,000 in 2013).[40]

Such credits should be limited to individuals who are not covered through their work, since employer-sponsored coverage is already tax subsidized. However, individuals offered coverage through their work should be able to decline that coverage and purchase coverage through the marketplace and claim tax credits if this alternative is more affordable. This program structure may lead some employers to stop offering coverage, as firms and workers compare the value of the fixed credit to the value of the tax exclusion. As long as marketplaces offer good coverage, we regard this as an acceptable policy tradeoff.

Fixed-dollar tax credits for higher-income individuals would not require reconciliation based on actual income or to repayment to the Treasury, as long as total household income remained below the maximum eligibility level. Fixed dollar tax credits would thus be more predictable and simpler than income-based tax credits. It may not even be necessary to pay them in advance, as taxpayers could reduce withholding or estimated tax payments in anticipation of the credits and use the savings to help pay for health insurance.

A fixed-dollar tax credit such as that proposed here would come at some cost. Since it would only be available to individuals who do not enroll in employer coverage and who did not qualify for income-based credits, it would be much less costly than a universal tax credit. One attractive pathway to finance this system would be to cap the employer-sponsored coverage tax exclusion, a proposal that has wide support in the policy research community. Further research is needed to determine the amount of tax credits, their total cost, and how they would be financed.

2. MAKING HEALTH CARE AFFORDABLE

The ACA has reduced the financial burdens associated with injury and illness, and has made health care more affordable for millions of Americans.[41] Yet this coverage often comes with high deductibles, coinsurance, and copayments,[42] a pattern that reflects continuing trends within employment-based coverage as well.

Although ACA provides valuable limits on total out-of-pocket spending, it has not restrained the long-term trend toward higher deductibles and copayments in employer-sponsored coverage. Higher cost-sharing indisputably reduces the volume of care received by consumers, and thus overall expenditures. Yet there is considerable and growing evidence that such cost-sharing does so indiscriminately, reducing consumption of high-value as well as low-value care.[43] This is a particular problem for low-income individuals who cannot afford high cost-sharing levels, especially low-income people who experience significant health needs.

Covered individuals increasingly seek care from narrow provider networks and find medications listed on limited or tiered formularies.[44] Indeed some plans have implemented narrower networks to reduce annual deductibles in marketplace plans.[45]

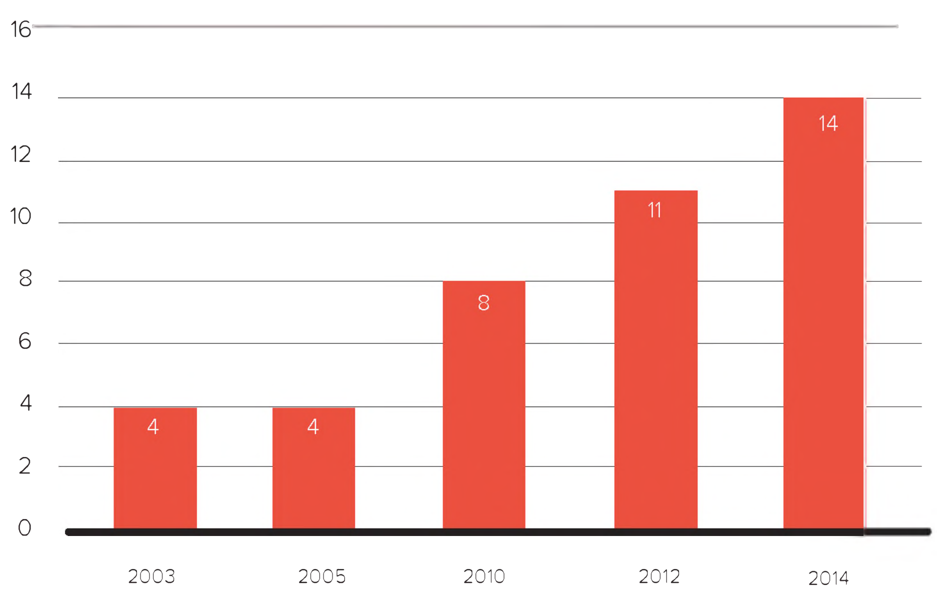
While narrower networks can provide high-quality, cost-effective care, too-narrow networks or formularies can pose significant barriers to consumers getting the care they need. In-network providers are not always easily identified, and out-of-network providers are not easily avoided. People served by out-of-network providers may therefore face large and unexpected bills.[46]

In sum, the ACA has expanded coverage, but too many Americans lack access to affordable and transparently priced health care. This section addresses problems raised by excessive cost-sharing and networks and formularies that are too restrictive.

FIGURE 7

AMERICANS AGE 19–64 FOR WHOM HEALTH CARE DEDUCTIBLE IS 5 PERCENT OF INCOME OR MORE

In millions



Source: Sara R. Collins, Petra W. Rasmussen, Sophie Beutel, and Michelle M. Doty, "The Problem of Underinsurance and How Rising Deductibles Will Make It Worse," Commonwealth Fund, May 20, 2015, http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance.

Moderating Costs for Insured Households

Although the ACA implements stop-loss provisions that reduce the risk of catastrophic financial loss, out-of-pocket medical costs continue to be a major concern for many Americans. Eleven percent of insured adults now have deductibles of at least $3,000, compared to 1 percent in 2003, while 38 percent have deductibles of $1,000 or more, compared to 8 percent in 2003.[47] Adjusting for inflation, out–of-pocket expenses have steadily grown.[48] (See Figure 7.)

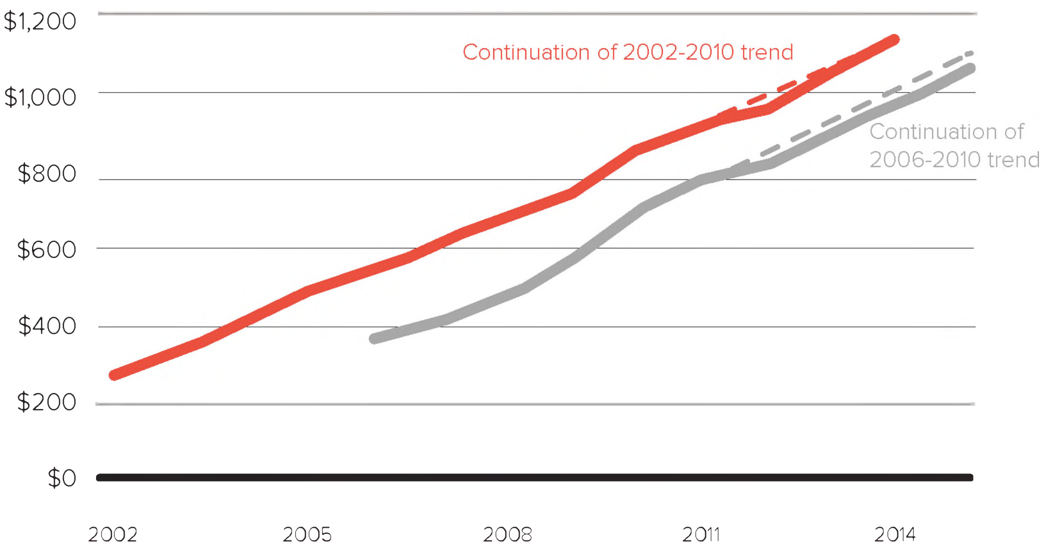
The ACA is sometimes wrongly blamed for increasing consumer out-of-pocket spending, so far the new law appears to have neither aggravated nor slowed the long-term trend toward higher deductibles and copayments in private coverage (see Figure 8).

High cost-sharing is having a real impact on American families. A recent Commonwealth Fund study finds that half of underinsured adults report being contacted by collection agencies or having to change their way of life because of medical bills.[49] Almost half reported having used all their savings or receiving a lower credit rating, while 7 percent declared bankruptcy.[50]

Being underinsured also has medical consequences—a quarter of those responding to the Commonwealth survey reported not going to the doctor for a medical problem, not filling a prescription, or skipping medical tests or treatments recommended by a physician for financial reasons. For those in deep poverty, any cost-sharing obligation—even a $2 copayment—can result in reduced access to medical care.[51] Many newly insured Americans are particularly unfamiliar with the structure of deductibles and copayments, and may thus be unprepared for cost-sharing obligations.[52] (See Figure 9, p. 20.)

FIGURE 8

AVERAGE DEDUCTIBLE IN EMPLOYER-BASED SINGLE COVERAGE



Source: Jason Furman, "Next Steps for Health Care Reform," October 7, 2015, Figure 4, https://www.whitehouse.gov/sites/default/files/page/files/20151007_next_steps_health_care_reform_slides.pdf

The ACA has a confusing array of rules governing the adequacy of coverage that can, in some circumstances, leave care essentially unaffordable. ACA requires individuals who can afford coverage and do not otherwise qualify for an exemption to have "minimum essential coverage."[53] Minimum essential coverage could be coverage through an employer, a government program, or individual coverage. Large employers (with more than fifty full-time equivalent employees) are required to provide minimum essential coverage to their full-time employees or to pay a penalty for each full-time employee if any employee receives premium tax credits for non-group coverage through the marketplace.

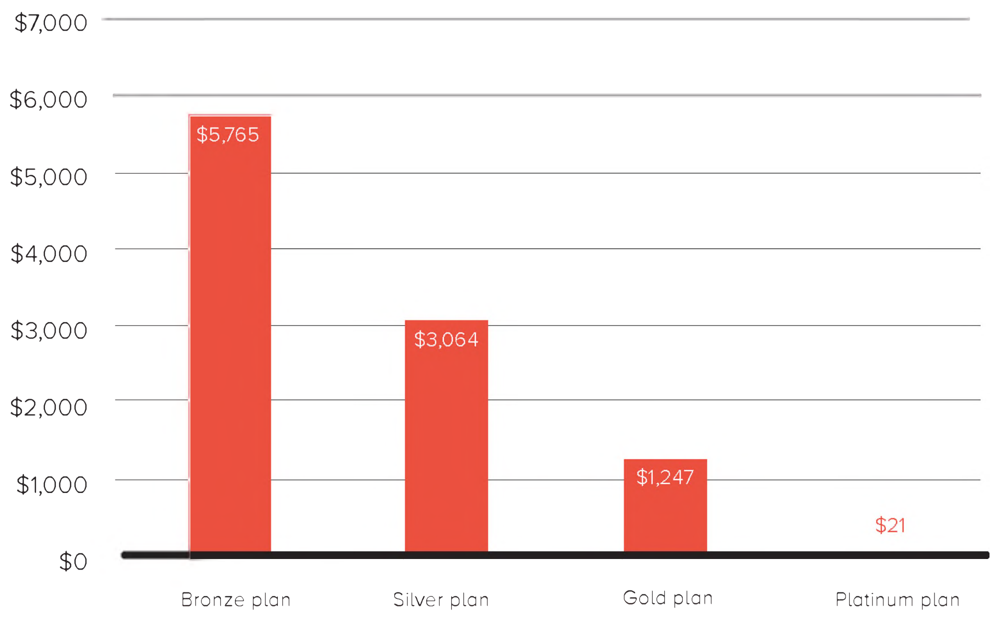
As applied to employer coverage, the minimum essential coverage definition requires vanishingly little.[54] Minimum essential coverage provided by employers must cover preventive services without cost-sharing, cannot impose annual or lifetime dollar limits, and cannot consist merely of "excepted benefit" plans, such as cancer or dental policies. Yet a "mini-med" policy that covered, say, only three physician visits and one day of hospitalization, in addition to preventive benefits, could conceivably pass muster.

Even if their employers offer minimum essential coverage, employees who are otherwise eligible for coverage can decline it and purchase coverage through the marketplace and receive APTC, if their employee does not offer them "minimum value coverage" that they can purchase for 9.56 percent or less of their modified adjusted gross income (MAGI).

Minimum value employer coverage is somewhat more comprehensive than minimum essential coverage.

FIGURE 9

AVERAGE MEDICAL DEDUCTIBLE IN PLANS WITH COMBINED MEDICAL AND PRESCRIPTION DRUG DEDUCTIBLE, 2016



Source: Matthew Rae, Gary Claxton, Cynthia Cox, Michelle Long, and Anthony Damico, "Cost-Sharing Subsidies in Federal Marketplace Plans, 2016," November 13, 2015, Slide 4, http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans-2016/ .

Minimum value employer plans must have an actuarial value of at least 60 percent (that is, they must cover at least 60 percent of the costs of a standard self-insured-plan population) and they must cover substantial hospitalization and physician services—but minimum value plans can still impose substantial cost-sharing on employees.[55]

Individual and small group insurance must meet higher standards (although it often in fact imposes higher cost-sharing than most large-employer plans). It must cover ten essential health benefits and provide coverage after cost-sharing set at one of four actuarial value levels—bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent).[56] "Catastrophic plans" (which have deductibles equal to the statutory out-of-pocket limit and only cover preventive services and three primary care visits annually but have actuarial values of less than 60 percent) are also available to young adults and individuals for whom other non-group coverage is unaffordable. Premium tax credits are keyed to the premium of the second lowest-cost silver plan in a market. Most marketplace enrollees who depend on premium tax credits choose to purchase bronze or silver plans.[57]

Bronze, silver, and catastrophic plans bring high cost-sharing. For 2015, bronze plans with combined medical and prescription drug deductibles averaged $5,200 for individuals and $10,500 for families,[58] while silver plan deductibles average $3,000 for individuals and $6,000 for families.[59] High cost-sharing allows lower monthly premiums. But high cost-sharing can impose significant burdens, particularly those with modest incomes

or costly health challenges. Lower-income families may face a choice between affordable coverage and affordable care.

Out-of-pocket costs for all ACA-compliant group health and individual insurance plans are also capped for 2015 at $6,600 for an individual and $13,200 for a family.[60] These caps provide important protections for many families experiencing serious injury or illness, yet they still exceed the available cash assets of many Americans. Indeed, a 2014 Federal Reserve survey found that 47 percent of Americans could not come with more than $400 without selling something, borrowing from a friend or relative, or taking out credit card debt or a payday loan.[61]

Other serious cost-sharing burdens remain.[62] The cap only applies to in-network services. Insurers and group health plans can cover services from out-of-network providers but are not required to do so (except for emergency services) and often impose higher caps on out-of-network out-of-pocket expenditures. Out-of-pocket caps also do not apply to services that do not qualify as essential health benefits.

Although a standard silver plan is one that covers 70 percent of the actuarial value of covered services, the ACA also provides cost-sharing subsidies that boost the total value of a silver plan for marketplace enrollees with incomes below 250 percent of the FPL.

Such assistance is greatest for those with incomes below 150 percent of the FPL (about $36,000 for a family of four), whose coverage has an actuarial value of 94 percent. Assistance is then reduced, and constraints on out-of-pocket payments gradually reduced up to 250 percent of the FPL (about $60,000 for that same family).[63]

Households with incomes above this threshold, particularly those who receive out-of-network care, are often responsible for far higher out-of-pocket payments, even if their household incomes are below 400 percent of FPL and they therefore remain eligible for financial assistance with their monthly premiums. The ACA requires the federal government to reimburse health plans for the amounts they provide modest-income consumers in reducing cost-sharing. Litigation is now pending challenging the legality of this reimbursement in the absence of explicit congressional appropriation.[64] Even as it is now applied, the ACA does not go far enough.

REDUCE COST-SHARING AND OUT-OF-POCKET LIMITS

The ACA should be amended to make health care more affordable. Cost-sharing should be reduced to reduce patients' financial burdens, and to avoid deterring patients from seeking valuable care. Urban Institute researchers Linda Blumberg and John Holahan propose that the premium tax credits be set to cover the cost of 80 percent actuarial value gold plans rather than the 70 percent silver plans.[65] These researchers also propose that actuarial values be increased to 90 percent for individuals with incomes between 150 and 200 percent of FPL and to 85 percent for individuals with incomes between 200 and 300 percent of FPL.

Running these provisions through Urban's microsimulation models, these researchers estimate that such changes would increase federal expenditures for ACA insurance affordability programs by $221 billion over ten years.[66] We support this proposal.

Health care could also be made more affordable by reducing out-of-pocket limits. As noted above, the ACA imposes an out-of-pocket limit on all forms of health coverage.[67] Under the ACA, this limit was supposed to be reduced by two-thirds for households with marketplace coverage with incomes below 200 percent of FPL, half for households with incomes

TABLE 2

MAXIMUM ANNUAL LIMITATION ON COST-SHARING

INCOME (PERCENT FEDERAL POVERTY LEVEL)	ACTUARIAL VALUE OF A SILVER PLAN	OUT-OF-POCKET MAX FOR INDIVIDUAL/FAMILY	
		2014	2015
100 percent–150 percent	94 percent	$2,250 / $4,500	$2,250 / $4,500
150 percent–200 percent	87 percent	$2,250 / $4,500	$2,250 / $4,500
200 percent–250 percent	73 percent	$5,200 / $10,400	$5,200 / $10,400
Over 250 percent	70 percent	$6,350 / $12,700	$6,600 / $13,200

Source: "Patient Protection and Affordable Care Act: HHS Notice of Benefit of Payment Parameters for 2015," Federal Register 79, no. 47 (March 11, 2014): 13744.

between 200 and 300 percent of FPL, and one-third for households with incomes between 300 and 400 percent of FPL.

The ACA provided, however, that these reductions in out-of-pocket limits should not increase the actuarial value of plans above the limits set for cost-sharing reduction payments.[68] As a practical matter, this has meant that out-of-pocket limits have not been reduced for individuals with incomes above 250 percent of FPL because to do so would require insurers to cover a larger share of claim costs and thus increase the actuarial value of coverage above the 70 percent silver plan actuarial value limit. Thus, while out-of-pocket limits are reduced by two-thirds for enrollees with incomes below 200 percent of FPL, out-of-pocket limits are reduced by less than a third for individuals with incomes between 200 and 250 percent of FPL, and not at all for those with higher incomes.

Significant cost-sharing relief could be afforded individuals with moderate incomes by effectuating the out-of-pocket limits imposed by the ACA without regard to actuarial value. If the actuarial value of ACA benchmark plans were increased from 70 to 80 percent, as Blumberg and Holahan suggest, the out-of-pocket limit could be decreased across the board to the levels found in the original ACA, since insures could pay a larger share of total covered costs.

Finally, the ACA employer responsibility regulations should be amended to improve coverage. Minimum value coverage should include substantial coverage for pharmacy and diagnostic tests as well as hospitalization and physician services. Minimum essential coverage should require coverage of hospital, physician services, pharmacy, and diagnostic tests as well. Employers who fail to provide these services should be subject to the employer mandate penalties. Employees who are not offered minimum value coverage as redefined should have access to marketplace coverage with premium tax credit support. As noted below, principles of value-based insurance design may prove helpful in defining the scope of coverage in these areas.

Improving Coverage for Some Individuals Whose Incomes Exceed 400 Percent of the Federal Poverty Line

Cost-sharing reduction payments are only available to individuals who purchase individual qualified health plans through the marketplaces and who are otherwise eligible for APTC assistance. This leaves millions of

individuals with coverage through their employment or through the individual market with incomes above 400 percent of FPL exposed to levels of cost-sharing that may still make health care a significant economic burden.

INCREASE USE OF HEALTH SAVINGS ACCOUNTS FOR MODERATE-INCOME AMERICANS

One way of increasing affordability for middle-income populations is through account-based programs such as health savings accounts (HSAs), health reimbursement accounts, flexible spending plans, and Archer medical savings accounts. These accounts permit tax subsidies for amounts set aside to cover medical costs, including cost-sharing imposed by health plans.

HSAs are sometimes touted as an all-purpose solution to health policy problems. In fact, HSAs provide one of the most heavily subsidized investment vehicles available and are used disproportionately by affluent taxpayers, who use them to maximize retirement savings rather than simply paying for health care, as money can be withdrawn from HSAs after age 65 for non-health care expenses without a penalty.[69] Simply increasing the generosity of federal subsidies for HSAs for people in high-tax brackets will not make health care more affordable for those who need help.

HSAs can, however, be of value to marketplace enrollees. For example, HSA contributions can provide "above the line" deductions to reduce modified adjusted gross income (MAGI). Since the MAGI is the income amount used to calculate APTC eligibility, a marketplace enrollee can by investing in an HSA both increase APTC and increase funds available to cover cost-sharing obligations. While it would be preferable to increase APTC and cost-sharing reduction eligibility levels and generosity, if this is not politically possible, HSA investments can provide some relief for individuals with moderate incomes or individuals who underestimate their income and are faced with high APTC repayments at tax filing time.

Some legislative changes could make HSAs even more helpful for those who actually use them to cover health care costs. First, the out-of-pocket limits under the ACA could be amended to align them with out-of-pocket maximums for HSA-linked high-deductible health plans. Although the limits were initially aligned, they increase under different inflation adjustment rules, making it possible that ACA compliant plans would not be HSA eligible. For 2016, for example, the maximum out-of-pocket expenditure limit for health savings account compliant high-deductible health plans is $6,550,[70] while the maximum ACA out-of-pocket limit is $6,850. These rules could be easily aligned.

Modest direct federal contributions to HSAs for moderate-income Americans could also be considered. These could be made available in fixed amounts ($500 per year, for example) to middle-income individuals who are not eligible for cost-sharing reduction payments but who have incomes below certain levels, perhaps 500 percent of FPL. These could be paid as a refundable tax credit at the time of tax filing based on actual taxable income, avoiding the need for reconciliation.[71] They could be made to individuals with employment-related coverage as well as individual market coverage.

As with retirement accounts, modest subsidies could be implemented with a well-designed choice architecture that could overcome behavioral inertia to encourage greater savings.[72] For example, the federal government could implement a matching-contribution framework. Government or private plans could also assist consumers with the logistical practicalities of establishing such accounts.

ALLOW USE OF HEALTH REIMBURSEMENT ACCOUNTS TO PURCHASE HEALTH INSURANCE

Consideration should also be given to allowing small employers to fund health reimbursement accounts (HRAs) that could be drawn upon by employees to purchase health insurance in the individual market. This is currently illegal under administration interpretations of the ACA and preexisting tax law.[73] Protections would be required to ensure that employers treated all employees the same and did not use this possibility to dump high-cost employees into the marketplaces. Provision would also have to be made to ensure that the offer of an HRA did not disqualify employees from receiving marketplace premium subsidies unless the HRA contribution made coverage genuinely affordable. Finally, "double-dipping" should not be permitted—employees should have to choose between employer HRA-financed coverage and APTC, and not receive both. But with these protections, found in current legislative proposals (HR2911), a program that allowed small employer contributions for coverage through HRAs could encourage some employers who would not otherwise offer traditional small group coverage to make coverage more affordable for their employees.[74]

Improving Health Insurance Design to Increase Coverage

Even if the ACA is not amended to increase cost-sharing support, health insurers could make health care more affordable. Some marketplace plans currently offer some services—coverage of generic drugs for example—that are not subject to the deductible.[75] Others permit limited access to some services—three primary care visits for example—before the deductible applies. In fact, in 2015, 80 percent of marketplace silver plan enrollees selected a plan with a primary care visit covered before the deductible while 82 percent selected a plan with generic drugs covered below the deductible.[76] These plan designs could be encouraged (or required) by the marketplaces—including the federal marketplace—which are required under the ACA to ensure that qualified health plans are "in the interests of" plan enrollees.

Such plan designs carry some danger of risk selection. If these plans impose lower cost-sharing on individuals with minimum medical demands, they must make up for it by imposing higher cost-sharing elsewhere, presumably on higher-cost individuals. On the other hand, if offering some covered services to individuals with low medical needs attracts those individuals into the marketplace, this might have the effect of lowering the cost of coverage for all marketplace participants.

As noted above, accumulating evidence confirms that greater patient cost-sharing leads to reduced utilization. But there is little evidence that consumers respond to cost-sharing by effectively comparing prices for costly services, or by focusing on the highest-value care.[77]

Zarek C. Brot-Goldberg and colleagues, in a recent National Bureau of Economic Research working paper, examined the experiences of workers who were shifted from a no-deductible plan to one with a $3,750 deducible linked with a correspondingly generous $3,750 health savings account.[78] Consumers were also provided innovative online shopping tools that were intended to assist them in comparing prices for doctors' visits and various accompanying services and tests. Annual medical spending quickly dropped, with total firm-wide medical spending declining by more than 10 percent.[79] Yet the decline was undiscriminating. Brot-Goldberg and colleagues found little evidence that workers effectively distinguished wasteful from valuable care. Given a financially generous high-deductible health plan with an accompanying HSA, even this group of relatively high-income, highly educated workers markedly reduced its receipt of clinical preventive services and other valuable care.[80]

There was also little evidence that this relatively advantaged consumer group used available tools to identify cheaper services and providers, or even that consumers strategically responded to the actual economic incentives created by their insurance plan. Researchers found especially concerning utilization declines among people with health problems, who may have foregone important forms of care. Almost half of the spending reduction also occurred among predictably sick individuals likely to exceed their annual deductibles, for whom the true marginal cost of specific services was often quite low. This overall pattern of findings casts doubt on the power of calibrated consumer incentives to safely and effectively improve the cost-effectiveness of medical care.

INCORPORATE VALUE-BASED INSURANCE DESIGN TO SUPPORT COVERAGE FOR HIGH-VALUE SERVICES

Value-based insurance design (VBID) attempts to balance the competing goals of greater economy and cost-effectiveness with greater financial protection and improved health. Consumers require the most generous coverage and most minimal cost-sharing for high-value services likely to improve health, with less generous cost-sharing for lower-value services such as name-brand drugs for which cheaper generic substitutes are readily available.

The ACA incorporates one form of VBID by requiring insurers to cover clinical preventive services without patient deductible or copayment when these are granted an "A" or "B" rating by the U.S. Preventive Services Task Force based on rigorous clinical trials. Equivalent bodies could develop an evidence-based list of secondary prevention and chronic disease management services that would similarly be covered without patient out-of-pocket cost or with minimal cost.[81]

The Center for Medicare and Medicaid Innovation recently announced an initiative to deploy VBID principles to align cost-sharing more carefully with high-value services in Medicare Advantage. Beginning in January 2017, these programs will test the utility of structuring patient cost-sharing and other health plan design elements to promote high-value clinical services in seven states. This effort provides a promising platform to design more innovative marketplace plans, which the federal and state marketplaces should encourage.[82]

Improving the Adequacy of Both Networks and Formularies

Further steps should be taken to improve the adequacy of provider networks and formularies. Consumers also need to be protected from surprise balance billing when they unintentionally use the services of out-of-network providers. This could be done by amendments to the ACA, but could be accomplished also by the administrative actions under existing authority and by state legislatures and insurance regulators.

Narrow provider networks are a familiar feature in American health care. These have become only more common and narrower in recent years, due largely to the concurrent effects of rising costs and competitive pressure on insurers to reduce premiums. As a result, insurer provider networks cover an ever smaller roster of providers to reduce costs from the insurer's perspective, thus permitting lower premiums.

With proper transparency, narrow networks can benefit consumers. Narrow networks provide insurers (and thus their customers) greater leverage to constrain prices and to maintain quality.[83] Excessive regulation of networks is problematic if regulations unduly tie the hands of insurers and consumers in provider negotiations.[84]

But narrow networks can leave consumers without necessary access to providers.[85] If networks include too few providers, or if none of these providers are accepting patients or can communicate in an enrollee's language,

enrollees may be denied care that they need and have contracted to receive. If providers are too far away, if delay times to obtain appointments (or the times in the waiting room after arriving for an appointment) are too great, the enrollee can effectively be denied coverage.

If an enrollee has special needs—pediatric oncology or HIV therapy, for example—and a network lacks providers that can provide specialized care, the enrollee may lack practical access to the most essential benefits of their insurance coverage. Moreover, some insurers might intentionally restrict networks to deter high-cost patients from enrolling. A particular concern is that insurers may restrict drug formularies to discourage individuals who need access to high-cost specialty drugs from enrolling in their plans.[86]

Recent analysis of plans available in six cities found that most marketplace plans include at least one marquis hospital or academic medical center.[87] Such participation is quite salient to both consumers and regulators, and is perhaps essential for a credible commercial product. But physician network adequacy is more complex and less readily observed by consumers. Proper regulation is therefore essential to ensure access and to avoid risk selection across plans.

The ACA marketplaces oversee network adequacy for qualified health plans (QHPs). QHP networks must, under the federal rules, include a sufficient number and variety of types of providers, including mental health and substance abuse providers, to ensure that all services are available without unreasonable delay.[88] Current marketplace regulatory oversight focuses on access to hospital systems, mental health, oncology, and primary care providers. QHP plans must also include essential community providers that serve low-income and medically underserved individuals. QHP insurers must make provider directories available online and in hard copy and must update their online directories monthly. If necessary in-network care is unavailable, plans should be required to pay for out-of-network care with in-network cost-sharing.

QHPs must also cover at least one drug from each U.S. Pharmacopeial Convention category and class and the same number of drugs in each category and class as the state's essential health benefits benchmark plan. QHPs must provide an exceptions process for enrollees who need drug not on the formulary and cannot discriminate through the use of their formulary, for example, by excluding HIV drugs.

The Department of Health and Human Services also regulates network and formulary adequacy for Medicare Advantage and Medicaid managed care plans. Regulation of Medicare Advantage plans has become quite sophisticated, with a focus on geographic accessibility of providers,[89] while regulation of Medicaid plans will be tightened up under recently proposed regulations.[90] Employer plans need only describe their network provisions and provide a list of their network providers.[91]

Regulation of network adequacy is, therefore, primarily the responsibility of state insurance regulators. State regulation, however, varies widely, while advocates and the news media are more focused on Washington, D.C. than on the fifty state capitals where the most critical decisions will be made. Therefore, progress on this front will require improving state regulatory efforts directed at network adequacy.

IMPROVE STATE REGULATION OF NETWORK AND FORMULARY ADEQUACY

Although the National Association of Insurance Commissioners (NAIC) has had a managed care plan network adequacy model act since 1996, fewer than one-quarter of states had adopted the model, as of a recent survey.[92] While most responding states

reviewed plans of health maintenance organizations for compliance with network adequacy standards, far fewer performed similar reviews of preferred provider organizations, except when complaints were received. Only about half the states imposed quantitative standards in place for evaluating time and distance to providers.[93] Only about one-fifth limited how long enrollees must wait for an appointment with providers or require minimum ratios of enrollees to providers.[94] Most states did not require network directories to be updated more often than annually. Many states did not affirmatively monitor ongoing network adequacy for non-HMO plans unless they received a complaint.

A program for regulation of network adequacy has been proposed by the consumer representatives to the NAIC.[95] Much of this program is included in a redraft of the model law recently adopted by the NAIC. Under the program proposed by the consumer representatives, states should have to adopt network adequacy regulations governing all insured plans that use networks—that is, virtually all insurance plans. States should ensure consumers' accessibility to providers within reasonable distances and without unreasonable waiting times for appointments. Access should be guaranteed to the full range of providers needed by plan enrollees, with an emphasis on primary care, mental health and substance abuse care, and care for children. Failure to include providers necessary to address certain conditions should be treated as a discriminatory benefit design issue. Regulators should also ensure that formularies are adequate and non-discriminatory, and that an exceptions process is readily available.

Regulations should also require insurers to enroll at least some providers that offer extended hours and weekend appointments. State regulators should pay special attention to access to essential community providers. Regulators should also ensure that health plans not only have network contracts with hospitals, but also with physicians within those hospitals, particularly with hospital-based physicians such as anesthesiologists, radiologist, pathologists, emergency room doctors, and hospitalists.

Insurers should be required to file access plans that describe in detail their networks, how those networks adequately address the needs of their enrollees, and how pertinent and timely information about their networks is clearly communicated to consumers. The access plans should in particular address the criteria an insurer uses to select providers, including measures that address quality of care, and protocols for maintaining and updating network directories. These access plans, and any changes to them, should be reviewed and approved by regulators before they go into effect.

Regulators should regularly review compliance with network adequacy regulations, using such tools as secret shoppers and review of provider contracts to ensure adequacy. Regulators should not passively rely on complaints to ensure insurer compliance. Regulators should also not simply rely on accreditation status to ensure network adequacy. Accreditation can provide an additional check on adequacy, but cannot substitute for public regulation.

Some enrollees will inevitably be unable to receive needed care in network plans. All network plans should thus be required to provide an exceptions process for enrollees who cannot find within-network providers, either because of their specialized needs or because of network capacity. Requests for exceptions in urgent cases should be handled within twenty-four hours. Regulators should collect routinely data to monitor the frequency of use of out-of-network providers, the cost of out-of-network services, and the use of the exceptions process.

Consumers should also be protected when their providers leave their plan's network. Providers should be required to ordinarily give ninety days' notice to health plans before terminating their contractual participation. Network providers (or the plans) should give the same notice to patients under treatment before the provider is allowed to disenroll from a plan's network. If a provider and a plan terminate their contract or a provider is moved from one cost-sharing tier to a different tier, an enrollee who is pregnant, terminally ill, or under a course of treatment for a serious condition should be able to continue treatment at the same cost-sharing level for ninety days, or until a baby is delivered or the condition resolved. If an enrollee's primary care physician or provider with whom they are in active treatment leaves a plan in the middle of a plan or policy year, the enrollee should also be given a special enrollment period to move to a plan in which their provider is enrolled.The Centers for Medicare and Medicaid Services (CMS) has recently proposed regulations that would require federally facilitated marketplace qualified health plans to provide similar continuity of care protections.

IMPROVE PROTECTION FROM BALANCE BILLING

Consumers should be protected from balance billing unless they have freely assumed the risk by knowingly seeking care from a non-network provider fully aware that they will receive a balance bill.[96] Consumers who receive emergency care from an out-of-network provider should not need to pay more just because they could not get to an in-network provider. Federal law now requires network plans to pay minimum provider rates and to not charge consumers higher coinsurance or copayments for out-of-network emergency care. It does not, however, ban balance billing in emergency situations. A few states have laws requiring insurers to hold consumers harmless for emergency out-of-network care, but many states do not.[97] All states, and the federal government for QHP plans, should adopt laws holding insured individuals harmless from balance billing when they must receive out-of-network emergency care.

Protections are also needed for consumers who have exercised reasonable caution to make sure that they are receiving treatment from in-network providers but nonetheless receive out-of-network services, for example from anesthesiologists, pathologists, or surgical consultants. CMS has recently proposed a rule under which a marketplace health plan could provide notice to an enrollee at least ten days in advance of the receipt of services from an in-network facility that there was a possibility that the enrollee might receive out-of-network services while at the facility. If a plan failed to provide this notice, any cost-sharing imposed by out-of-network providers would have to be charged against the plan's out-of-pocket limit so that the insurer would absorb costs above that limit. This is a step in the right direction, but does not go far enough.

When consumers schedule a procedure with an in-network provider in a nonemergency situation, they should be informed as to whether professionals that might be involved in the procedure are out-of-network and, if so, be offered the option of choosing in-network providers. If consumers end up being treated by out-of-network providers despite reasonable efforts to receive only in-network care, an arbitration process should be provided to resolve the issue between the provider and insurer without involving the consumer. "Final-offer" arbitration, in which the parties, in this case the provider and insurer, each submit bid amounts and the arbitrator chooses one or the other, is one simple process for reaching a reasonable solution to balance billing disputes.[98] The recently finalized NAIC model act provides a similar approach, requiring mediation or negotiation of large balance bills between the insurer and provider.

3. IMPROVING THE CONSUMER MARKETPLACE EXPERIENCE

One goal of the ACA is to provide consumers with a range of health plan choices. Another is to encourage competition among insurers to constrain premium growth and improve quality and value. To accomplish both of these ends, the ACA created exchanges—now called marketplaces—where consumers can shop for individual and small group coverage and insurers can compete for their business.

The ACA constrains marketplace choices and competitions in several ways. Insurers are restricted from competing in the way they have traditionally—by avoiding high-risk enrollees or charging them higher premiums. Insurers also cannot compete in the individual and small group market by offering skinny benefit packages. All insurers in these markets must cover a reasonably comprehensive package of essential health benefits. Qualified health plans sold through the marketplaces must also meet other requirements, including inclusion of essential community providers that cover low-income and high-need enrollees, and accreditation by recognize accrediting entities.

Within these constraints, insurers are free to compete for consumer business, and consumers are free to choose the plan that they think best suits their own needs and resources. Although the extent of competition, and the ways in which insurers have competed, have varied from state to state, and from one region to another within a given state, competition has been robust throughout much of the country. Consumers have, on average, five insurers and fifty health plans to choose from per county in the 2016 open enrollment period.[99]

Insurer competition has focused intensively on premiums. In a recent Commonwealth Fund survey, 41 percent of participants reported that low premiums were the most important factor in their selection of a qualified health plan (see Figure 10, p. 30). Another 25 percent identified out-of-pocket payments as most important, with only 22 percent reporting that access to a preferred provider was most important.[100] Marketplace price competition is particularly powerful because premium tax credits are set with reference to the second-lowest cost silver plan available to a consumer. Any amount that a consumer pays for a plan above that benchmark comes directly from the consumer's pocket.

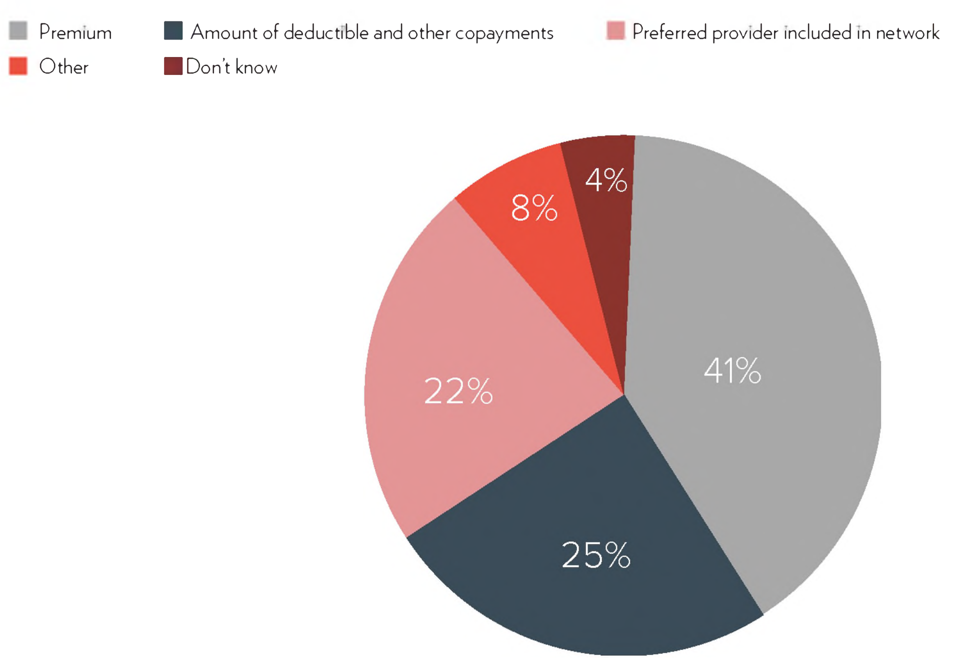
Narrowing provider networks provides the most common approach used by insurers to lower both premiums and out-of-pocket payments.[101] This appears to be an appealing strategy to many consumers. Fifty-four percent of consumers who report that they had the opportunity to save money by enrolling in a QHP with a narrower provider network chose to do so.[102]

Insurers also compete by offering a range of cost-sharing alternatives. Although cost-sharing packages must meet actuarial value standards, there are many different ways in which plans can be designed to meet the same actuarial standard. Different cost-sharing packages may be attractive to different consumer groups. Although, as we noted earlier, high cost-sharing may harm low-income populations, within limits, diversity and choice in cost-sharing alternatives is beneficial to consumers. Competition in this area, however, also imposes significant possibilities for confusion, imposing large responsibilities for processing information on individual consumers.

There is evidence that premiums are lower in marketplaces in which many insurers actively compete.[103] Consumers also presumably benefit from being able to choose from a number of plans that offer different provider networks and cost-sharing packages. The challenge is to improve consumer choice while managing the accompanying cognitive and informational burdens. Experience from Medicare

FIGURE 10

MOST IMPORTANT FACTOR CITED FOR PLAN SELECTION



Source: Sara R. Collins, Munira Gunja, Michelle M. Doty, and Sophie Beutel, "To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance under the Affordable Care Act While Others Have Not," The Commonweatlh Fund, September 25, 2015, Exhibit 4, http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/to-enroll-or-not-to-enroll.

Advantage and other arenas indicate that, absent proper structure and decision supports, offering consumers too many choices can actually impede consumers' ability to make effective decisions.[104] Important deficits in the information provided to consumers also limit their ability to make optimal plan choices.

Expanding Human and Automated Decision Supports for Both Medicaid and the New Marketplaces

In the run-up to the implementation of the ACA, proponents occasionally spoke of the process of buying marketplace coverage as something that could be done with the ease of selecting a book on Amazon.com. That vision was over-optimistic, given the complexity of insurance products. The current consumer experience, in both the state and federal marketplaces, certainly does not approach that standard.

The sheer volume of Americans who have used the marketplace accounts for much of the technical challenge. According to a recent Commonwealth Fund report,[105] one-quarter of all U.S. adults age 19 to 64 have visited the new marketplaces. Fifteen percent of visitors enrolled in Medicaid; 30 percent enrolled in a private plan. Each of these individuals required extensive information processing, linking across multiple federal agencies and qualifying health plans, including identity verification, citizenship checks, and the computation of premium tax credits. These challenges crashed the initial launch of the federal healthcare.gov website and some state marketplace websites. They still affect the consumer experience in many ways.

With due allowance for inherent complexity, the human experience interacting with the new marketplaces remains mediocre. Partly as a result of these shortcomings, consumers often err in choosing marketplace health plans.[106]

Survey data collected in 2014–15 by the Commonwealth Fund underscores the challenge. The low response rate (12.8 percent) suggests a need for further investigation regarding consumer experience. Yet the overall pattern is consistent with other data and media accounts.[107] Fifty-eight percent of marketplace visitors rated the experience unfavorably, as either "fair" or "poor." Forty-seven percent of those who successfully obtained coverage nonetheless rated the experience unfavorably. Among those could not or did not enroll, 54 percent flatly rated the experience as "poor."[108] In the absence of greater decision supports and transparency, consumers understandably base their plan choices on their monthly premiums or on behavioral inertia, even when such choices provide a demonstrably poor match to their true needs based on predicted out-of-pocket payments, health needs, and other pertinent factors.

Consumers require significant help making sense of complex provider networks; premiums, deductibles, copayments, and coinsurance; and pharmaceutical formularies.[109]These activities must be made easier and more transparent, especially since the mechanics of the process compel consumers to comparison-shop every year.[110] Policymakers must also consider other changes to ensure that plans provide both consumers and regulators with standardized and timely information regarding provider networks, covered medications, and other basic issues.

Improved decision aids could help consumers make better and more informed choices. This is a critical concern to ensure that individuals obtain affordable coverage, and to ensure that marketplace competition disciplines premium increases across plans.

The dynamics of the 2015 open enrollment process underscored the importance of active consumer comparison-shopping. An individual who purchased the cheapest 2014 silver plan and retained it in 2015 would experience an average 8.4 percent premium increase. That same consumer, if she had chosen the cheapest 2015 silver plan, would have experienced only an average 1.0 percent increase.[111]

One-third of re-enrolling marketplace participants changed plan metal levels in 2015. The remaining two-thirds of metal plan participants retained their 2014 plan level. Many who remained with their same plans likely over-pay, since switchers saved an average of $400 annually.[112] Comparable data from 2016 plans are now becoming available. These likely will exhibit similar patterns.

Some tools for improving consumer decision-making are emerging in the federal marketplace and across the states. Consumers can obtain much more information and browse available marketplace options as "anonymous" users. This is a major advance over the initial open enrollment, which generally required individuals to establish personally identified marketplace accounts before gaining access to such information.

For the 2016 open enrollment period, healthcare.gov has substantially upgraded shopping tools. Materials recently released by CMS indicate important changes for the current marketplace. These include faster and improved browsing and account management, more user-friendly navigation, and simplified re-enrollment processes with comparisons to other local available plans. A new out-of-pocket cost calculator helps consumers estimate overall costs, beyond the monthly premium. This feature provides further information on premiums, deductibles, and co-pays for each plan, based on different anticipated levels of health care utilization. New doctor and prescription drug

lookup features will provide consumers with more readily searchable information about network and prescription-drug coverage in different plans.[113]

By 2017, additional data will be incorporated, including plan quality ratings and the results of consumer satisfaction surveys.[114] But much more can be done to simplify consumer choice and to improve the choice architecture facing individuals selecting plans.

ACTIVELY GUIDE CONSUMERS IN COVERAGE SELECTION

A recent paper by economists Ben Handel and Jonathan Kolstad exemplifies how personalized decision supports and defaults could make marketplaces more transparent and competitive, and also less burdensome to individual consumers.[115] A key insight is that useful decision supports should extend beyond the convenient provision of pertinent information to more much active guidance based on specific information regarding patients' specific preferences and needs.

These authors make several proposals to guide consumers towards plans most likely to match their projected health needs, network of providers, preferences about risk, and other factors. Handel and Kolstad also recommend an "opt-out" approach, in which marketplaces would be enabled to default-enroll a consumer into a particular plan when that represents an "unambiguous and substantial increase in value for the consumer."

More should be done to integrate decision-making and consumer support tools with the predictable needs of Americans with chronic conditions. Expert organizations such as the American Cancer Society could play a valuable role in preparing materials and automated decision aids that help consumers assess the quality of qualified health plans in treating specific conditions.[116]

Although all of these tools will be helpful, they are not sufficient. Navigators and other types of enrollment assisters, including traditional agents and brokers, must help.[117] Many people need human help accessing online resources. The most knowledgeable consumers may already have signed up for coverage, leaving many remaining uninsured who will need outreach and other services to obtain coverage and financial help. According to one recent survey, half of uninsured adults who were potentially eligible for financial help had not heard about subsidies or looked for information on the new marketplaces.[118]

When the ACA first launched, the federal government financed much of this human help, funding many programs that help consumers with the mechanics of plan enrollment and marketplace subsidies. During the first open enrollment period, some 4,400 assister programs with more than 28,000 staffers and volunteers helped nearly 11 million consumers.[119] The federal government also funded state consumer assistance programs through the ACA.[120]

Some policymakers had hoped that the need for such supports would decline as the ACA became a permanent fixture and the new marketplaces enrolled increasing numbers of the previously uninsured. Experience in Massachusetts and elsewhere suggests these hopes are misplaced. A particularly important challenge arises in reaching severely disadvantaged populations, such as individuals with substance use disorders or those under the supervision of the criminal justice system. States—particularly those that have rejected ACA's Medicaid expansion—are now providing little outreach and technical assistance in these areas.[121]

The federal government can help to fill this gap.[122] A permanent, well-trained corps of 10,000 additional full-time outreach and enrollment specialists would

augment existing efforts. A large city such as Chicago might have 200 additional specialists, who would be available to assist individuals with complicated health conditions or life circumstances, and to assist others such as Medicaid-eligible indigent individuals who would otherwise remain uninsured. The annual costs of such a corps, which we estimate to be on the order of $500 million, amount to less than $50 for every participant in the new marketplaces. Such costs may be offset by the savings to states of increased Medicaid enrollment, and by savings to both individuals and the federal government if such enrollment assisters could help marketplace participants more effectively comparison-shop different plans.

Private brokers and agents can also play a useful role. Some ACA supporters were initially skeptical that brokers could still play a valuable role once state marketplaces were implemented. In part because of initial implementation difficulties, but also because of their specific expertise and experience in the insurance market, brokers and agents have played an important and continuing role. Rather than being dis-intermediated by the new marketplaces, brokers are accounting for a surprisingly high proportion of enrollment in California, Kentucky, and other states.[123] Effective collaboration with private agents and brokers requires due attention to their commercial needs. Such collaboration also requires regulation of potential conflicts of interest and new training regarding low-income consumers and other populations likely to participate in state marketplaces, who have rarely interacted with agents or brokers before.[124]

IMPROVE NETWORK AND FORMULARY TRANSPARENCY

Improved network and formulary transparency would greatly improve the consumer shopping experience. Federal regulations and the laws in some states require health plans to make their network directories and drug formularies available online and to update them regularly. Comprehensive federal regulations, however, apply only to qualified health plans sold through the ACA marketplaces (and to Medicare Advantage and Medicaid managed care plans), and state laws and regulations do not apply to self-insured group health plans, which cover the majority of employees covered through employee benefit plans. ERISA, which does cover employer plans, imposes less rigorous network disclosure requirements.[125] Current statutes and regulations do not go far enough to ensure that insurers make available reliable provider directories and networks.

Transparent network coverage is necessary to ensure that consumers who enroll in narrow network plans understand the constraints they are accepting and can determine whether the providers they want or need are in-network.[126] A uniform rating system should be developed for disclosing the breath or narrowness of provider networks. For example, McKinsey in its analysis of networks defines broad networks as those with 70 percent of all hospitals in the rating area participating, narrow networks with 31 percent to 70 percent of all hospitals, and ultra-narrow networks with 30 percent or less of all hospitals participating.[127] Ratings such as these should be included on the summaries of benefits and coverage that health care plans are required to give all enrollees and shoppers so that consumers can determine up front the breadth of the plan's network. Plans should also describe the criteria used for determining network participation, the cost differentials for enrollees who use in- or out-of-network providers, and how balance bills are handled.

Provider directories should be readily available online and in paper form. These must be easily searchable and understood by the general public. Consumers should be able to determine whether specific providers with whom they have established relationships, specific

types of specialties that they need, providers in their geographic location, or providers who speak their language or are accepting patients, are available in a network before they sign up for it.

Directories for individual and small group plans should be available to the public online without the need to log-in or to provide a password. Directories for all individual market plans should also be provided by insurers in machine-readable form to permit private companies to create search tools. Directories should include, and be searchable by, information on providers including name, contact information, location, specialty, languages spoken, and whether or not the provider is accepting patients. The recently launched federally facilitated marketplace doctor lookup tool should be supplemented by private marketplace search tools. If a network is tiered, providers should be identified and be searchable by tier. The directory should clearly define the ramifications of tiered status in terms comprehensible to ordinary consumers.

Consumers should also be able to trust the accuracy of provider directories. Directories should be updated monthly. Only a handful of states currently require this, although CMS now require monthly updates from QHPs in the federally facilitated marketplaces.[128] If a directory erroneously lists a provider as participating or accepting patients when the provider in fact is not, enrollees should be permitted to disenroll and enroll in a different plan. Network directory updates should be filed with state insurance regulators, who should make reviewing network directories part of their regular market conduct analysis, as well as respond to complaints about directories. Trusted consumer organizations such as Consumers Union or Consumer Checkbook could also rate plan networks for their comprehensiveness and quality.

Formularies should be available online and in machine-readable form and regularly updated. Insurers and group health plans should not be allowed to remove drugs from a formulary or change its tier status within a plan year unless the drug is determined to not be safe or effective, a generic form of a previously brand-name only drug becomes available, or an over-the-counter equivalent of the drug becomes available. Nevada has recently considered a formulary regulation that takes this approach.[129]

STANDARDIZE INSURANCE PRODUCTS

Consumer shopping in the non-group market could also be improved through greater standardization. While it is important for consumers to have options in insurance markets and while product innovation can be beneficial to consumers, consumers do not benefit from having available many plans with minimal and confusing differences. Several state marketplaces have developed standardized designs for marketplace plans.[130] Federal regulations already limit insurers to offering marketplace plans that are "meaningfully different,"[131] but the standards for determining differences among plans are minimal.

The California marketplace requires insurers to offer plans in each of the four metal tiers and to offer a standardized plans in each tier.[132] Research involving standardization of plans in Massachusetts found that it simplified consumer choice and improved consumer welfare.[133] Although such comparisons do not demonstrate causality, another study found health insurance premiums significantly lower in California, with standardized plans, than in Florida, which allows insurers to market plans of their choosing without standardization.[134] But states with greater plan standardization do not necessarily have lower rates than states with less standardization; product design issues are also important.[135] CMS has recently proposed the establishment of a set of standardized plans for each metal level that insurers offering marketplace plans could use for 2017.

Marketplaces should develop a limited number of standard product designs and require insurers that want to offer products in the market to offer those products. Insurers could also be allowed to offer a limited number of nonstandard products, but would have to justify why the product is valuable for some specific group of consumers and that offering such a product would not aggravate risk-segmentation or deter high-cost consumers.

4. IMPROVING MEDICAID FOR LOW-INCOME AMERICANS

Medicaid expansion is the ACA's main strategy for expanding health care to low-income Americans. Seventy-two million Americans are enrolled in Medicaid, 13.2 million more than were enrolled in 2013 before the ACA expansion was implemented.[136] For these Americans, Medicaid plays a vital role, giving them access to health care they could never otherwise afford.

The Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* (known as NFIB) gave states permission to opt out of the ACA's Medicaid expansion. At this writing, twenty states have chosen to opt out.[137] To attract states into the program, the administration has been allowing states substantial discretion under Section 1115 of the Social Security Act (known as the 1115 waiver program). This process should continue. Indeed, ongoing dialogue between conservative state officials and the Obama administration may be the most effective bipartisan negotiation now occurring in health policy. Yet the extent of discretion permitted states must be limited to avoid undermining Medicaid's broader goals. And states could be offered additional incentives to expand Medicaid. Finally, several steps, outlined below, could be taken to make Medicaid more beneficial to Medicaid beneficiaries.

HAVE THE FEDERAL GOVERNMENT PERMANENTLY ASSUME THE ENTIRE COST OF THE MEDICAID EXPANSION POPULATION

In the wake of the Supreme Court's NFIB decision, twenty states have declined to implement ACA's Medicaid expansion, despite extremely generous federal matching rates that are currently 100 percent and will taper down to a permanent matching rate of 90 percent by 2020. ACA's Medicaid expansion represents one of the most generous federal-state financing arrangements in the history of health policy. The Congressional Budget Office estimated that the federal government will pay 93 percent of the costs of the Medicaid expansion between 2014 and 2022. The additional cost to states represents a 2.8 percent increase in what they would have spent on Medicaid over the same period in the absence of health reform.[138] Indeed, a recent study has shown that Medicaid costs are growing more rapidly in states that have not expanded Medicaid than in states that have.[139]

Economic analyses indicate that the local economic impact of Medicaid expansion is highly favorable to state government and to state economies.[140] Resources provided through the Medicaid expansion frequently substitute for other state and local expenditures—for example, in the provision of correctional-system health services—and many Medicaid providers are actually public-sector entities or nonprofits financed by state or local governments.

Despite these benefits, many state officials and citizens report concerns regarding the fiscal burdens associated with ACA's Medicaid expansion. One simple response to these concerns would be for the federal government to assume all remaining costs of the Medicaid expansion in all states. Given that the federal government is already committed to permanently assume 90 percent of the costs of covering this relatively healthy population, this

step would require little added federal expenditure—about $5.2 billion to cover the 11.9 million newly eligible adults in calendar year 2020.[141]

CONSTRAIN 1115 WAIVERS

Section 1115 of the Social Security Act has long authorized research and demonstration projects in Social Security Act programs, including Medicaid. Medicaid research and demonstration projects have been used for decades to waive or vary program requirements, often for many years, without meaningful research purpose or oversight and with little transparency.[142] The ACA attempted to increase accountability for 1115 waivers, requiring opportunities for public comment both at the state and federal level and greater assurances that an 1115 project would actually comply with Medicaid requirements.[143]

After the NFIB decision, conservative states began demanding that program requirements be waived under section 1115 as a condition of the states expanding Medicaid.[144] In some ways, the resulting process has proved valuable. It has allowed genuine bipartisan negotiations between Republican state office-holders and the Obama administration, in which each side has strong incentives to expand health coverage. The resulting negotiation provided a politically palatable pathway for some states to implement Medicaid expansion despite deep-seated political opposition to the ACA itself.

States might also design innovative and constructive 1115 waivers that improve the terms of the Medicaid expansion. For example, a state might explore better mechanisms to reduce churn between the Medicaid and marketplace plans, or to better coordinate care for individuals and families who move from one program to the other. Arkansas' 1115 waiver program, which provides access for the Medicaid expansion population to the health insurance marketplace with premium assistance, appeared at least initially to help hold down premium increases and reduce "churn" between marketplace and Medicaid coverage.[145]

Caution is warranted, however, in reviewing 1115 waivers, as some states have submitted waiver requests that serve no research or demonstration purpose and are contrary to the goals of Medicaid itself. It is important for the Obama administration (and its successor) to reject waiver requests that would erode basic protections for Medicaid recipients.

Some waiver requests, seek to enroll Medicaid recipients into mandatory wellness programs or charge copayments for selected forms of emergency department care or other services. The RAND Health Insurance Experiment and subsequent research indicate that even modest copayments and deductibles deter use of valuable care and can harm individuals facing the dual challenge of low-income and significant injury or illness. Efforts to impose cost-sharing on low-income or chronically ill populations thus deserve particular scrutiny.[146] Although many specific waiver requests are poor public policy, these must be evaluated in light of their corresponding contributions to political compromise that might facilitate the provision of Medicaid to millions of low-income Americans who would otherwise go uninsured.

Some of the most concerning waiver requests would require families with incomes below the federal poverty line to pay monthly premiums, or to satisfy a work requirement. These policies limit Medicaid access by making the program unaffordable for precisely the low-income population that needs the greatest help.[147] Moreover, they likely cost more to administer than they can potentially save—outside of their role in deterring appropriate take-up of the Medicaid program.[148] The administration should continue to refuse 1115 waiver conditions that would suppress expansion-program

enrollment or make care unaffordable or that serve no legitimate research or demonstration purpose. If necessary, Congress should amend the Medicaid statute or section 1115 to prohibit such waivers.

ELIMINATE MEDICAID ESTATE RECOVERIES FROM THE EXPANSION POPULATION

The Medicaid statute allows states to recover program expenditures from the estates of certain Medicaid beneficiaries. This program is primarily targeted at elderly individuals who receive expensive long-term care and who may have a home or other assets that could be sold to repay the Medicaid program for the cost of these services at their death. The Medicaid statute, however, gives states the option of recovering Medicaid expenditures from the estates of any Medicaid beneficiary aged 55 or older. This includes beneficiaries in the expansion population.[149]

Ten states have indicated that they may try to recover Medicaid expenditures from the estates of expansion population enrollees aged 55 or over.[150] When beneficiaries are enrolled in a Medicaid managed care plan that is paid on a capitation basis, the full amount of the capitation charge is considered to be a Medicaid expenditure which could be recovered.[151]

The possibility of an estate claim may tend to discourage individuals who are aware of it from enrolling in Medicaid, regardless of their need for health care. In fact, Medicaid beneficiaries who fall within the expansion population are likely to account for low health care expenditures compared to the elderly long-term residents against whom the estate recovery program is directed. They are also likely to live for a considerable period, during which the state will have to keep track of these individuals and the expenditures it has incurred before it can finally make a claim against the estate.

Medicaid estate recovery raises serious concerns in every beneficiary population. Enforcement of the estate claims against the expansion population is especially unwise, imposing high administrative costs for minimum recoveries and deterring appropriate take-up of the Medicaid program. Congress should amend the statute to bar estate recoveries against the expansion population. Alternatively, states can amend their statutes or regulations to eschew estate recoveries against members of the expansion population. At the very least, research should be undertaken to determine what the costs and benefits would be of eliminating these requirement.

IMPROVE MEDICAID PAYMENT RATES

It is vitally important that Medicaid beneficiaries not only possess Medicaid coverage but are actually able to use that coverage to obtain care. Indeed, the ACA amended the Medicaid statute to clarify that states were obligated under the program not just to pay for care, but also to ensure that care was actually available.[152] For this to happen, providers must be paid rates sufficient to ensure adequate access.[153] There is evidence that higher Medicaid reimbursement rates are associated with improved health outcomes, including lower infant mortality.[154] Both liberal and conservative commentators regularly lament Medicaid's low reimbursement rates, though neither political party has invested significant political capital in maintaining more competitive rates.

In many states, Medicaid reimbursement rates have fallen below the levels required to ensure practical access to needed services. Indeed, six states—Rhode Island, Florida, New Jersey, California, Michigan, and New York—impose Medicaid reimbursements for primary care that are 50 percent or less of what Medicare pays for primary care services.[155] States that provide such low Medicaid payments for general or specialty providers are more likely to experience

access barriers among low-income recipients.[156] Such access barriers are most obvious in anonymous patient-caller tests, which in some states indicate that the majority of specialty physicians are reluctant to schedule appointments for Medicaid patients.[157] Other data indicate that physicians spend less time per visit treating Medicaid patients.

The ACA provided a temporary increase, covering 2013 and 2014, in selected Medicaid reimbursement rates to achieve parity with Medicare rates.[158] Recent research indicates that these changes induced significantly greater availability of appointments to Medicaid recipients, with the greatest improvement found in states that implemented the largest changes in reimbursement rates.[159] After reimbursement rates were increased by the ACA, Medicaid recipients were about 8 percentage points more likely to successfully schedule appointments (66.4 percent versus 58.7 percent success rate seeking to schedule appointments).[160]

Fifteen states have continued to provide such enhanced reimbursement after these provisions expired. Interestingly, some of these states, such as Mississippi, Alabama, and South Carolina, are among those most adamantly opposed to Medicaid expansion and other more politically prominent provisions of the ACA.[161] It is encouraging that political leadership in these states spans the ideological spectrum.

CMS has recently issued a final rule for ensuring access to care in state Medicaid fee-for-service programs.[162] Under the new rule, states are required to develop Access Monitoring Review Plans that specify data sources to be used to review beneficiary access. These plans must address the extent to which beneficiary needs are met, availability of care and providers, changes in beneficiary service utilization, and comparisons between Medicaid rates and rates paid by Medicare and commercial insurers. States must use these tools to review proposals for reducing or restructuring provider payments before submitting those proposals to CMS. States must also consider input from beneficiaries and providers prior to submitting such proposals. States will be required to monitor the effect of changes reducing or restructuring provider payments on access for at least three years after the changes are effective.

States must additionally review every three years access to a core set of services—primary care (including dental), physician specialists, behavioral health, pre- and post-natal obstetrics (including labor and delivery), and home health services. States may review additional services at their discretion and must also review services for which the states or CMS receive a high level of complaints. States are required to implement ongoing mechanisms for receiving provider and beneficiary feedback on access to care. States must develop remediation plans within ninety days of discovering an access deficiency that would correct the problem within twelve months.

The final rule is a step forward in ensuring access to care for Medicaid beneficiaries, but more needs to be done. First, the final rule does not provide beneficiaries or providers a mechanism for initiating CMS review of the adequacy of Medicaid access to care in a state. With access to the federal courts further limited by the *Armstrong* case (discussed below), beneficiaries and providers need some means for initiating an independent review of state limits on access to care. This rule does not provide it. Second, the rule does not provide any concrete metrics for determining whether access is sufficient. CMS has requested further information on what metrics might be appropriate, but for now leaves the states to develop their own metrics.[163] Finally, the rule does not prohibit states from implementing state plan amendments prior to CMS approval. Once a state submits a proposed amendment it can proceed to implement it, subject to later disapproval. CMS approval should be a prerequisite for implementation.

Congress should also make permanent ACA's 2013 and 2014 increases in Medicaid rates for primary care providers. As of June 2014, the federal government had spent an estimated $5.6 billion on this effort.[164] This is a relatively modest expenditure given the overall scale of Medicaid expenditures, and it could be expanded to important classes of specialty providers, particularly those with known supply shortages for the Medicaid population.

Another valuable carrot would be to raise the federal government's Medical Assistance Percentage (FMAP) on Medicaid services for states that pay providers competitive rates. This reform would provide states with concrete incentives to raise provider rates. It may also alter Medicaid politics by calling specific attention to these concerns at the state level.

One template policy would be to raise federal matching rates five percentage points for each service in which the state reimburses providers some minimum rate. The threshold could, for example, be set at 70 percent of the corresponding Medicare rate.[165] This modest threshold is close to the median in state rankings of the Medicare-Medicaid gap. Such a policy would have the further advantage of increasing overall federal support for Medicaid, which would relieve fiscal pressure on states.

ENSURE A JUDICIALLY ENFORCEABLE RIGHT TO ADEQUATE ACCESS TO MEDICAID PROVIDERS AND TO ADEQUATE MEDICAID PAYMENT RATES

The Supreme Court has long recognized that federal requirements under programs such as Medicaid enacted through the authority of Congress under the spending clause are binding on the states under the Supremacy Clause of the Constitution. State laws, regulations, and practices that violate the Medicaid statute are thus illegal. The federal government has limited power, however, to enforce these federal requirements. As a practical matter, it cannot defund Medicaid programs. While it can reduce funding to the states when states spend money in violation of federal law, this strategy is usually counterproductive, hurting the beneficiaries the program is intended to help. Moreover, federal enforcement actions against the states cannot be initiated by beneficiaries who are harmed by illegal state actions.

The Supreme Court has also long recognized that beneficiaries of Social Security Act public assistance programs, including Medicaid, are not able to enforce their rights through federal or state administrative proceedings, and thus are dependent on the federal courts to protect their rights. These rights are enforceable under 42 U.S.C. §1983, a Reconstruction-era civil rights statute that allows individuals who are harmed by the actions of state officials acting in their official capacity to sue for violation of their rights under federal law. Several courts have also in the past recognized the rights of Medicaid beneficiaries and providers to sue state officials directly under the Constitution's Supremacy Clause for violation of federal law.[166]

Under 42 U.S.C. § 1396a(a)(30)(A), a state that accepts federal Medicaid funds must adopt a state plan containing methods and procedures to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population." In *Armstrong v. Exceptional Child Center*,[167] the Supreme Court concluded that providers cannot sue state officials under the Supremacy Clause to enforce this requirement. Medicaid providers and beneficiaries are still permitted to sue under Section 1983 to protect rights that they are

clearly granted under the Medicaid program. Supreme Court decisions have sharply circumscribed the scope of rights protected by that provision, however, and the lower courts have generally held that providers have no rights to sue for adequate payments under this section.

The Department of Health and Human Services should provide beneficiaries and providers an administrative remedy for challenging inadequate provider access before CMS, as recommended above. Where CMS approves rates without adequate review or in the face of evidence that the rates are not adequate, providers and beneficiaries should be able to sue in federal court to review the CMS decision. Congress should also clarify that beneficiaries have a right to sue in federal court to enforce other Medicaid requirements. The courts should not be allowed to pare these rights back further.

RECONSIDER A "PUBLIC OPTION" EARLY MEDICARE COVERAGE WITHIN HEALTH INSURANCE MARKETPLACES

Early legislative draft versions of what eventually became the ACA included language that would have provided marketplace participants the option of purchasing public coverage, modeled on Medicare. The competing public option proposals considered at the time would also have allowed the public plan different degrees of leverage in exploiting Medicare's great market power for care provided to retirees to force doctors and hospitals to accept lower reimbursement rates for younger public option patients.

Fear of Medicare's bargaining power among insurers, hospital and physician groups, pharmaceutical firms, and medical supply and device companies politically doomed the public option in the 2008–10 ACA debate. The public option also raised significant implementation concerns. In the absence of proper risk-adjustment and plan regulation, public plans could fall prey to adverse selection, serving disproportionate numbers of the most costly, complex, or disadvantaged patients. Nonetheless, a well-designed public option might seriously compete with private coverage. It would also impose needed price discipline on providers, particularly those that dominate particular local market areas.

Congress rejected public option proposals during the ACA debate, substituting in its place a nonprofit cooperative (CO-OP) insurance program. The CO-OP program was severely hobbled by legislative restrictions, however, and was further weakened by funding limits imposed by subsequent congresses. Half of the CO-OPs have now failed. The program has not proven an adequate substitute for a robust public option. Considering the defects of the CO-OP program, it may be time to reconsider the public option, despite the political and operational challenges.

One initial step could be to offer a public plan to people over the age of 60. This is a costly coverage group, whose needs most closely resemble traditional Medicare. Many near-retirees face rather high premiums and out-of-pocket expenses, yet earn too much to receive marketplace subsidies. A public option plan geared to this population may thus be especially beneficial. A demonstration project within selected markets with limited insurer competition might demonstrate important benefits for both patients and payors.

RAISE OR ELIMINATE MEDICAID AND SUPPLEMENTAL SECURITY INCOME ASSET LIMITS FOR PEOPLE LIVING WITH DISABILITIES

The ACA assists Americans living with disabilities through a number of important provisions, including the elimination of annual and lifetime insurance caps, bans on discrimination based on preexisting conditions, and the requirement of essential health benefit

coverage in the individual and small group market, including benefits previously limited or unavailable through commercial insurance, such as rehabilitation and habilitation services. The ACA also supported a number of demonstration projects and supports for state governments, such as the Balancing Incentive Program, seeking to reduce reliance on institution-based care.[168]

Despite these advances, the ACA failed to address several issues of special importance to the disability community. The ill-fated CLASS Act—the Community Living Assistance Services and Supports program, which would have offered a long-term insurance option that would allow the elderly and disabled to remain in their homes—was the most prominent provision specifically directed to disability concerns.

One important issue unaddressed in the ACA concerns the asset limits imposed on individuals who become Medicaid recipients on the basis of a qualifying disability.[169] Medicaid asset limits aggravate the separate and stringent asset limits imposed by the Supplemental Security Income (SSI) program, which limits countable resources to $2,000 for an individual and $3,000 for a couple.[170] These asset limits exclude from consideration the value of one's residence, one vehicle, and personal effects such as wedding rings. Yet they count even modest emergency savings, retirement accounts, life insurance, and other routine financial tools that people with disabilities likely need to live in the economic mainstream.

Retention of Medicaid asset limits is especially puzzling, because benefits provided through Medicaid's eligibility expansion for low-income recipients do not impose similar asset requirements. Thus, individuals who receive Medicaid on the basis of spinal cord injury are typically barred from possessing more than a few thousand dollars in financial assets. Yet in the same states, individuals who qualify for Medicaid on the basis of low-income face no similar asset limitation.

The extreme nature of these asset limits has generated bipartisan calls for less-stringent policies. The Achieving a Better Life Experience (ABLE) Act represents one effort to address this challenge. The bill was co-sponsored by seventy senators and by 359 members of the House. The presence of such co-sponsors as Senators Bernie Sanders, Jay Rockefeller, Mitch McConnell, and James Inhofe indicates the bipartisan support for a change.[171]

The ABLE Act establishes tax-advantaged accounts modeled on the 529 accounts many affluent parents use to save for their children's college expenses. These accounts can be used for qualified expenses, including education, housing, training services, technology, and transportation. These accounts are exempt from Medicaid asset limits. Families can contribute up to $14,000 annually, with the first $100,000 exempt from standard SSI asset limits. Individuals who accumulate more than $100,000 become ineligible for SSI cash benefits but would retain Medicaid eligibility.[172]

The ABLE Act helps many families with long-term saving and planning by freeing them from tight asset limits. By reducing the complexity of financial planning, it reduces incentives for furtive or otherwise unwise Medicaid asset-shielding practices. Yet the ABLE Act has key limitations. Most important, it is confined to individuals whose onset of disability was prior to age 26. Most people with adult-onset disabilities are thus excluded. The ABLE Act does not address other financial assets people might have accumulated over the course of their lives.

One obvious improvement in the ABLE Act would be to raise the age threshold to 65. This would provide substantial protection to the entire population of working age living with disabilities. Congress should also substantially increase Medicaid financial asset thresholds for individuals with qualifying disabilities.

Raising these thresholds to $100,000 would accommodate the typical needs of disabled individuals while retaining incentives for the truly affluent to obtain private insurance for long-term care.

Raising Medicaid and SSI asset limits is only one component of a more comprehensive policy. This policy change would at least render Medicaid policies less punitive and destructive when individuals encounter disability, while improving incentives for saving and investment. Given support among both Democrats and Republicans for such efforts, this is one fruitful area for bipartisan compromise.[173]

CONCLUSION

Even as the successes of the ACA become increasingly apparent and it becomes more deeply embedded in our health care system, political calls to repeal it continue. The House of Representatives has voted nearly sixty times to repeal the ACA. Yet a majority of Americans would rather keep or expand the law than repeal it.[174] Millions of Americans are now insured through ACA. Millions more benefit from its regulatory protections, such as bans on insurer discrimination against the sick and injured. Billions of dollars are now flowing to state governments, insurers, and medical providers. In short, ACA is now embedded in the fabric of American life.

This report offers a number of proposals for building on the ACA, to make health coverage and health care even more affordable, accessible, and understandable for Americans. We understand that in the current political climate, improvements to the ACA that require congressional action are unlikely. Yet an administration committed to improving access could take some of the actions we recommend without new legislation, while other proposals could be implemented by the states, marketplace, or simply by insurers.

The ACA was the beginning, not the end, of a process that holds out the promise of transforming health insurance and health care for the better. It has covered millions of people who otherwise would be uninsured. It has set in place mechanisms to help control the growth of spending. It will enhance the quality of health care by improving information and promoting competition. But, like most major laws, it contains flaws and left many problems unaddressed. It was the first, not the last, word in health reform. "Repair and improve," not "repeal and replace," is the current political and policy challenge.[175] We hope our report advances this goal.

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By Adele Shartzer, Sharon K. Long, and Nathaniel Anderson

Access To Care And Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain

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ABSTRACT There is growing evidence that millions of adults have gained insurance coverage under the Affordable Care Act, but less is known about how access to and affordability of care may be changing. This study used data from the Health Reform Monitoring Survey to describe changes in access and affordability for nonelderly adults from September 2013, just prior to the first open enrollment period in the Marketplace, to March 2015, after the end of the second open enrollment period. Overall, we found strong improvements in access to care for all nonelderly adults and across income and state Medicaid expansion groups. We also found improvements in the affordability of care for all adults and for low- and moderate-income adults. Despite this progress, there were still large gaps in access and affordability in March 2015, particularly for low-income adults.

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Beginning in January 2014 the Affordable Care Act (ACA) expanded access to health insurance coverage through the establishment of health insurance Marketplaces offering premium and out-of-pocket subsidies for certain individuals and, at state option, the expansion of Medicaid eligibility to nearly all adults with family income at or below 138 percent of the federal poverty level. As of January 2014 twenty-four states and the District of Columbia were participating in the Medicaid expansion, and as of December 2015 five more states had opted in.[1] Evidence to date from a variety of private nongovernmental surveys such as Gallup and RAND[2] showed a marked decrease in uninsurance for nonelderly adults through March 2015, which corresponded with the end of the second open enrollment period for the Marketplace. Estimates of the decline in uninsurance for nonelderly adults ranged from 14.1 million to 16.9 million.[3–6] The federal Current Population Survey reports a decline of 8.8 million uninsured people between 2013 and 2014, and early-release estimates from the National Health Interview Survey (NHIS) through June 2015 show a decline of 14.7 million uninsured nonelderly adults, with a larger percentage decrease in Medicaid expansion states compared with a smaller but still significant decrease in nonexpansion states.[7,8] These findings echo earlier estimates from the private surveys and provide support for the value of private surveys in early tracking of the ACA.

These gains in health insurance coverage would be expected to translate into improved health care access and affordability as insurance coverage has been found to be strongly associated with higher levels of access to care and reduced challenges to affordability of health care.[9,10] To date, little is known about how access to and affordability of care are changing under the ACA, although early evidence suggests that these outcomes are improving.[11–13] Notwithstanding that early evidence, the timeline for gains in access and affordability for the newly insured is difficult to predict, as these individuals may need to learn how to use their new insur-

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ance coverage and may need to change their care-seeking patterns and behaviors or may run into provider capacity issues as they seek care.[14–16]

Prior evidence from insurance expansions such as the Children's Health Insurance Program,[17,18] the 2006 Massachusetts health reform,[19,20] and the Oregon Health Insurance Experiment[21,22] shows improvements in access and affordability over time as coverage is increased, although these studies do not capture the national effects of a multifaceted approach to expanding coverage to adults such as the ACA. In addition, other provisions of the ACA such as expanded coverage for certain preventive services could influence access to care for the broader population.

This study adds to previous literature by examining changes in access to and affordability of care for nonelderly adults from September 2013, just before the first open enrollment period for the Marketplace, to March 2015, just after the second open enrollment period.[23] The study uses data from the Health Reform Monitoring Survey (HRMS), a nationally representative survey conducted by the Urban Institute that benchmarks well against federal surveys.[24] We examined changes among all nonelderly adults as well as among key subgroups targeted by the ACA coverage provisions, including lower-income adults and adults in states that expanded Medicaid.[25] We also identified where gaps in access and affordability remained more than a year into ACA implementation.

Study Data And Methods

DATA The HRMS, a quarterly Internet-based survey that began in early 2013, provides real-time estimates on ACA implementation and outcomes to complement the more robust assessments that will be possible when federal survey data are available. The HRMS is based on cross-sectional samples of about 7,500 nonelderly adults ages 18–64 per quarter drawn from market research firm GfK's KnowledgePanel.[26] Each round of the HRMS is weighted to be nationally representative. Additional information on the HRMS and the measures used in this study are available in the online Appendix.[27]

For surveys based on Internet panels, the overall response rate incorporates the survey completion rate (about 60 percent for the HRMS) as well as the rates of panel recruitment and panel participation over time, for an overall completion rate of about 5 percent each quarter.[28,29] Despite the low response rate, studies assessing KnowledgePanel for its reliability have found little evidence of nonresponse bias and have yielded comparable estimates to phone surveys for a range of measures related to demographic and socioeconomic characteristics, health status and behaviors, and other characteristics.[30,31] In benchmarking the HRMS estimates to the NHIS, researchers found greater access and affordability problems among adults in the HRMS compared to the NHIS across most of the measures. These results are consistent with other comparisons, which have found that respondents are more likely to report problems in self-administered surveys, such as the HRMS, than in phone or face-to-face surveys administered by an interviewer.[24] These systematic differences in the reported levels of access and affordability measures are of less concern here, given that we were focused on changes over time.

MEASURES OF ACCESS AND AFFORDABILITY For measures of access to care, we focused on whether the respondent reported having a usual source of care, a routine checkup within the past twelve months, or one or more problems accessing care in the past twelve months.[27] Measures of affordability of care included whether an individual reported an unmet need for care because of cost or problems paying family medical bills in the past twelve months.

DEFINING FAMILY INCOME We focused on three income groups: adults with family incomes at or below 138 percent of poverty, who are targeted by the ACA's Medicaid expansion (referred to as low-income adults); adults with family incomes between 139 percent and 399 percent of poverty, who are targeted by subsidies for coverage through the Marketplace (referred to as moderate-income adults); and adults with family incomes of 400 percent of poverty or higher (referred to as higher-income adults). In states that have not expanded Medicaid, subsidies for coverage through the Marketplace begin at 100 percent of poverty, so some low-income adults are eligible for Marketplace subsidies and some will be eligible for Medicaid under pre-ACA standards. In the HRMS, "family" includes a spouse and dependent children younger than age nineteen living with the respondent, reflecting the health insurance units used for determining eligibility for public or private coverage.[32]

METHODS For this analysis we compared access and affordability in March 2015 to that in September 2013 using multivariate regression models based on all nine rounds of the HRMS. In the regression models, we controlled for differences in the demographic and socioeconomic characteristics of the respondents across the different rounds of the survey.[33] This allowed us to remove changes in access and affordability caused by changes in the types of people responding to the survey over time instead of by changes in the health insurance and health care landscape.

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To address changes in the economy, we also controlled for the county unemployment rate and county labor-force growth. The basic patterns shown for the regression-adjusted measures are similar to those based solely on simple estimates.

In presenting the regression-adjusted estimates, we used the predicted rate of the outcome in each quarter for the same nationally representative population. For this analysis we based the nationally representative sample on survey respondents from the most recent twelve-month period of the HRMS (that is, the second, third, and fourth quarters of 2014 and the first quarter of 2015). We focused on statistically significant changes in access and affordability between September 2013 and March 2015 (defined as changes that are significantly different from zero at the 5 percent level or lower).

LIMITATIONS There were several limitations to this analysis. First, as with all surveys, the HRMS relies on self-reported data, which are subject to potential biases and recall error. Second, because our estimates captured changes in outcomes from just prior to the first open enrollment period under the ACA, we understated the full scope of changes under the ACA. The reason is that the estimates did not capture the effects of some important ACA provisions (such as the dependent coverage expansion to age twenty-six and early state Medicaid expansions) that were implemented before September 2013. In addition, to the extent that other factors were changing over the same time period that were not controlled for in the regression model (such as expanding legalization of same-sex marriage), these estimates will also capture the effects of those changes. Studies that attempt to disentangle the impacts of the ACA from other factors changing between 2013 and 2015, including comparing previously insured adults to uninsured or newly insured adults, will need to rely on federal surveys, with their longer time frames and larger sample sizes. The HRMS would not allow us to identify changes in outcomes that are the result of increased insurance coverage versus changes in the distribution of health insurance coverage or other changes, including changes in the economy.

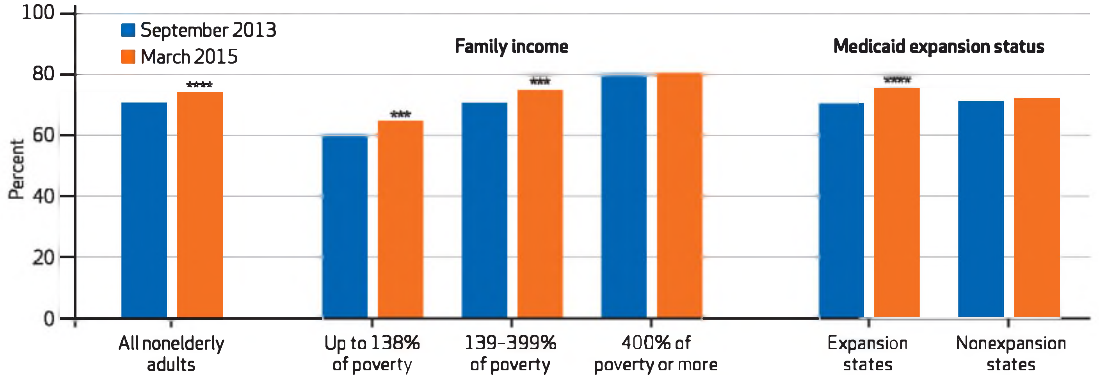
Study Results

We found improvements in access to care and affordability of care for all nonelderly adults between September 2013 and March 2015. Furthermore, health care access and affordability improved for adults at all income levels and for adults in both Medicaid expansion and nonexpansion states, consistent with the broad expansion in health insurance coverage under the ACA.[3,7,8]

The share of nonelderly adults with a connection to the health care system increased under the ACA, as more low- and moderate-income adults reported a usual source of care in March 2015 than in September 2013 (Exhibit 1). In March 2015, 73.9 percent of nonelderly adults reported having a usual source of care—an increase of 3.4 percentage points from September 2013. Among low-income adults targeted by the Medicaid expansion, there was a 5.2-percentage-point increase in the share with a

EXHIBIT 1

Share Of Nonelderly US Adults With A Usual Source Of Care, By Family Income And State Medicaid Expansion Status, September 2013 And March 2015



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. Expansion status is of January 1, 2014 (twenty-four states and the District of Columbia). "Family" is the health insurance unit, which reflects eligibility for family health insurance coverage. Estimates of percentage-point changes calculated from exhibits may differ from those reported in the text because of rounding. ***$p < 0.01$ ****$p < 0.001$

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usual source of care. In addition, the share of moderate-income adults showed a significant increase of 4.2 percentage points. Among adults in expansion states, there was a 4.9-percentage-point increase in the share with a usual source of care; the small increase among adults in nonexpansion states was not statistically significant.

Despite these gains, in March 2015, 25.7 percent of nonelderly adults reported that they did not have a usual source of care; these adults were more likely to be young (ages 18–29), male, Hispanic, and low income compared with adults who had a usual source of care (data not shown).

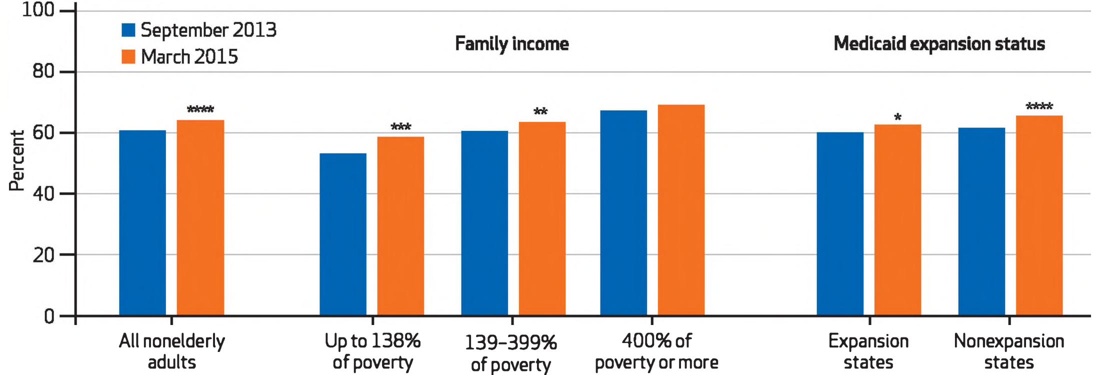
The share of adults using health care also increased as more adults reported a routine checkup in the past twelve months between September 2013 and March 2015 (Exhibit 2). Obtaining a usual source of care is an important indicator of potential access to care; a routine checkup—although imperfect, as not all adults will need a routine care visit during a given year[34]—provides a measure of realized access. The share of nonelderly adults who had a routine checkup in the past twelve months increased 3.4 percentage points to 64.0 percent. All groups experienced an increase in routine checkups in the past twelve months, although the increase was not statistically significant ($p < 0.05$) for adults with higher incomes and adults in Medicaid expansion states.

Consistent with stronger connections to the health care system and increased health care use, the share of adults reporting problems obtaining health care decreased between September 2013 and March 2015 (Exhibit 3). Looking across all adults, access problems declined from 18.7 percent in September 2013 to 16.4 percent in March 2015. These declines occurred across the income and Medicaid expansion groups, including significant declines among higher-income adults and adults in expansion states. Among those who reported access problems in March 2015, 30.1 percent could not find a doctor who would see them; 35.0 percent were told that a doctor was not taking new patients; 44.3 percent were told that a doctor's office did not accept their insurance type; and 67.3 percent delayed care because they could not get an appointment (data not shown).[35] Adults who reported access problems were more likely to be younger, female, Hispanic, low income, and in fair or poor health than adults with no reported access problems (data not shown).

Affordability of care improved, with a lower share of nonelderly adults reporting unmet need for care because of cost during the past twelve months in March 2015 than in September 2013 (Exhibit 4). In March 2015, 32.3 percent of nonelderly adults reported unmet need for care because of cost—a 2.7-percentage-point decrease from September 2013. Unmet need for care decreased markedly among low-income adults, declining 10.5 percentage points from 55.3 percent in September 2013 to 44.8 percent in March 2015. This decrease likely reflects the strong cost-sharing protections in Medicaid and the cost-sharing subsidies for coverage through the Marketplace in nonexpansion states. Unmet need for care because of cost did not change significantly among moderate- and higher-income adults. The decreases in unmet need for care because of cost seen in both Med-

EXHIBIT 2

Share Of Nonelderly US Adults With A Routine Checkup In The Past Twelve Months, By Family Income And State Medicaid Expansion Status, September 2013 And March 2015



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. Expansion status is of January 1, 2014 (twenty-four states and the District of Columbia). "Family" is the health insurance unit, which reflects eligibility for family health insurance coverage. Estimates of percentage-point changes calculated from exhibits may differ from those reported in the text as a result of rounding. $*p < 0.10$ $**p < 0.05$ $***p < 0.01$ $****p < 0.001$

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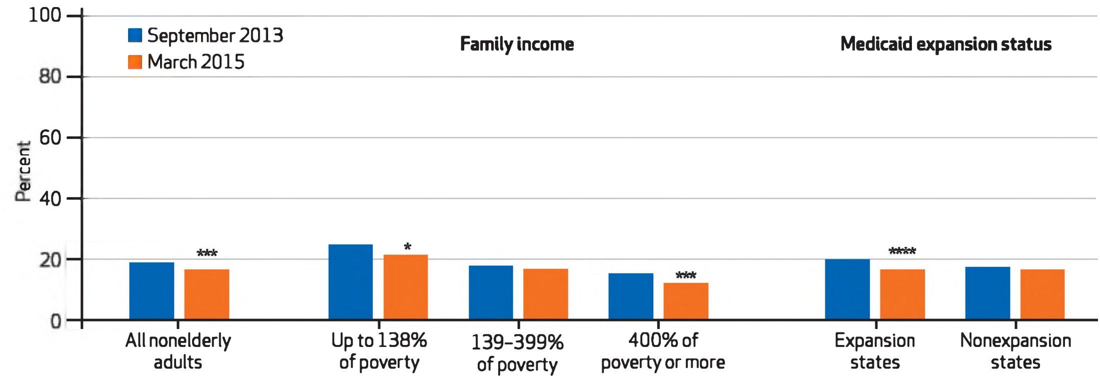
EXHIBIT 3

Share Of Nonelderly US Adults Reporting Problems Accessing Care In The Past Twelve Months, By Family Income And State Medicaid Expansion Status, September 2013 And March 2015



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. Expansion status is of January 1, 2014 (twenty-four states and the District of Columbia). "Family" is the health insurance unit, which reflects eligibility for family health insurance coverage. Estimates of percentage-point changes calculated from exhibits may differ from those reported in the text because of rounding. $*p < 0.10$ $***p < 0.01$ $****p < 0.001$

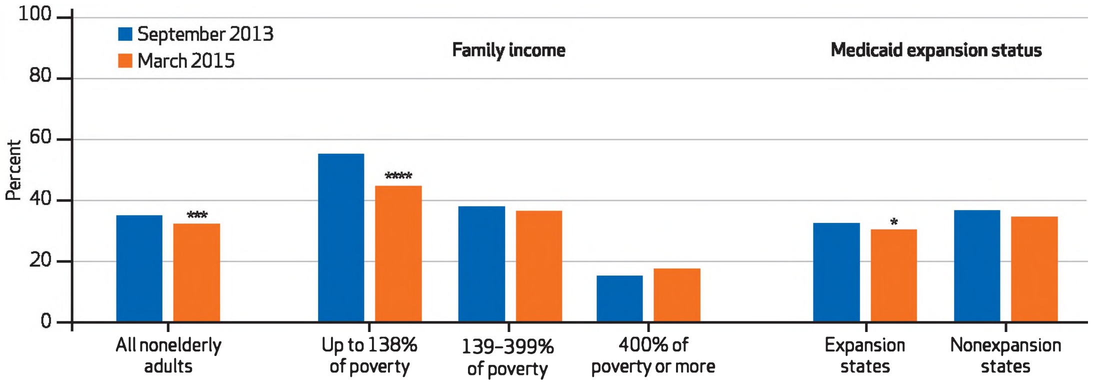
icaid expansion and nonexpansion states were not statistically significant ($p < 0.05$).

Among adults who reported an unmet need for care because of cost, gaps in the affordability of dental care (70.1 percent) and prescription drugs (47.5 percent) were particularly high (data not shown). Despite enhanced coverage for many preventive services under the ACA, coverage for dental care was left largely unchanged.[36]

Problems paying family medical bills similarly declined between September 2013 and March 2015, particularly for low-income adults (Exhibit 5). Low-income adults reported a 10.5-percentage-point decline in family medical bill problems—down to 24.2 percent in March 2015—while moderate-income adults reported a smaller decline of 3.1 percentage points. In contrast, the share of higher-income adults reporting problems paying family medical bills held steady at about 7.0 percent. There were reductions in problems paying medical bills for adults in both Medicaid expansion and nonexpansion states (4.8 and 2.8 percentage points, respectively). Problems paying medical bills in March 2015 were most prevalent for women, low-income adults, and adults in fair or poor

EXHIBIT 4

Share Of Nonelderly US Adults With Unmet Need For Care Because Of Cost During The Past Twelve Months, By Family Income And State Medicaid Expansion Status, September 2013 And March 2015



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. Expansion status is of January 1, 2014 (twenty-four states and the District of Columbia). "Family" is the health insurance unit, which reflects eligibility for family health insurance coverage. Estimates of percentage-point changes calculated from exhibits may differ from those reported in the text because of rounding. $*p < 0.10$ $***p < 0.01$ $****p < 0.001$

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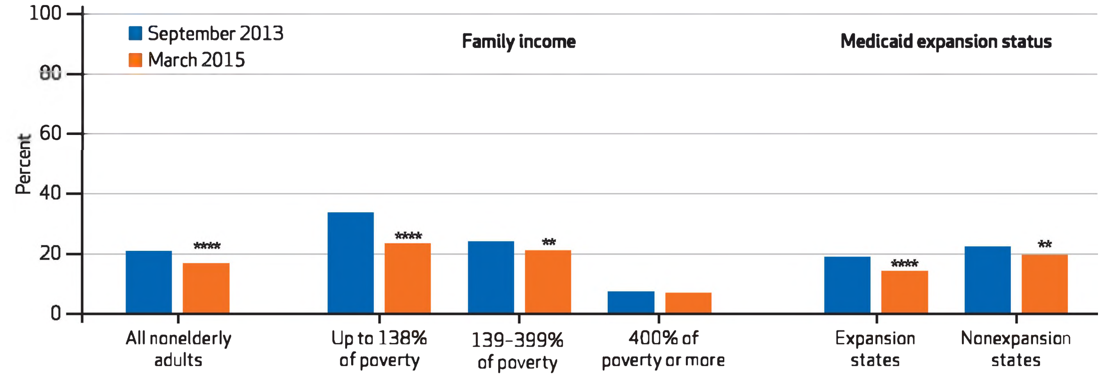
EXHIBIT 5

Share Of Nonelderly US Adults With Problems Paying Family Medical Bills In The Past Twelve Months, By Family Income And State Medicaid Expansion Status, September 2013 And March 2015



SOURCE Authors' analysis of data from the Health Reform Monitoring Survey. **NOTES** Estimates are regression-adjusted. Expansion status is of January 1, 2014 (twenty-four states and the District of Columbia). "Family" is the health insurance unit, which reflects eligibility for family health insurance coverage. Estimates of percentage-point changes calculated from exhibits may differ from those reported in the text because of rounding. ** $p < 0.05$ **** $p < 0.001$

health (data not shown).

As our exhibits demonstrate, despite significant improvements in access to care and affordability of care between September 2013 and March 2015, problems in access and affordability still exist, especially for low-income adults. In March 2015 a quarter of nonelderly adults and a third of low-income adults did not have a usual source of care. Access problems were also common, with 16.4 percent of nonelderly adults and 21.3 percent of low-income adults reporting a problem accessing care in the past twelve months. Similarly, while affordability problems declined significantly among low-income adults, 44.8 percent of low-income adults reported unmet need for care because of cost, and 24.2 percent reported having problems paying medical bills in the past twelve months. Moderate-income adults also reported affordability challenges in March 2015, with 36.6 percent reporting unmet need for care because of cost and 21.6 percent reporting problems paying family medical bills. This highlights the burden of health care costs even among more middle-class families.

Discussion

By March 2015—more than a year following the implementation of the ACA's major coverage provisions and the increases in coverage that have been reported across a number of studies[3,4,6–8]—we found significant improvements in access to care and significant reductions in affordability challenges. Reflecting the focus of many provisions in the ACA on low-income adults, we found great improvements in access and affordability for the adults targeted by the ACA Medicaid expansion, who also had the lowest baseline levels of access and affordability in September 2013.

At the same time, improved access to care for higher-income adults suggests that factors beyond the ACA's coverage provisions—such as delivery system reform, enhanced coverage for preventive services, and the individual mandate, along with other factors that we did not capture in our analysis, such as broader changes in the economy—could be contributing to the observed gains in access to care. Furthermore, while we expected greater gains in access and affordability in expansion states given the stronger coverage gains there, differences across states in unmeasured characteristics of newly insured adults could also have affected estimates of change in access and affordability. For example, adults in nonexpansion states who gained Medicaid coverage, who are more likely to be very low income, may be sicker and less stable than adults in expansion states gaining coverage and, thus, stand to benefit more from new coverage.

There was concern that the ACA's rapid expansion of health insurance coverage would strain the health system and have detrimental effects for those already "in the system." With measures improving or at least holding steady for all of the subgroups we examined, our findings suggest that gains for low-income adults have not detracted from health care access and affordability for other adults.

While we did see improvements in access and affordability early in the ACA implementation,

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Despite recent progress, there is still much to do to improve access and affordability for Americans overall.

we would expect additional gains over time as health insurance coverage becomes the norm for more Americans. Continued monitoring of key outcomes is needed to assess whether those long-term gains are achieved. Finally, despite recent progress, there is still much to do to improve access and affordability for Americans overall, given the prevalence of the problems that persisted in March 2015, especially for low-income adults. More than 40 percent reported that it had been a year or more since they had a routine checkup and that they had gone without needed care because of costs over the past year; more than 20 percent reported problems accessing care and trouble paying family medical bills over the past year. Outreach and education efforts to enroll the remaining uninsured could make further headway in addressing access and affordability gaps, particularly those with incomes in the range targeted by the ACA's Medicaid expansion and subsidies for Marketplace coverage. However, federal and private resources to support these efforts are limited and declining as the pace of implementation slows down. In addition, measures to improve health insurance and health care literacy such as consumer-friendly tools to support health plan selection, care-seeking behaviors, and treatment decisions can further increase access to care and affordability for people across the income spectrum, helping people find available providers and make informed decisions based on health care cost and outcomes data. These tools could be especially beneficial for low-income adults who are newly insured as they transition into the health care system.

Conclusion

Other policy changes are on the horizon that may affect access to and affordability of care, particularly for low-income adults. Reductions in funding for uncompensated care could limit the ability to access safety-net services, particularly for uninsured adults in Medicaid nonexpansion states and for noncitizens who are not eligible for coverage under Medicaid or the Marketplace.[37] Temporary increases in Medicaid reimbursements for primary care providers that ended in December 2014 could also affect access to care for Medicaid beneficiaries through 2015 and beyond.[38] Continued monitoring of the impact of the ACA and related policy developments on insurance coverage, access to care, and affordability of care will help determine whether this landmark legislation is meeting its key goals or whether further refinements are needed. ■

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By Sayeh Nikpay, Thomas Buchmueller, and Helen G. Levy

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DATAWATCH

Affordable Care Act Medicaid Expansion Reduced Uninsured Hospital Stays In 2014

In states that expanded Medicaid, uninsured hospital stays decreased sharply and Medicaid stays increased sharply in the first two quarters of 2014. There was no change in payer mix in states that did not expand Medicaid.

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Helen G. Levy is a research associate professor in the Institute for Social Research at the University of Michigan.

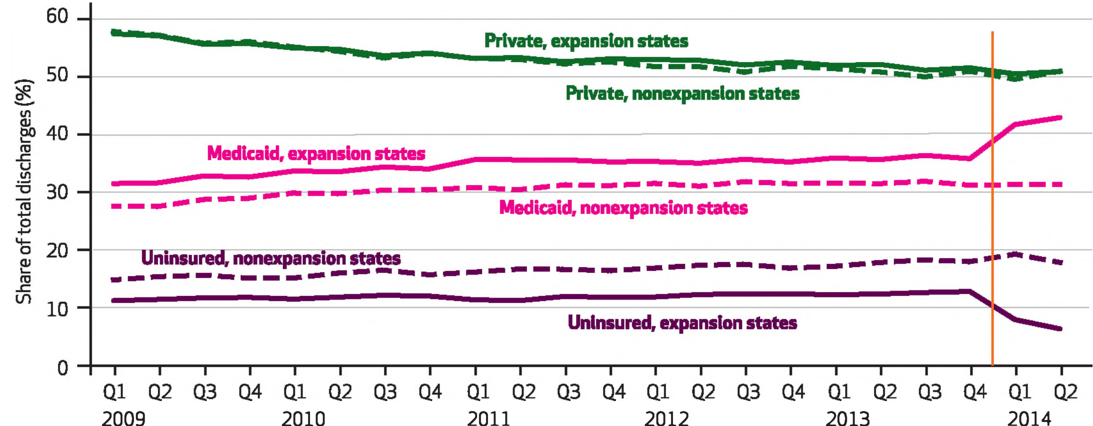
In their first year, the main coverage provisions of the Affordable Care Act (ACA)—related to the health insurance Marketplaces and expansions of eligibility for Medicaid—resulted in up to seventeen million Americans' gaining coverage.[1-4] Early analyses suggest that coverage expansion has increased access to physicians and reduced cost-related barriers to care, with the largest effects occurring in the twenty-nine states (including the District of Columbia) that had expanded Medicaid by the first quarter of 2015.[4,5]

In addition to the benefits of coverage for the newly insured, the prospect that reducing the number of uninsured patients would also reduce hospitals' burden of uncompensated care figured importantly in the debate over the ACA and persists in state-level discussions concerning Medicaid expansion.[6,7] To shed light on whether coverage expansions are delivering on this promise, we present newly available data on trends in payer mix for non-Medicare adult inpatient hospital stays from HCUP Fast Stats, a new online database query tool from the Agency for Healthcare Research and Quality (AHRQ).[8]

States that expanded eligibility for Medicaid in 2014 (Arizona, California, Colorado, Hawaii, Iowa, Kentucky, Minnesota, New Jersey, and New York) saw dramatic decreases in uninsured hospital stays and increases in Medicaid-covered stays, while those that did not (Florida, Georgia, Indiana, Missouri, Virginia, and Wisconsin) experienced very little change in the mix of payers for inpatient care (Exhibit 1). Indiana expanded

EXHIBIT 1

Trends In The Share Of Private, Medicaid, And Uninsured Discharges Of Non-Medicare Adult Hospital Inpatients In Expansion And Nonexpansion States, Before And After Expansion, By Quarter, 2009–14



SOURCE Authors' analysis of discharge data from the Agency for Healthcare Research and Quality's HCUP Fast Stats (see Note 8 in text). **NOTES** The data come from nine states that expanded eligibility for Medicaid (Arizona, California, Colorado, Hawaii, Iowa, Kentucky, Minnesota, New Jersey, and New York) and six states that did not (Florida, Georgia, Indiana, Missouri, Virginia, and Wisconsin). Data are weighted by total non-Medicare hospital discharges. The orange line indicates the beginning of the implementation of the Affordable Care Act's major coverage provisions, including Medicaid expansion.

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its Medicaid program in 2015. Results are based on fifteen states for which data were available through at least the second quarter of 2014.

These results build on previous analyses of the early experiences of several states and of five large for-profit hospital chains, which suggested that coverage expansions shifted the mix of payers for inpatient care toward Medicaid and away from self-pay, reducing uncompensated care.[9–11] Our analysis also makes it possible to disentangle the relative importance of Medicaid expansion versus the private Marketplace expansion in driving changes in payer mix. This analysis provides the best evidence to date on how ACA coverage expansions affected the mix of payers for hospitalized patients, and what states that so far have chosen not to expand Medicaid might expect to experience should they decide to embrace expansion in the future.

Study Data And Methods

HCUP Fast Stats is a new online database query tool maintained by AHRQ that reports adult hospital discharges by calendar quarter at the state level.[8] The underlying data are drawn from state hospital discharge databases participating in the Healthcare Cost and Utilization Project (HCUP) that contain information on all discharges in the state and cover more than 95 percent of inpatient hospitalizations in each state. HCUP Fast Stats provides state-level data aggregated by patient age and primary expected source of payment (Medicaid, private insurance, Medicare, and no insurance).

Forty-one states participate in HCUP Fast Stats, and data through at least the second quarter of 2014 are available for sixteen of these states. We excluded one of those states—Michigan—from our analysis because its Medicaid expansion did not take effect until the second quarter of 2014. Collectively, the remaining fifteen states represent 54 percent of the US population. Our analytic sample consisted of quarterly observations from these states, from the first quarter of 2009 through the second quarter of 2014.

To assess the impact of the ACA's coverage provisions on hospital payer mix, we divided states into those that did and those that did not expand Medicaid, and we compared changes before and after coverage expansions. Underlying payer-mix data are available in online Appendix Exhibit 1.[12] We used multivariate linear regression to compare changes in payer mix over time between states that did and those that did not expand Medicaid in a difference-in-differences analysis, controlling for state-level demographic and economic characteristics.

We also present state-specific changes in payer mix between the third quarter of 2013 and the second quarter of 2014. The state-specific results show that the aggregate differences between expansion and nonexpansion states evident in Exhibit 1 were not driven by the experiences of one or two large states in each group; instead, they reflect trends that were evident across most states within each group.

Study Results

Several important facts are evident from Exhibit 1. First, the proportions of Medicaid and uninsured inpatients were gradually increasing during the years leading up to 2014, while the proportion of inpatients with private coverage was gradually decreasing. This mirrors well-documented trends in the insurance coverage of the general population.[13]

Second, before the ACA coverage expansions, states that later expanded Medicaid had higher Medicaid shares and lower uninsured shares, compared to nonexpansion states. However, trends in the inpatient payer mix were quite similar in expansion and nonexpansion states.

Third, and most striking, the data show a sharp break in the trends in Medicaid and uninsured shares in the first two quarters of 2014 for expansion states only. Between the third quarter of 2013 and the second quarter of 2014, expansion states experienced a 7-percentage-point jump in the Medicaid share and a 6-percentage-point drop in the uninsured share. These differences represent a 20 percent increase and a 50 percent decrease in Medicaid and uninsured discharges, respectively. Meanwhile, in nonexpansion states, changes in Medicaid and uninsured discharges were small—less than 1 percentage point—and not significant.

Exhibit 2 summarizes the levels of and changes in payer mix between the period before expansion, defined as the first quarter of 2009 through the third quarter of 2013, and the latest period after expansion for which data were available, defined as the second quarter of 2014, for the two groups of states. We chose to include the fourth quarter of 2013 in the period after expansion because previous work has found that Medicaid coverage began to increase during the open enrollment period.[2,4]

Exhibit 2 also presents simple difference-in-differences estimates of the effect of Medicaid expansion, including adjusted differences-in-differences based on multivariate regression analyses that controlled for economic and demographic differences across individual states (full results are available in Appendix Exhibit 2).[12] The results from this more rigorous statistical

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EXHIBIT 2

Changes In Hospital Payer Mix For Discharges Of Non-Medicare Adult Inpatients In Medicaid Expansion And Nonexpansion States, Before And After Expansion

	Before expansion	After expansion	Difference	Unadjusted DD	Adjusted DD
Uninsured discharges					
Expansion	0.118	0.062	−0.056***		
Nonexpansion	0.163	0.178	0.014		
DD				−0.070**	−0.086**
Medicaid discharges					
Expansion	0.344	0.429	0.085***		
Nonexpansion	0.303	0.313	0.010		
DD				0.075***	0.062*
Private discharges					
Expansion	0.538	0.509	−0.029***		
Nonexpansion	0.533	0.509	−0.024**		
DD				−0.005	0.024

SOURCE Authors' analysis of discharge data from the Agency for Healthcare Research and Quality's HCUP Fast Stats (see Note 8 in text). **NOTES** The analysis sample includes 330 quarter-year observations from nine states that expanded eligibility for Medicaid and six states that did not. "Before expansion" is the first quarter of 2009 through the third quarter of 2013. "After expansion" is the second quarter of 2014. The exhibit shows the average share of total hospital discharges for uninsured, Medicaid, and privately insured discharges. Adjusted regressions control for the fraction of the state's population that is female, married, has a less than a high school diploma, average age, unemployment rate, and income categories. Regression details are included in Appendix Exhibit 2 (see Note 12 in text). DD is difference-in-differences. $^*p < 0.10$ $^{**}p < 0.05$ $^{***}p < 0.01$

analysis confirm the significant drop in the uninsured and the significant increase in the Medicaid discharges in expansion—but not in nonexpansion—states following the coverage expansions in 2014 (Exhibit 1).

Finally, we saw no significant change in the share of inpatients with private insurance in expansion states relative to nonexpansion states (Exhibit 2). This should not be taken to mean that the ACA did not expand private coverage. On the contrary, previous work suggests that it has.[2–4] A more likely explanation is that the majority of uninsured individuals who were sick enough to need hospital care in 2013 gained Medicaid, instead of private coverage, in 2014 because they had very little income. In addition, because of the initial problems with the Marketplace enrollment websites, much of the enrollment in private health plans occurred at the end of the first quarter of 2014.

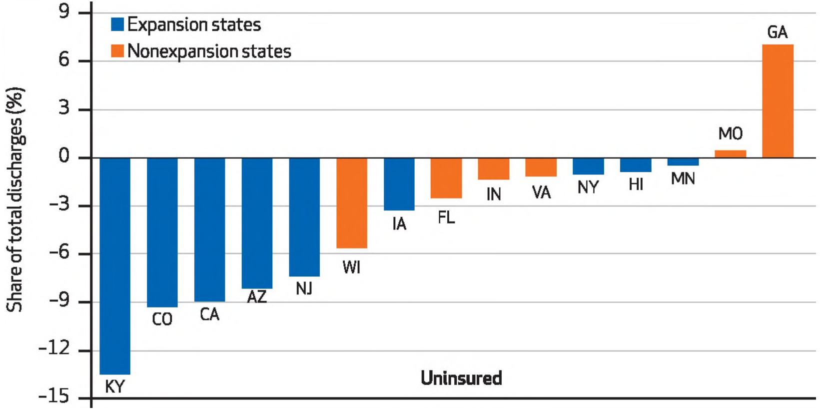
For a closer look at what happened in each of the study states, we also present unadjusted state-specific changes between the third quarter of 2013 and the second quarter of 2014 in the fraction of hospital stays that were uninsured (Exhibit 3), covered by Medicaid (Exhibit 4), and covered by private insurance (Exhibit 5). A formal statistical analysis of how trends in payer mix in each state changed in the period after expansion is presented in Appendix Exhibit 3.[12] Because that analysis largely confirms the observations seen in the exhibits, we focus here on the exhibits.

Uninsured hospitalizations declined in the majority of states, but the declines were much larger in expansion than in nonexpansion states (Exhibit 3). This result would be expected given the trends shown in Exhibit 1. The decrease in uninsured discharges was especially pronounced in Kentucky, where they fell by 13.5 percentage points.

Medicaid stays increased sharply in all nine expansion states except Minnesota, which had already expanded Medicaid to low-income adults

EXHIBIT 3

Changes In The Uninsured Share Of Hospital Discharges For Non-Medicare Adult Inpatients, By State, From The Third Quarter Of 2013 To The Second Quarter Of 2014



SOURCE Authors' analysis of discharge data from the Agency for Healthcare Research and Quality's HCUP Fast Stats (see Note 8 in text).

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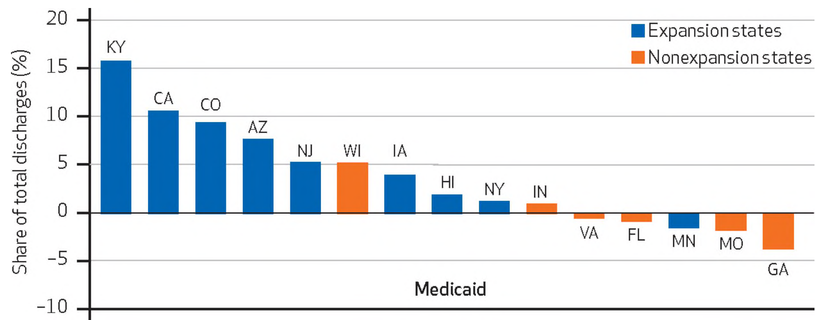
in 2011 (Exhibit 4). At that time the Medicare share of discharges increased sharply in Minnesota (data not shown). In contrast, among nonexpansion states, only Wisconsin experienced a meaningful increase in Medicaid discharges. This was likely because all adults in Wisconsin with incomes of up to 100 percent of the federal poverty level were already eligible for Medicaid. We speculate that this reflects a "welcome mat" effect, in which previously eligible but unenrolled individuals signed up for coverage in 2014.

Although the aggregate trend in the share of hospital stays covered by private insurance showed little change in 2014 (Exhibit 1), some states did experience increases in private coverage for hospital stays (Exhibit 5). For example, Virginia and Florida—both nonexpansion states—experienced an uptick in private-payer share in 2014 (for a table of regression-adjusted state-specific changes, see the Appendix).[12] In contrast, Georgia, another nonexpansion state, saw its share of private discharges fall by a little more than 3 percentage points. This heterogeneity illustrates the importance of considering the unique circumstances of each state, a consideration with which state policy makers are already likely well acquainted.

EXHIBIT 4

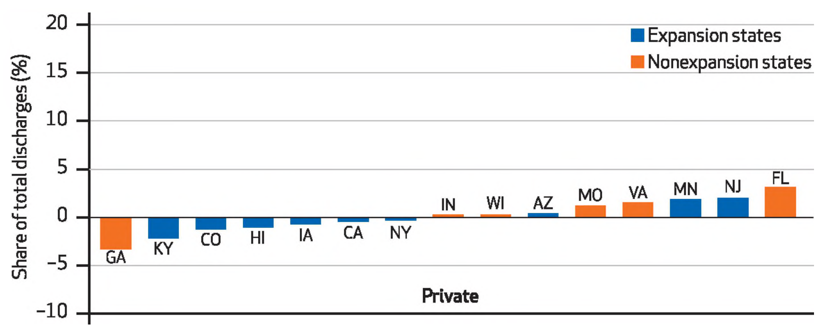
Changes In The Medicaid Share Of Hospital Discharges For Non-Medicare Adult Inpatients, By State, From The Third Quarter Of 2013 To The Second Quarter Of 2014



SOURCE Authors' analysis of discharge data from the Agency for Healthcare Research and Quality's HCUP Fast Stats (see Note 8 in text).

EXHIBIT 5

Changes In The Private Share Of Hospital Discharges For Non-Medicare Adult Patients, By State, From The Third Quarter Of 2013 To The Second Quarter Of 2014



SOURCE Authors' analysis of discharge data from the Agency for Healthcare Research and Quality's HCUP Fast Stats (see Note 8 in text).

Discussion

Our analysis used discharge data through the second quarter of 2014. Our findings suggest that the ACA resulted in immediate changes in payer mix for hospitals in states that expanded Medicaid eligibility, with reductions in patients having no expected source of payment and increases in patients covered by Medicaid. These changes should reduce hospitals' burden of uncompensated care.

However, with only half a year of post-ACA data available, our results were limited, in that they may not reflect the experience of hospitals in all of 2014 or in 2015. A definitive analysis of this issue awaits population-level data on both insurance coverage and health care utilization. In addition, a complete analysis of how changes in payer mix affect the amount of uncompensated care provided by hospitals will require Medicare cost report data for fiscal years 2014 and 2015, which are not yet available.

Conclusion

Our findings underscore the significant benefits of Medicaid expansion not only for low-income adults, but also for the hospitals that serve this population. Understanding the impact of Medicaid expansion on hospitals will become even more important as we approach 2017, when hospitals in all states will begin facing increasingly large annual cuts in disproportionate-share hospital payments that subsidize the cost of uncompensated care.[14] ■

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Both The 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults

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ABSTRACT Under the Affordable Care Act, thirty states and the District of Columbia have expanded eligibility for Medicaid, with several states using Medicaid funds to purchase private insurance (the "private option"). Despite vigorous debate over the use of private insurance versus traditional Medicaid to provide coverage to low-income adults, there is little evidence on the relative merits of the two approaches. We compared the first-year impacts of traditional Medicaid expansion in Kentucky, the private option in Arkansas, and nonexpansion in Texas by conducting a telephone survey of two distinct waves of low-income adults (5,665 altogether) in those three states in November–December 2013 and twelve months later. Using a difference-in-differences analysis, we found that the uninsurance rate declined by 14 percentage points in the two expansion states, compared to the nonexpansion state. In the expansion states, again compared to the nonexpansion state, skipping medications because of cost and trouble paying medical bills declined significantly, and the share of individuals with chronic conditions who obtained regular care increased. Other than coverage type and trouble paying medical bills (which decreased more in Kentucky than in Arkansas), there were no significant differences between Kentucky's traditional Medicaid expansion and Arkansas's private option, which suggests that both approaches improved access among low-income adults.

The Affordable Care Act (ACA) has produced the largest expansion of health insurance since the creation of Medicare and Medicaid fifty years ago. But the 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* gave states the option of whether or not to expand Medicaid eligibility to all nonelderly adults with incomes under 138 percent of the federal poverty level. Thirty states and the District of Columbia have chosen to expand coverage thus far.[1] ACA supporters point to research that has linked coverage expansions with improvements in access to care, self-reported health, and survival.[2–5] Expansion opponents have voiced concerns about budgetary impacts,[6] low provider participation,[7] and the quality of care in Medicaid.[4]

In addition to debating whether or not to expand Medicaid eligibility, several states are also exploring how to expand it and, in particular, whether or not to follow Arkansas's approach in using Medicaid funds to purchase private insurance through the federal and state-based Marketplaces (an approach known as the "private option").[8] Proponents of the private option contend that enrollment in Marketplace plans can improve access to high-quality care because more providers may be willing to accept higher-paying private insurance than lower-paying

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Medicaid.[9] However, adoption of the private option may also lead to higher costs,[10] confusion about coverage among beneficiaries, and reduced access to safety-net providers, compared to traditional Medicaid.[11]

Arkansas and Iowa implemented versions of the private option in 2014, and New Hampshire plans to do so in 2016.[12] Pennsylvania received federal approval for a private coverage approach but subsequently reverted to a traditional Medicaid expansion. Other states that have yet to expand Medicaid may consider versions of the private option, as Utah is doing.[13]

Research shows that the ACA's Medicaid expansion has already improved access to care and increased coverage rates.[14–16] Much less is known about its impacts on health care utilization, chronic disease management, and health. Moreover, despite the vigorous debate about whether to expand public or private insurance to low-income populations, there is scant evidence on the relative merits of these approaches.

In this study we examined the experiences of low-income adults during the first year of the ACA Medicaid expansion in three southern states—Kentucky, Arkansas, and Texas—that have adopted different expansion policies. Kentucky expanded traditional Medicaid coverage, relying heavily on Medicaid managed care plans.[17] Arkansas's private option used federal funds to direct newly eligible adults (excluding 10 percent of applicants deemed medically frail) to the health insurance Marketplace to obtain silver-level private coverage with additional cost-sharing protections and no premium payments.[9] Texas did not expand Medicaid, which means that only adults who met the state's pre-ACA eligibility criteria (parents with incomes below 25 percent of poverty or disabled adults with incomes below 74 percent of poverty) were eligible for Medicaid coverage.[18,19] Texas residents with incomes of 100–138 percent of poverty were able to purchase subsidized private coverage through the Marketplace. Individuals with incomes of 138–400 percent in all three states were eligible for subsidized Marketplace coverage.

Using two years of survey data from 5,665 low-income adults (roughly half surveyed in each year), we examined the following three questions: What changes in insurance coverage for low-income adults were associated with the first year of the ACA Medicaid expansion? Were there any changes in access to care, affordability and use of care, care for chronic conditions, or self-reported health? And lastly, did outcomes differ when the expansion employed private coverage instead of traditional Medicaid?

Study Data And Methods

STUDY DESIGN We surveyed low-income adults in the three states, collecting baseline data from one cohort in November–December 2013 and post-expansion data from a second cohort twelve months later. We next conducted a difference-in-differences analysis, comparing changes in outcomes between 2013 and 2014 for the two expansion states (Arkansas and Kentucky) versus the nonexpansion state (Texas). Then we separately estimated changes in outcomes in Kentucky and Arkansas to compare the traditional Medicaid expansion and the private option.

SURVEY INSTRUMENT We conducted a random-digit-dialed telephone survey of US citizens ages 19–64 who resided in the study states and reported family incomes below 138 percent of poverty (the ACA's cutoff for Medicaid eligibility).[20] The sample was limited to those who reported being US citizens because many immigrants are not eligible for ACA-related coverage, and one of our study states (Texas) has a much higher proportion of immigrants than the other study states.

The survey included landline and mobile phones and was offered in English and Spanish. It assessed type of insurance, access to a usual source of care, cost-related barriers to care, use of care (including preventive care and care for chronic conditions), out-of-pocket spending, and self-reported mental and physical health. We collected data on demographic factors and whether a person had been diagnosed with any of the following conditions: hypertension; heart attack, coronary artery disease, or heart failure (referred to below as "heart disease" for brevity); stroke; asthma or chronic obstructive pulmonary disease; kidney disease; diabetes; depression; cancer; or substance abuse.

Survey questions were adapted from the National Health Interview Survey,[21] the Behavioral Risk Factor Surveillance System,[22] the American Community Survey,[23] and the Oregon Health Insurance Experiment.[2,4] The survey was pilot-tested with eligible individuals and revised based on recorded interviews. The full text of the survey and additional methodological details have been published previously.[24]

The response rate was 26 percent (for details, see the "Methods" section in the online Appendix).[25] To minimize nonresponse bias,[26] we weighted results, using estimates from the American Community Survey and the National Health Interview Survey, for the following characteristics of each state's population of low-income adult citizens: age, sex, education, race/ethnicity, marital status, geographic region, population density, and use of landline versus mobile phone.

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Because we had access only to deidentified survey data, this study was deemed not to be human subjects research by the Institutional Review Board of the Harvard T.H. Chan School of Public Health.

OUTCOMES Health insurance was categorized into the following four mutually exclusive groups: uninsured, Medicaid, private insurance, and other (for details, see the "Methods" section in the Appendix).[25] Access to care was measured based on having a personal doctor, a usual location of care, any cost-related delays in seeking care or taking prescribed medications, trouble obtaining primary or specialty care appointments or paying medical bills, and annual out-of-pocket medical spending.

Utilization over the previous year was measured by the numbers of office visits and emergency department (ED) visits and whether a person had been hospitalized overnight. Preventive care was assessed for the following three services: a checkup, a glucose check, and a cholesterol check in the previous year.

Quality measures were perceived overall quality of care and, among those with a chronic medical condition, whether the respondent had "seen or communicated regularly" with a health care provider for that condition in the past year. Overall health was assessed using a five-point scale,[27] and mental health was assessed using the Patient-Health Questionnaire 2, a validated two-item screening test for depression.[28]

STATISTICAL METHODS We used multivariate regression to estimate the difference-in-differences model, comparing pre- versus post-expansion changes by state, with Texas residents serving as the control group. Each outcome was analyzed as a function of state of residence, year (2013 versus 2014), and the interaction between state and year.

We specified two series of analyses. First, we modeled the interaction between year and expansion status, pooling the results for Arkansas and Kentucky compared to Texas, to assess the impact of expansion versus nonexpansion with greater power from the pooled expansion sample (compared to considering each expansion state separately). Second, we modeled the two expansion states separately (using separate interaction terms for Arkansas and Kentucky, respectively, with the year 2014, both relative to Texas as the control state), to determine whether any significant differences were evident between the traditional Medicaid expansion and the private option. Models were adjusted for sex, age, race/ethnicity, marital status, family size, education, income, and urban versus rural residence. For regression equations, management of missing values resulting from nonresponses, and further analytical details, see the Appendix.[25]

For most outcomes, we used linear probability models to provide straightforward estimates of absolute changes in the proportions of respondents with the outcomes of interest.[29] For self-reported health and the depression score, we considered both categorical outcomes (excellent or very good health versus good, fair, or poor health; and a depression score of ≥2, respectively) and the full numeric scores. Medical out-of-pocket spending was converted from six discrete categories into a linear variable, using the midpoint of each dollar-value category, and then analyzed as the logarithm of spending. In sensitivity analyses we considered alternative models, which produced similar results (see the Appendix "Methods" section).[25]

All regressions used robust standard errors clustered at the county level to account for the nonindependence of observations within the same county over time. State policies such as the ones we studied are often analyzed using state-level clustering. However, when there is only a small number of clusters (such as the three states in our study), these models produce falsely precise standard errors.[30] Our use of county-level clustering generally produced much more conservative results. We also tested a multilevel mixed model that incorporated state fixed effects and county-level random effects, and the results were nearly identical to those of our main analysis.

The primary sample size was 5,665 adults. We also conducted subgroup analyses for clinical measures, examining cholesterol screening rates for adults with cardiovascular risk factors or established disease (hypertension, heart disease, stroke, or diabetes), glucose screening rates for adults with diabetes, and regular care for chronic conditions for adults reporting at least one such condition.

Analyses were conducted using Stata, version 12.1.

LIMITATIONS Our study had several important limitations. First, we used a quasi-experimental study design, which precluded a clear causal interpretation of our findings.

Second, we chose three states in the same census region with similar low-income populations, but demographic or economic differences across states—for instance, the higher share of Latinos and urban residents in Texas, compared to Arkansas and Kentucky—may have affected our study outcomes. We directly adjusted for these factors, but we could not rule out the possibility that other unmeasured time-varying confounders biased our results.

Third, our results might not be generalizable to other states. For example, both Kentucky and

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Arkansas had provider participation rates in Medicaid that were above the national median prior to the ACA.[7] This may have led to more favorable results in those states from expanding coverage, compared to states with lower provider participation rates. However, we contend that these two study states were the best available options for evaluating this policy: Of the states enacting the private option, only Arkansas had a policy in effect for 2014 that applied to nearly the full population that was eligible for Medicaid, and Kentucky was the only state in the same vicinity that implemented a traditional Medicaid expansion. Future research in other states and program settings would be worthwhile.

Fourth, our first-year data came from late 2013, before the ACA's eligibility expansions had taken effect but during the law's first open enrollment period. Some respondents may have been influenced by coverage changes that were about to occur or may have misreported 2014 coverage as having already started in late 2013.

Fifth, using survey questions to assess different types of coverage under the ACA is complex, and respondents may have been confused about different forms of coverage. It is unclear whether the Medicaid expansion in Kentucky based on managed care or the private option in Arkansas is more likely to confuse beneficiaries and cause reporting errors.

Sixth, our survey measurement of family income differed from the more detailed approach used by states to determine Medicaid and Marketplace eligibility. This may have introduced bias or reduced our power to detect significant changes associated with the different approaches to coverage expansion.

Finally, our survey had a lower response rate than government surveys.[31] However, recent studies indicate that response rates may not be a meaningful gauge of nonresponse bias[32] and that random-digit-dialed telephone surveys generally produce valid results when estimates are appropriately weighted using observed population features.[26] Similar surveys with response rates lower than ours[15,33,34] have been used to assess the early impact of the ACA and have produced findings comparable to those from analyses of subsequently released governmental survey and administrative data.[35,36]

Study Results

DESCRIPTIVE STATISTICS The sample contained nearly 1,900 low-income adults in each of the three study states, with roughly equal numbers in each survey year (Exhibit 1). The racial and ethnic composition of the sample varied, with more Latinos in Texas (40 percent) than in Arkansas (4 percent) or Kentucky (2 percent). Compared to respondents from the other states, more respondents in Texas had attended college, but fewer lived in rural areas. More than half of the respondents in all three states reported at least one chronic medical condition, with asthma or chronic obstructive pulmonary disease, depression, and hypertension the most common.

COVERAGE CHANGES In 2013, in all three states, approximately 40 percent of low-income adults were uninsured (Exhibit 2). In 2014 this rate dropped significantly in all three states, but the changes in Kentucky and Arkansas were larger than the change in Texas.

Coverage gains were primarily via private insurance in Arkansas, via Medicaid in Kentucky, and via a combination of the two in Texas (Exhibit 2). Even in nonexpansion states, the streamlined application process and publicity surrounding the ACA can produce a "woodwork" or "welcome mat" effect, increasing Medicaid coverage among previously eligible but unenrolled individuals.

EXPANSION VERSUS NONEXPANSION After covariates were adjusted for, the reduction in the uninsurance rate was significantly larger (by 14.0 percentage points) in the expansion states than in Texas, with concurrent significant increases in Medicaid and private insurance in the expansion states (Exhibit 3). For state-by-state unadjusted changes, see Appendix Table 1.[25]

In outcomes related to access and affordability of care, there were significant reductions among respondents in expansion states in skipping medications because of cost (a reduction of 9.9 percentage points) and in trouble paying medical bills (a reduction of 8.9 percentage points), relative to Texas (Exhibit 3). There was a significantly greater increase of 4.9 percentage points in ED visits because of the unavailability of outpatient appointments in the expansion states, compared to Texas, and a reduction of 5.1 percentage points in use of the ED as a usual source of care, which was of borderline significance.

Among adults with chronic conditions, we found a significantly greater increase (11.6 percentage points) in the proportion of respondents in expansion states who had regularly received care for those conditions, compared to respondents in Texas. We did not detect significant changes in measures related to mental or physical health, utilization, or preventive care.

MEDICAID VERSUS PRIVATE COVERAGE EXPANSION Both Arkansas and Kentucky had significantly greater reductions in uninsurance rates compared to Texas: 11.3 percentage points in Arkansas and 16.6 percentage points in

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EXHIBIT 1

Characteristics Of The Survey Sample By State, 2013 And 2014

Characteristic	Arkansas	Kentucky	Texas	*p* value
Total sample size	1,879	1,898	1,888	—[a]
2013 respondents	944	965	955	—[a]
2014 respondents	935	933	933	—[a]
Family income				
Less than 50% of poverty	32%	34%	28%	0.24
50–100% of poverty	36	37	37	
>100% and <138% of poverty	25	23	27	
Did not know or refused to answer	7	6	8	
Female	57%	56%	58%	0.79
Age (years)				
19–34	43%	41%	47%	0.15
35–44	19	20	18	
45–54	16	17	16	
55–64	22	22	19	
Race/ethnicity				
White, non-Latino	66%	84%	36%	<0.001
Latino	4	2	40	
Black, non-Latino	25	11	19	
Other	4	3	5	
Education				
Less than high school diploma	20%	26%	23%	0.001
High school graduate	47	43	40	
At least some college	33	31	37	
Married or living with a partner	40%	42%	41%	0.60
Number of people in family	2.9	2.9	3.3	<0.001
Rural residence	55%	55%	13%	<0.001
Medical conditions				
Asthma or COPD	26%	29%	19%	<0.001
Cancer	5	6	3	0.02
Depression	39	44	28	<0.001
Diabetes	15	16	14	0.28
Heart disease	8	10	5	<0.001
Hypertension	36	38	27	<0.001
Kidney disease	2	3	2	0.18
Stroke	5	5	4	0.40
Substance abuse	4	4	3	0.23
One or more condition	67	70	53	<0.001

SOURCE Authors' analysis of data from telephone surveys of 5,665 US citizens ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2014. **NOTES** Significance refers to the differences (measured by a chi-square test) in each variable across the three states. COPD is chronic obstructive pulmonary disease. [a]Not applicable.

Kentucky—two estimates that were not significantly different from one another ($p = 0.12$) (Exhibit 4). Compared to respondents in Texas, those in Kentucky experienced greater gains in coverage via Medicaid (16.1 percentage points), while those in Arkansas experienced greater gains via private insurance (12.4 percentage points). The differences between the changes in the two coverage types for Kentucky versus Arkansas were both significant ($p < 0.001$).

Compared to Texas, coverage expansion in both Arkansas and Kentucky was associated with significant reductions in skipping medications because of cost. Trouble paying medical bills decreased significantly in Kentucky compared to Texas. Kentucky experienced both a decline in use of the ED as a usual source of care and an increase in ED visits because of a lack of available office visits, compared to Texas. Both Arkansas and Kentucky experienced large increases in rates of regular care among adults with chronic conditions relative to Texas (increases of 13.0 percentage points and 10.3 percentage points, respectively), though the increase in Kentucky was of borderline significance.

Alternative approaches to measuring out-of-pocket spending all showed significant reductions in Kentucky compared to Texas, with a

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median estimate of a 33 percent relative decline from a baseline average of $434 per year and a smaller decline in Arkansas that was not significant (Appendix Table 2).[25]

Aside from the differential change in private versus public coverage, the between-group tests for Arkansas versus Kentucky showed only one other significant difference: a greater reduction in trouble paying medical bills in Kentucky than in Arkansas (Exhibit 4). Results using logistic models for categorical outcomes and Poisson models for count data produced findings similar to those in our primary analysis, as did a multilevel mixed-effects model.

Discussion

In surveys of 5,665 low-income adults overall before and after the first year of the ACA's coverage expansions, we found that Kentucky's traditional Medicaid expansion and Arkansas's private option led to large population-level declines in the uninsurance rate and to significant improvements in affordability of care; access to prescription medications; and regular care for individuals with chronic conditions such as hypertension, asthma, and depression—all compared to the lack of expansion in Texas.

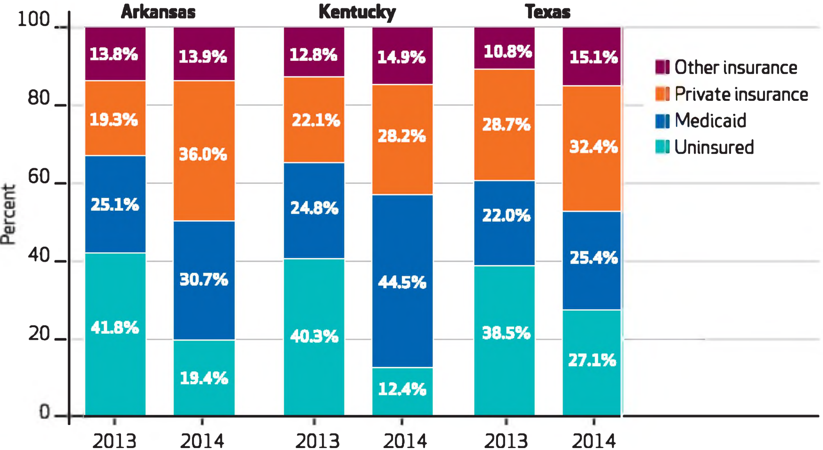
Our finding of large coverage gains in Arkansas and Kentucky is consistent with recent reports showing the two states experienced the largest reductions in uninsurance rates in the country.[37,38] Our estimates of coverage gains in Arkansas and Kentucky are even larger than those reported previously. This makes sense, given that our sample was limited to low-income nonelderly adults (instead of all adults) and that we used year-end estimates that captured the full impact of the 2014 expansion (instead of average estimates across the full calendar year).

Our results are also consistent with previous studies that showed improved access to care and financial protection in several Medicaid expansions prior to the ACA in Oregon, New York, Arizona, Maine, and Wisconsin,[2–5] and to results of national studies of the ACA's early effects.[15] To our knowledge, ours is the first study to identify similar changes from the ACA's Medicaid expansion in southern states in particular, which historically have had high poverty rates and poor access to care.[39]

We did not detect significant changes in utilization, which would have been expected based on previous studies of insurance expansion.[2,4] It is possible that our sample size was too small to detect such changes after only a single year. Previous research suggests that coverage expansions can produce rapid improvements in self-reported physical and mental health,[2,3,40,41] but we did not find any significant changes.

EXHIBIT 2

Health Insurance Coverage Among Low-Income Adults In Three States, 2013–14



SOURCE Authors' analysis of data from telephone surveys of 5,665 adults ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2014. **NOTES** Individuals who reported multiple forms of coverage were assigned a primary form of coverage using a health insurance hierarchy. Details are available in the Appendix "Methods" section (see Note 25 in text).

Many of these measures asked respondents about the previous twelve months, meaning that for those who acquired coverage late in 2014, much of the study period had occurred before they enrolled. Nonetheless, we found borderline significant changes for several outcomes, including having a personal doctor and having had a checkup in the previous year. Additional research will be valuable in determining whether more changes become apparent in the future, as coverage expansions typically take several years to reach maximum enrollment.[42]

One somewhat unexpected pattern of findings was that the Medicaid expansion was associated with both an increase in use of the ED because of a lack of available outpatient care and a decrease in relying on the ED as a usual source of care. These results seem somewhat contradictory at first glance. However, they may indicate that gaining health insurance removes financial barriers to pursuing outpatient care when it is available, but the increased demand may make it more likely that patients will experience delays in obtaining outpatient appointments. The recent expiration of the ACA's higher Medicaid payment rates to primary care providers—which in one study was shown to increase physician participation in Medicaid[43]—may further exacerbate this problem.

Several improvements in access to and affordability of care were evident in the two expansion states in our study. However, our comparison of the traditional Medicaid expansion and the pri-

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EXHIBIT 3

Changes In Coverage, Access To Care, And Health After The First Year Of Medicaid Expansion In Arkansas And Kentucky (Expansion States) Versus Texas (Nonexpansion State), 2013 And 2014

Outcome	Baseline mean in expansion states (2013)	Net change after expansion[a]	*p* value
COVERAGE			
Uninsured	41.0%	−14.0	<0.01
Medicaid	25.0	9.4	<0.01
Private insurance	20.7	7.6	0.02
ACCESS TO AND AFFORDABILITY OF CARE			
Had personal doctor	56.9%	7.9	0.07
Had usual source of care[b]	80.8	3.8	0.31
Had cost-related delay in care	39.5	−4.3	0.20
Skipped prescribed medication because of cost	39.2	−9.9	<0.01
Had trouble obtaining primary care appointment	15.7	3.6	0.24
Had trouble obtaining specialist appointment	14.0	2.6	0.37
ED was usual location of care[b]	9.6	−5.1	0.06
Had ED visit because office visit was unavailable	12.9	4.9	0.05
Had trouble paying medical bills	42.9	−8.9	<0.01
Annual out-of-pocket medical spending	$434	−0.24[c]	0.06
UTILIZATION			
Office visits in past year (number)	2.8	0.5	0.22
Any office visits in past year	55.5%	2.2	0.46
ED visits in past year (number)	1.2	−0.1	0.47
Any ED visits in past year	21.0%	−1.7	0.55
Any hospitalization in past year	16.9%	−1.7	0.54
PREVENTION AND QUALITY			
Checkup in past year	45.8%	6.9	0.07
Cholesterol check in past year (full sample)	42.0	−1.1	0.76
Cholesterol check in past year (those with heart disease, stroke, diabetes, or hypertension; $n = 2,871$)	63.5	2.7	0.61
Glucose check in past year (full sample)	43.0	2.3	0.54
Glucose check in past year (those with diabetes; $n = 1,139$)	86.2	4.2	0.50
Regular care for chronic condition ($n = 3,932$)[d]	65.7	11.6	0.02
Overall quality of care was excellent or very good	53.8	−2.4	0.57
Overall quality of care was fair or poor	19.9	−2.7	0.40
PHYSICAL AND MENTAL HEALTH			
Excellent or very good self-reported health	31.1%	−0.2	0.97
Self-reported health score (1 to 5; lower is better)	3.09	0.02	0.87
PHQ-2[e] depression score (0 to 6; lower is better)	1.78	0.22	0.08
PHQ-2 depression score ≥2	47.5%	1.9	0.61

SOURCE Authors' analysis of data from telephone surveys of 5,665 adults ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2014. **NOTES** The "net change after expansion" column shows difference-in-differences estimates for Arkansas and Kentucky versus Texas, 2013 to 2014. All analyses are adjusted for sex, age, race/ethnicity, marital status, family size, education, income, urban versus rural residence, state, and year. The sample contained 5,665 adults (minus nonresponses for each specific outcome), except where otherwise noted. [a]All estimates are reported as percentage-point changes for binary outcomes, except for annual out-of-pocket spending, numbers of office and emergency department (ED) visits, self-reported health score, and depression score. [b]Usual source of care was divided into the following three categories: those reporting an office-based usual source of care, those using the ED as the usual source of care, and those without any usual source of care. The results reported in the exhibit are for the first two groups. [c]Out-of-pocket spending estimates show relative change (for example, 24 percent) using the logarithm of spending as the outcome. [d]Chronic conditions assessed in the survey were hypertension; heart attack, coronary artery disease, or heart failure ("heart disease"); stroke; asthma or chronic obstructive pulmonary disease; kidney disease; diabetes; depression; cancer; and substance abuse. [e]Patient-Health Questionnaire 2 (PHQ-2) is a validated two-item screening test for depression (see Note 28 in text).

vate option revealed only two significant differences. First, the type of insurance obtained differed, with public coverage gains in Kentucky and private coverage gains in Arkansas. The other outcome that showed a significant difference was trouble paying medical bills: Beneficiaries in Kentucky experienced a significantly larger reduction in this measure than those in Arkansas. This finding may indicate that Medicaid expansion is financially advantageous for low-income

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EXHIBIT 4

Changes In Coverage, Access To Care, And Health After The First Year Of The Private Option (Arkansas) And Medicaid Expansion (Kentucky) Compared To Nonexpansion (Texas), 2013 And 2014

Outcome	Private option (AR vs. TX) Baseline mean (2013, AR)	Net change after expansion[a]	*p* value	Traditional Medicaid (KY vs. TX) Baseline mean (2013, KY)	Net change after expansion[a]	*p* value	*p* value,[b] private option vs. traditional Medicaid
COVERAGE							
Uninsured	41.8%	−11.3	<0.01	40.2%	−16.6	<0.01	0.12
Medicaid	25.1	2.7	0.42	24.8	16.1	<0.01	<0.01
Private insurance	19.3	12.4	<0.01	22.1	2.8	0.45	<0.01
ACCESS TO AND AFFORDABILITY OF CARE							
Had personal doctor	57.2%	7.1	0.13	56.6%	8.6	0.07	0.67
Had usual source of care[c]	78.4	4.8	0.24	83.1	2.8	0.49	0.55
Had cost-related delay in care	39.5	−2.9	0.47	39.6	−5.8	0.15	0.49
Skipped prescribed medication because of cost	40.9	−8.8	0.02	37.5	−10.9	<0.01	0.59
Had trouble obtaining primary care appointment	16.0	3.2	0.38	15.4	4.1	0.25	0.80
Had trouble obtaining specialist appointment	12.1	3.0	0.32	15.8	2.1	0.53	0.77
ED was usual location of care[c]	9.9	−4.3	0.16	9.3	−5.9	0.05	0.54
Had ED visit because office visit was unavailable	12.7	4.0	0.17	13.1	5.8	0.04	0.54
Had trouble paying medical bills	43.1	−4.8	0.19	42.7	−12.9	<0.01	0.05
Annual out-of-pocket medical spending[d]	\$446	−0.15	0.29	\$423	−0.33	0.02	0.12
UTILIZATION							
Office visits in past year (number)	2.61	0.7	0.14	2.98	0.4	0.42	0.40
Any office visits in past year	55.3%	1.5	0.65	55.7%	2.9	0.43	0.71
ED visits in past year (number)	1.04	−0.1	0.56	1.27	−0.2	0.53	0.81
Any ED visits in past year	21.7%	−3.6	0.30	20.4%	0.1	0.98	0.36
Any hospitalization in past year	14.7	−0.1	0.98	19.0	−3.1	0.31	0.34
PREVENTION AND QUALITY							
Checkup in past year	45.3	7.3	0.10	46.3	6.5	0.13	0.83
Cholesterol check in past year (full sample)	38.1	−1.1	0.78	45.8	−1.1	0.81	0.99
Cholesterol check in past year (those with heart disease, stroke, diabetes, hypertension; $n = 2,871$)	60.7	2.8	0.70	66.2	2.7	0.65	0.99
Glucose check in past year (full sample)	41.5	1.6	0.72	44.5	3.1	0.47	0.71
Glucose check in past year (those with diabetes; $n = 1,139$)	88.5	1.1	0.88	84.1	7.1	0.33	0.41
Regular care for chronic condition ($n = 3,932$)[e]	61.8	13.0	0.02	69.4	10.3	0.06	0.56
Overall quality of care was excellent or very good	51.8	−1.6	0.74	55.7	−3.1	0.52	0.75
Overall quality of care was fair or poor	22.5	−5.0	0.20	17.2	−0.5	0.89	0.19
PHYSICAL AND MENTAL HEALTH							
Excellent or very good self-reported health	30.3	2.9	0.53	31.9	−3.2	0.50	0.19
Self-reported health score (1 to 5; lower is better)	3.08	−0.03	0.81	3.10	0.06	0.56	0.41
PHQ-2[f] depression score (0 to 6; lower is better)	1.81	0.17	0.22	1.74	0.27	0.09	0.54
PHQ-2 depression score ≥2	48.1%	0.2	0.96	46.8%	3.7	0.41	0.44

SOURCE Authors' analysis of data from telephone surveys of 5,665 adults ages 19–64 with family incomes below 138 percent of the federal poverty level, November–December 2013 and November–December 2014. **NOTES** The "net change after expansion" columns show difference-in-differences estimates for Kentucky (KY) versus Texas (TX) and Arkansas (AR) versus TX. AR implemented the private option—using Medicaid funds to purchase private insurance through the state's health insurance Marketplace. KY implemented an expansion of traditional Medicaid. Texas did not expand eligibility for Medicaid. All analyses are adjusted as explained in the Notes to Exhibit 3. The sample contained 5,665 adults (minus nonresponses for each specific outcome), except where otherwise noted. [a]All estimates are reported as percentage-point changes for binary outcomes, except for annual out-of-pocket spending, numbers of office and emergency department (ED) visits, self-reported health score, and depression score. [b]*p* values for the post-estimation hypothesis test that the Kentucky and Arkansas difference-in-differences estimates were equivalent. [c]Usual source of care was grouped into three categories, as explained in the Notes to Exhibit 3. [d]Out-of-pocket spending estimates show relative change (percent) using the logarithm of spending as the outcome. [e]Conditions assessed in the survey are listed in the Notes to Exhibit 3. [f]Patient-Health Questionnaire 2 (PHQ-2) is a validated two-item screening test for depression (see Note 28 in text).

adults compared to Marketplace coverage, even though Arkansas's private option included additional cost-sharing protections for poor adults.[11] This pattern would be consistent with previous research demonstrating that Medicaid's financial protection is more comprehensive than that of private insurance.[44,45]

It is possible that a longer follow-up period and a larger sample might reveal other significant differences between the private option and Med-

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icaid expansion. It is also possible that our findings were specific to the three study states, and that results would differ considerably in other states that might be considering a traditional Medicaid expansion or a variation on the private option. Nonetheless, our overall first-year results suggest that the two expansion approaches were largely similar in their impacts on several dimensions of beneficiary experience.

Conclusion

In a two-year survey of nearly 6,000 low-income adults in three southern states, we found major declines in the uninsurance rates in two states, Arkansas and Kentucky, that enacted different approaches to coverage expansion. We also detected preliminary improvements in some measures of access, affordability, and care for important chronic diseases among low-income adults in the two expansion states, compared to those in a nearby nonexpansion state (Texas). However, we did not find any significant changes in utilization or health status in the first year of the expansion. We also found limited differences after one year between Kentucky's traditional Medicaid expansion and Arkansas's private option.

As several states continue to debate coverage expansion for low-income adults under the ACA, our findings suggest that deciding whether or not to expand matters much more than deciding how to expand, at least in the models used to date. Both Arkansas's private option and Kentucky's traditional Medicaid expansion appear to be promising approaches that have thus far produced similar improvements in access to care among low-income adults. Future research that monitors alternative approaches to coverage expansion in these states and elsewhere will be critical to evaluating the ACA's long-term impact on low-income populations. ■

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25 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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Medicaid Expansion Spending and Enrollment in Context: An Early Look at CMS Claims Data for 2014

Laura Snyder, Katherine Young, Robin Rudowitz and Rachel Garfield

There have been long-standing questions about the effect the Medicaid expansion would have on spending and enrollment. Preliminary data from the Medicaid Budget and Expenditure System (MBES) released by the Centers for Medicare and Medicaid Services (CMS) may provide some early insights into these questions. CMS released preliminary spending and enrollment data from the MBES that covers the period from January 2014 through December 2014. This period is of particular interest because these are the first quarters that the Medicaid expansion was in effect. During this period, 27 states including DC, had implemented the Medicaid expansion; all but two of these states – Michigan (April 1, 2014) and New Hampshire (August 15, 2014) – implemented the Medicaid expansion January 1, 2014.

The MBES provides monthly Medicaid enrollment and quarterly Medicaid expenditure data with specific information about enrollment and spending for the new adult eligibility group, also referred to as the "Group VIII." The new adult group includes both those newly eligible under the Medicaid expansion (eligible for 100% federal match through December 2016) and those previously eligible (that were matched at traditional match rates but now receive a higher federal match.) While all states have reported expenditure data for the January – December 2014 period, California and North Dakota have not reported enrollment data for that same period.[1] This brief examines the MBES data to be able to put the spending and enrollment for the expansion into the context of total Medicaid spending and enrollment. Key findings from this data show:

- The new adult group represented a relatively small share (10%) of total Medicaid spending across all states in CY 2014. Looking at just expansion states, spending for the new adult group made up a slightly larger share (16%) total spending. The vast majority of spending for the new adult group is federal dollars (94%). This is driven by the 100% federal match available for those newly eligible adults, which make up three-quarters of enrollment in the new adult group.
- Looking at current enrollment data available, the new adult group made up a relatively small share (13%) of total enrollment. The new adult group made up a larger share of total enrollment in expansion states. However, data are preliminary and enrollment data for large states like California are missing.
- Spending per enrollee for the new adult group is notably lower than spending per enrollee across all groups ($4,513 vs. $7,150.)

Since this data claiming and reporting process is new, ensuring that the data are comparable and accurate across states may take time. This analysis is preliminary and will continue to be updated as data from missing states are added and data continue to be revised and updated.

Background

Data from the Medicaid Budget and Expenditure System (MBES) released by the Centers for Medicare and Medicaid Services (CMS) provides monthly enrollment and quarterly expenditure data with specific information about enrollment and spending on the new adult group (Group VIII). Historically, states have reported only expenditure data through the MBES, not enrollment data. However, to enable states to claim the enhanced funding available for adults made newly eligible by the ACA, CMS revised the form to require states to report claims separately by eligibility group, including separate reporting of claims for the new adult eligibility group, also referred to as the "Group VIII." Group VIII or the new adult group consists of those who are newly eligible as well as some other adults described in the box below. Those that do not qualify under the new adult group are referred to as "traditional Medicaid" for this analysis, which includes individuals with disabilities, the elderly, children, pregnant women and some low-income parents. Since this data claiming and reporting process is new, ensuring that the data are comparable and accurate across states may take time. Additionally, the enrollment data reported through the MBES differ in important ways from other enrollment data reported by CMS through the Performance Indicator process (see Appendix A for more details.)

Data included in this analysis looks at enrollment and expenditure data for January 1, 2014 through December 31, 2014, the first calendar year that the Medicaid expansion was in effect. During this period, 27 states including DC, had implemented the Medicaid expansion; all but two of these states – Michigan (April 1, 2014) and New Hampshire (August 15, 2014) – implemented the Medicaid expansion January 1, 2014. States that expanded after December 31, 2014 (Pennsylvania, Indiana, Alaska and Montana) are treated as non-expansion states in this analysis.

While all states have reported expenditure data for the January – December 2014 period, California and North Dakota have not reported enrollment data for that same period; other states had reported some but not all quarters.[2] This brief examines the MBES data to be able to put the spending and enrollment for the expansion into the context of total spending and enrollment.

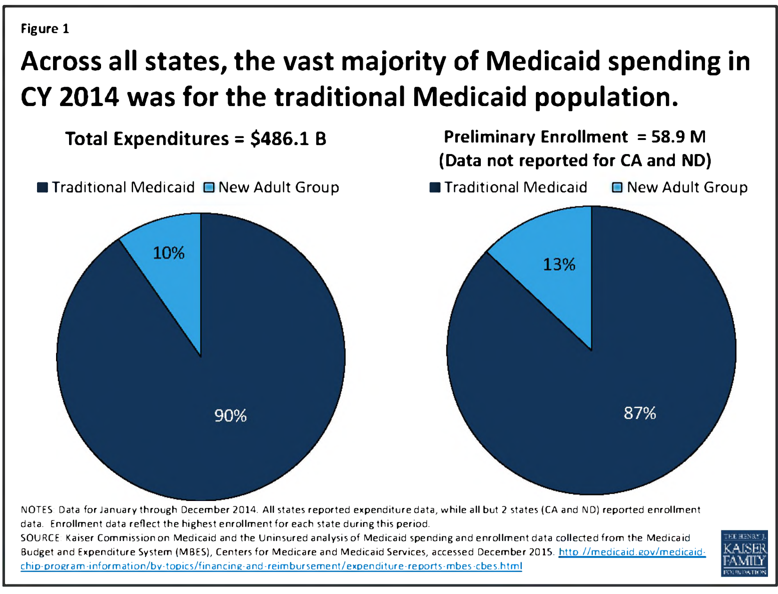
Who is eligible under the New Adult Group (Group VIII)

Newly-Eligible Adults. Beginning in 2014, newly eligible adults consist of 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. The ACA provides 100% federal financing for those made newly eligible for Medicaid by the law; the federal match rate falls to 95% in 2017, 94% in 2018, 93% in 2019, and then 90% in 2020 and beyond.

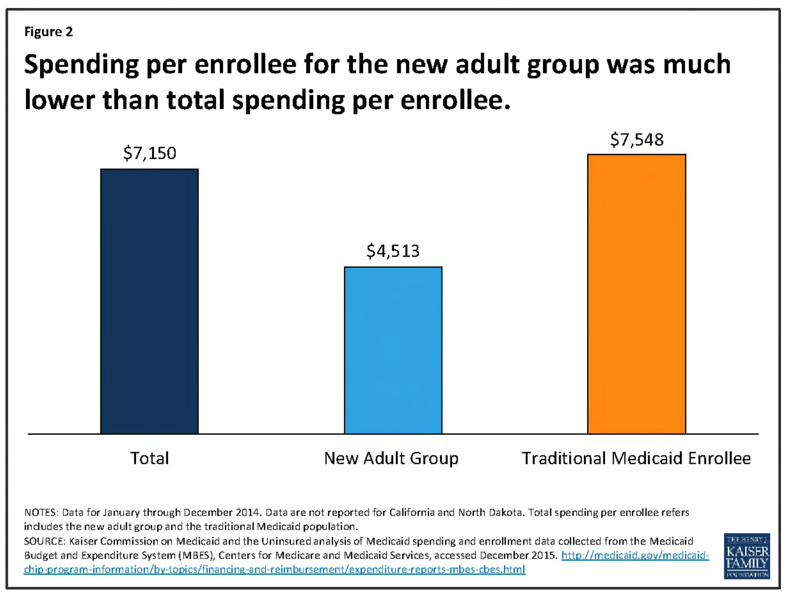
Other Group VIII Adults. Other Group VIII Adults include some childless adults in early expansion states as well as those who may be subject to technical adjustments. Some states already provided coverage at the traditional match rate to parents and adults without dependent children up to at least 100% FPL statewide as of March 23, 2010, when the ACA was enacted. The law provides additional federal funding to these states through the "expansion state match rate" for adults without dependent children under age 65; this "expansion state match rate" is higher than the traditional match rate.[3] A few states were able to make adjustments to account for individuals who would not have been eligible because of asset test requirements in place on December 1, 2009, enrollment caps in effect for waiver populations receiving full benefits as of December 1, 2009, and other special circumstances. These adjustments may result in some adults being enrolled in the expansion category who do not qualify for the 100% federal match for newly eligible adults.[4]

Trends across All States

During calendar year 2014, Medicaid expenditures totaled $486.1 billion dollars. This includes Medicaid spending for all groups – the new adult group as well as the traditional Medicaid population (individuals with disabilities, the elderly, children, etc.) (Appendix Table 2) Spending for the new adult group represented only 10 percent of all Medicaid spending – the vast majority of Medicaid spending was for the traditional population, funded at the regular matching rate. (Figure 1) Across all states and all groups, federal dollars made up nearly 62 percent of Medicaid spending – reflecting both the regular matching rates for the traditional Medicaid population as well as the enhanced funds for the new adult group. The share of federal dollars funding Medicaid spending has increased; historically the federal share has been lower (57%.)

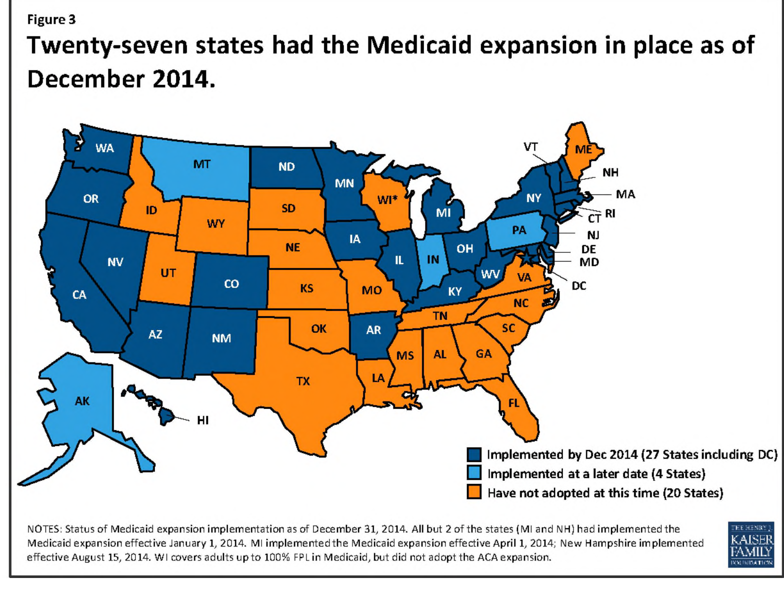


Over calendar year 2014, at least 58.9 million individuals were enrolled in Medicaid for at least some part of the year across the states that reported data. (Appendix Table 3) The inclusion of enrollment data as part of the MBES reporting process was new in 2014. While all states reported data for expenditures, not all states were able to report enrollment data, including large states like California. As revised data are published, this figure is expected to increase. Just as with spending, the new adult group made up a relatively small share (13%) of total Medicaid enrollment. (Figure 1) Among those states reporting both spending and enrollment data, spending per enrollee for the new adult group was much lower than total spending per enrollee across all groups (traditional Medicaid and the new adult group) - $4,513 vs. $7,150. (Figure 2)



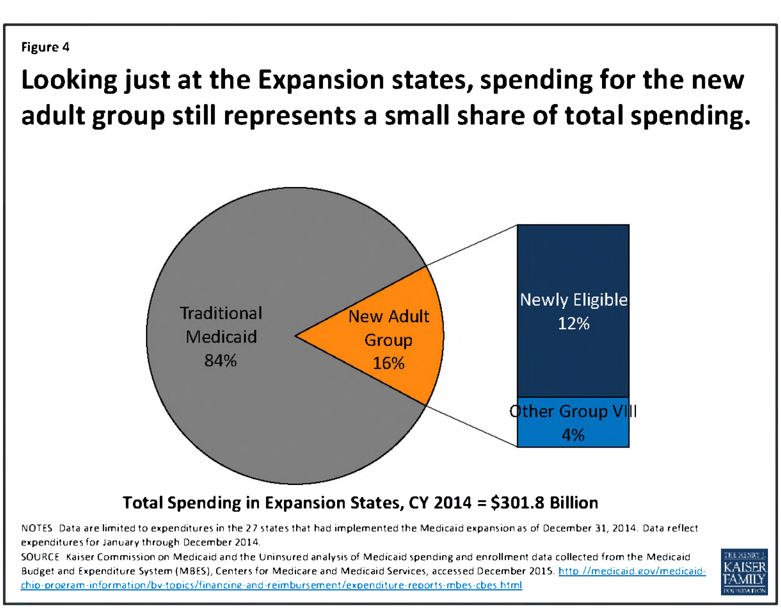
Trends in Expansion States

One of the major changes in the Affordable Care Act was the Medicaid expansion – establishing a new eligibility floor for non-elderly, non-disabled groups at 138 percent FPL and eliminating the long-standing exclusion of childless adults. The June 2012 Supreme Court decisions effectively made this optional for states. As of December 31, 2014, there were 27 states that had implemented the Medicaid expansion; states that expanded later (Pennsylvania, Indiana, Alaska and Montana) are treated as non-expansion states in this analysis. (Figure 3) The remainder of this analysis focuses on spending and enrollment trends in the 27 expansion states only.



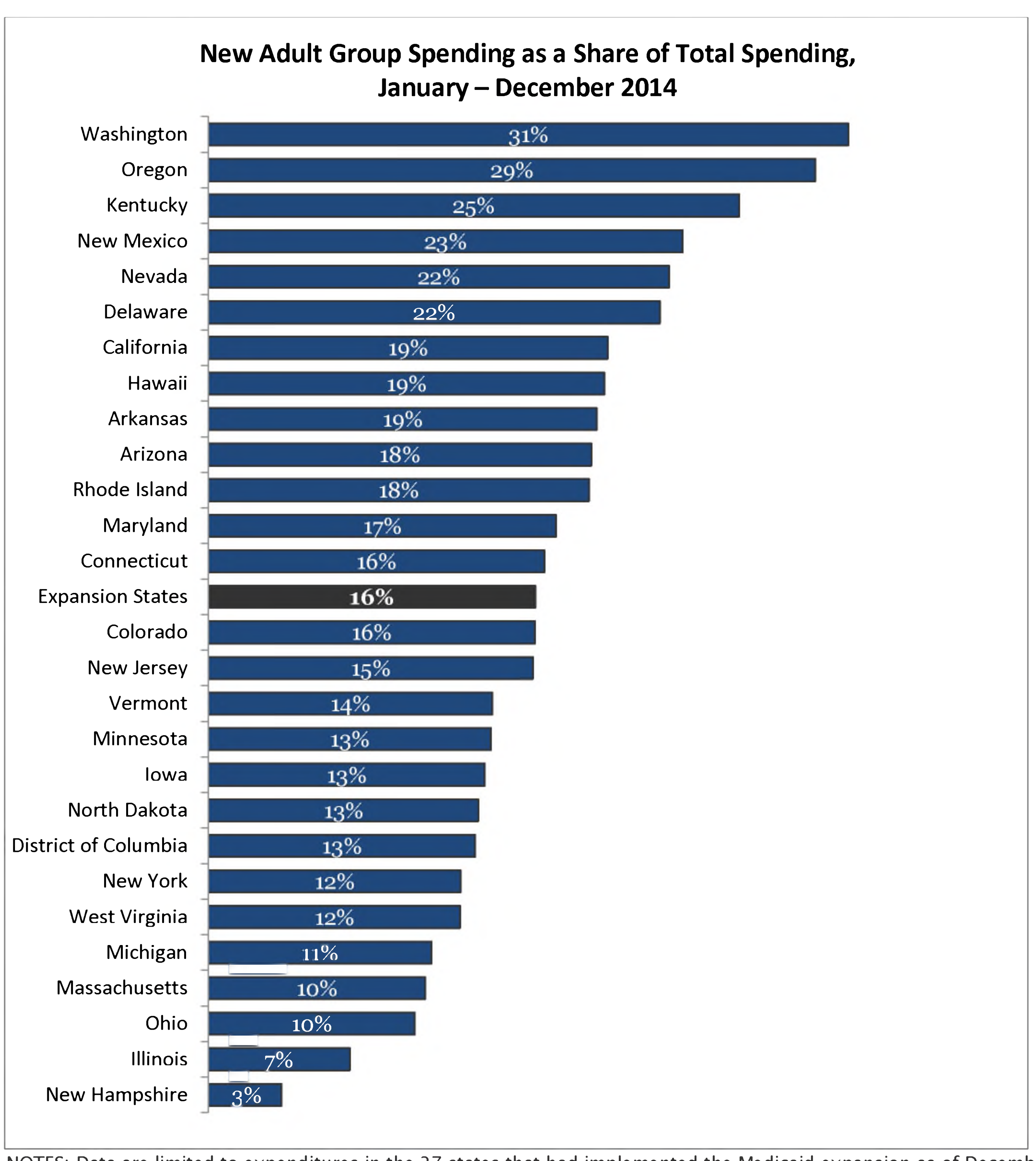
Total and New Adult Group Spending

Across the 27 states that implemented the expansion during calendar year 2014, spending for the new adult group totaled $47.2 billion, representing 16 percent of total Medicaid spending across these states. (Figure 4) The vast majority of this spending (78%) was for those newly eligible adults whose expenditures qualify for the 100 percent federal match. The remaining share of spending for the new adult group was for those adults that were previously eligible at traditional match rates or subject to technical adjustments (see Box 1 for more details); expenditures for these adults are still matched at a higher rate than the traditional match rate, but not the 100 percent federal match.



Spending for the new adult group as a share of total Medicaid spending for this period varies across expansion states, ranging from more than 25 percent in Washington, Oregon and Kentucky to less than 10 percent in Illinois and New Hampshire (New Hampshire implemented the Medicaid expansion later - August 15, 2014.) (Figure 5)

Figure 5: The share of spending for the new adult group varies across expansion states.

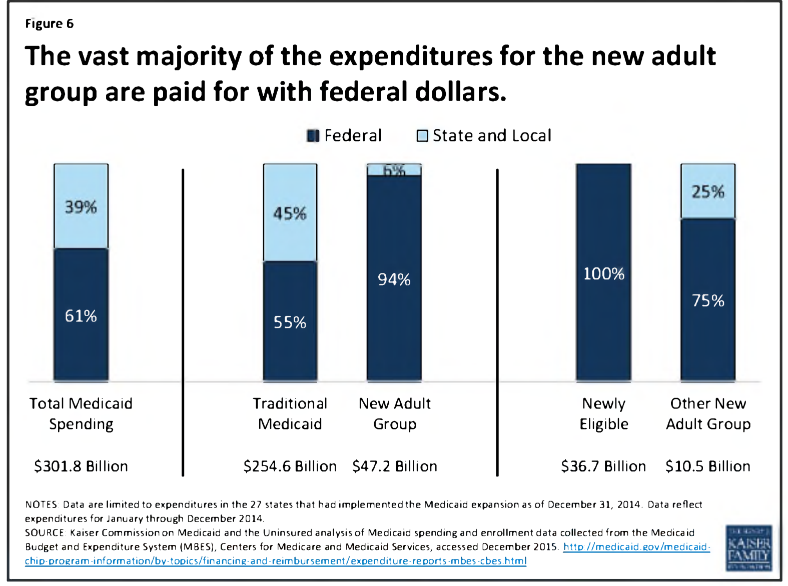


NOTES: Data are limited to expenditures in the 27 states that had implemented the Medicaid expansion as of December 31, 2014. Data reflect expenditures for January through December 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Federal and State Spending Distribution of Spending

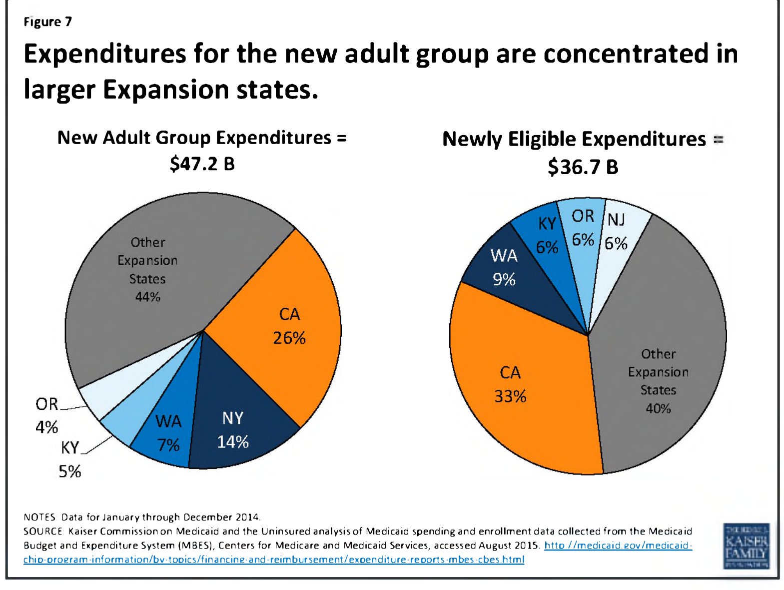
Across all expansion states, the federal share for all Medicaid spending in calendar year 2014 was 61 percent and the state share of spending was 39 percent (virtually the same as at the national level.) (Figure 6) However, there were large differences in these shares for the traditional Medicaid program and the new adult group.

The federal government paid more than half of the costs for the traditional Medicaid population in expansion states (55%). This share varies by state according to the traditional FMAP. For the new adult group, virtually all of the expenditures (94%) were paid for with federal dollars. As noted earlier, the new adult group consists of spending for those newly eligible (which are paid for with 100% federal dollars) as well as some other adults that qualify for the new adult group but are not newly eligible. The newly eligible group accounted for more than 3 out of 4 dollars spent on the new adult group ($36.7 billion of the $47.2 billion in new adult group spending). While the other new adult enrollees are not eligible for the 100 percent federal match, the federal share for this group is still well above the traditional match rates that had previously applied to expenditures for these adults.



Distribution of Spending for the New Adult Group by State

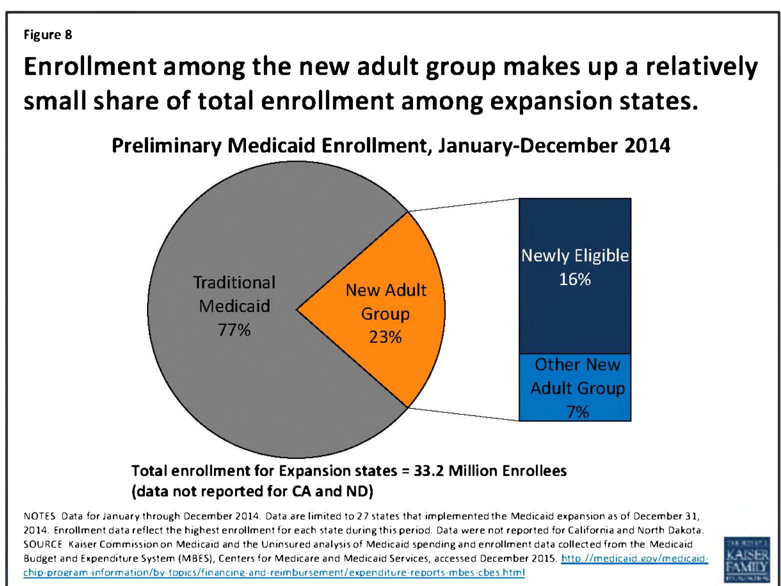
In calendar year 2014, states claimed $47.2 billion in total Medicaid spending for the new adult group. Looking at the distribution across states, it is not surprising that larger expansion states had a higher share of expenditures for this group. Expenditures for the new adult group in California represent one quarter (26%) of all the expenditures for the new adult group during this period, followed by New York (14%), Washington (7%), Kentucky (5%) and Oregon (4%). Focusing just on expenditures for the newly eligible (which are 100% federally funded,) California reported one-third of all of these expenditures during this period, followed by Washington (9%), Kentucky, Oregon and New Jersey (all at 6%.) (Figure 7) Some large states, such as New York, Massachusetts and Arizona, which had expanded coverage prior to the ACA, reported larger shares of new adult group spending for other new adult group enrollees whose expenditures don't qualify for the 100 percent federal match. However, even in these states the vast majority of expenditures for the new adult group were federal, as the expenditures for the other new adult group enrollees still received a higher federal match than the traditional match rate available before.



TOTAL AND GROUP VIII ENROLLMENT

The MBES data have historically not included information about enrollment or spending by eligibility group. To account for the newly eligible federal match rate, CMS has revised the CMS-64 form to require states to report claims separately by eligibility group, including separate reporting for newly eligible adults, as well as to report enrollment by eligibility group. Since this data reporting process is new, ensuring that the data are comparable and accurate across states may take time. Moreover, because these initial data are preliminary, states may continue to provide updates to the enrollment data over time, so the numbers will change. Not all states were able to report enrollment data; enrollment data are not reported for California and North Dakota for all three quarters.

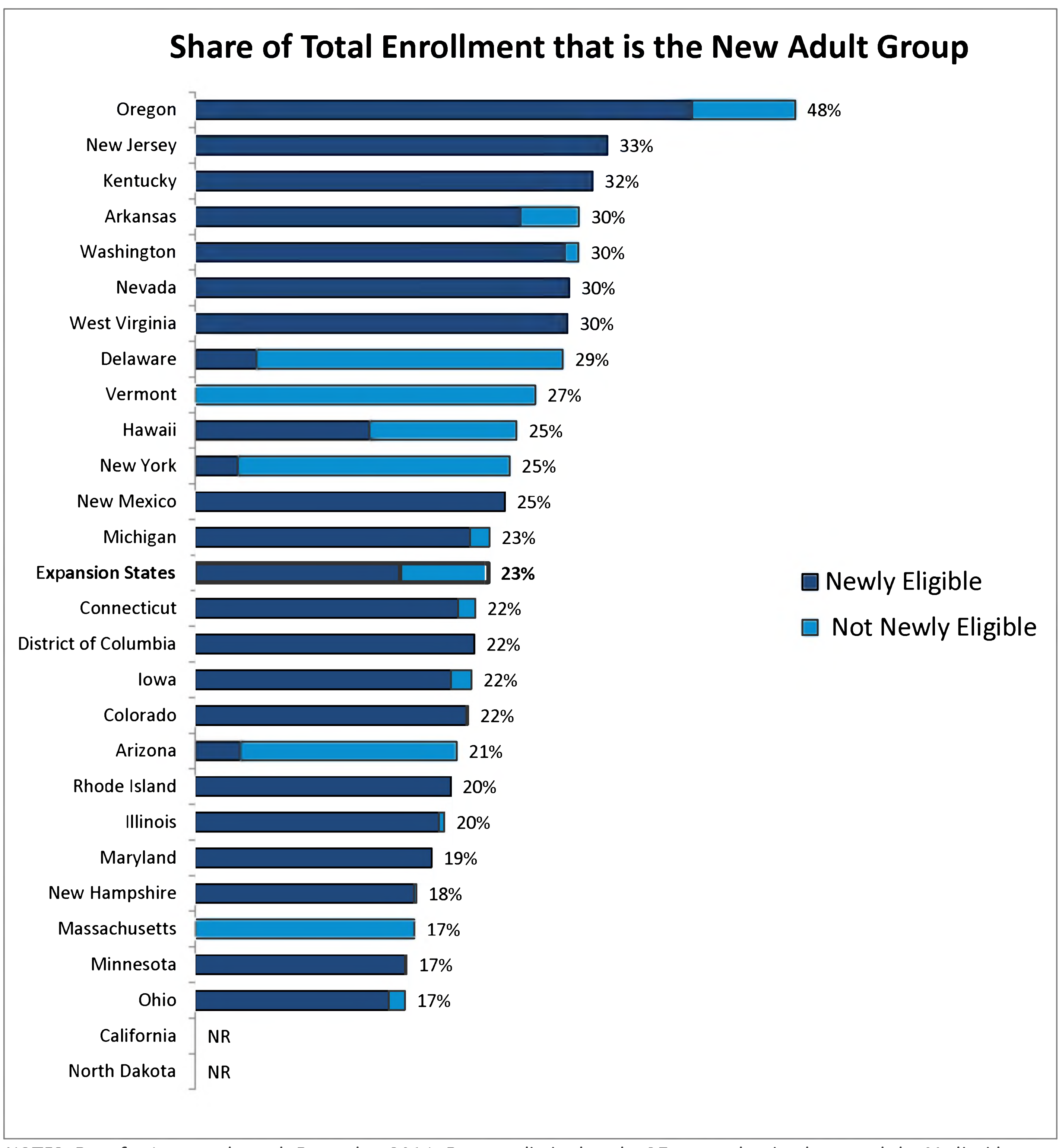
In the expansion states that reported enrollment data, approximately 23 percent of Medicaid enrollment was for the new adult group. (Figure 8) The remaining 77 percent of Medicaid enrollment was for those eligible under the "traditional" Medicaid program (e.g. children, pregnant women, elderly and individuals with disabilities.) However, this varies across expansion states. Enrollment in the new adult group made up nearly half of total enrollment in Oregon (48%) ranging down to 17 percent in Ohio, Minnesota and Massachusetts. (Figure 9)



The make-up of the new adult group (newly eligible vs. other) differs across expansion states. Across all expansion states, over two-thirds of enrollment in the new adult group were newly eligible (those whose expenditures are eligible for 100% federal match through December 2016.) While newly eligible adults made up the vast majority of new adult enrollment in many of the expansion states, there were a handful that saw the majority of enrollment in the new adult group among those not newly eligible (Arizona, Delaware, New York and Massachusetts.) (Figure 9) These states had expanded coverage to adults prior to the ACA.

Among the expansion states that reported enrollment data, the largest share of new adult enrollment was in New York (19% or nearly 1.5 million adults) followed by Illinois (8%), New Jersey, Washington and Michigan (7% each). These five states reported nearly half (47%) of all enrollment among the new adult group. However, the distribution of enrollment among newly eligible adults (those whose expenditures are eligible for 100% federal match through December 2016) differs slightly. Illinois accounted for the highest share of newly eligible adults (11%) followed by New Jersey (10%), Washington (9%), Michigan (9%) and Ohio (8%). As mentioned earlier, New York had expanded coverage to adults prior to the ACA so nearly 9 out of 10 adults eligible under the new adult group in New York are not newly eligible.

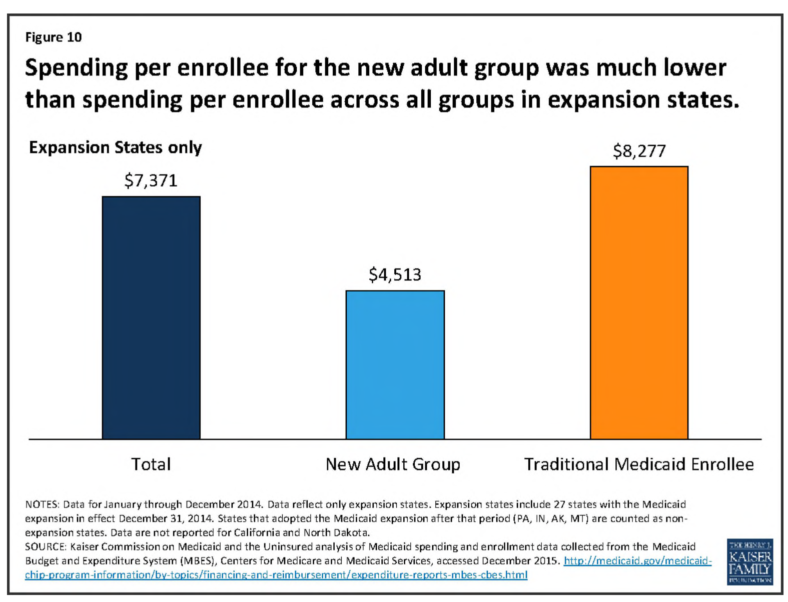
Figure 9: The share of enrollment in the new adult group varies across states.



NOTES: Data for January through December 2014. Data are limited to the 27 states that implemented the Medicaid expansion as of December 2014. Data reflect the highest enrollment for each state during this period. Data were not reported for California and North Dakota. All but 2 of these states (MI and NH) implemented the expansion January 2014; MI's expansion became effective April 1, 2014 and NH's expansion became effective August 15, 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

SPENDING PER ENROLLEE

Because childless adults were historically excluded from the Medicaid program prior to the ACA, there was limited data and experience to draw on for determining what utilization and expenditures for this group would be. While the data are preliminary and missing large states such as California, the MBES data provides a window into what spending per enrollee for the new adult group looks like and how it compares to the rest of the Medicaid population. Spending per enrollee for the new adult group is notably lower than spending per enrollee across all groups in expansion states; average spending per enrollee for the new adult group was $4,513 compared to $7,371 per enrollee (new adult group and traditional Medicaid population). (Figure 10) This is in line with historical data on adult spending per enrollee, which has been roughly 60 percent of total spending per enrollee figures.



Spending per enrollee for those in the new adult group varied widely across states; spending per new adult group enrollee ranged from $8,461 in Rhode Island to $1,706 in New Hampshire (which implemented the Medicaid expansion later). (Appendix Table 4) This level of variation mirrors in large part variation in total spending per enrollee seen across these states as well as patterns in historic spending per enrollee data for adults. There are a number of factors that can lead to this wide dispersion in spending per enrollee figures including differences in health care costs across states and the relative health status of the underlying populations.

Looking Ahead

Data from the MBES released by the CMS provide monthly enrollment and quarterly expenditure data with specific information about enrollment and spending for the new adult eligibility group, also referred to as the "Group VIII." This new MBES data on spending and enrollment provide further insight into the early effects of the Medicaid expansion on Medicaid spending and enrollment. However, the data are preliminary and this is the first time enrollment data have been collected as part of the claiming process. It also is incomplete with enrollment data missing from some states (California and North Dakota.) With additional updates and data from missing states, additional analyses can be conducted to understand differences across expansion states as well as difference across expansion and non-expansion states in terms of spending and enrollment patterns.

Methodology

Data from the Medicaid Budget and Expenditure System (MBES) released by the Centers for Medicare and Medicaid Services (CMS) provides monthly enrollment and quarterly expenditure data with specific information about enrollment and spending for the new adult eligibility group, also referred to as the "Group VIII." States began reporting enrollment data for the quarter beginning January 1, 2014 and more recently began reporting expenditure data for the new adult group on the Form CMS-64.

Spending data made public reflect the first full year that the Medicaid expansion was in effect: the last three quarters of FFY 2014 (January – September 2014) and the first quarter of FFY 2015 (October – December 2014.) During this period, 27 states including DC, had implemented the Medicaid expansion; all but two of these states – Michigan (April 1, 2014) and New Hampshire (August 15, 2014) – implemented the Medicaid expansion January 1, 2014.

Expenditure data reported in this brief were summed across the four quarters. Data reflect all Title XIX expenditures reported by states; data do not include expenditures under Title XXI (CHIP).

Enrollment data reported are based on the maximum enrollment level reported across the four quarters in each state for Title XIX only (enrollment for under Title XXI or CHIP are excluded.) While this measure is used to try to capture the total number of enrollees over the entire period, it is likely an undercount of the number of enrollees ever on the program; more detailed forthcoming data sources on enrollment (such as the T-MSIS) will yield more accurate (and likely higher) enrollment data. Because different states saw higher levels of enrollment among the newly eligible and the not newly eligible in the new adult group (Group VIII) the Group VIII enrollment reported for states reflects the sum of the maximum newly eligible and the maximum of the not newly eligible. Traditional Medicaid figures are calculated taking the maximum total enrollment figure and subtracting the maximum Group VIII enrollment figure. National numbers for total, traditional Medicaid, Group VIII, newly eligible and not newly eligible enrollment all reflect summations of state maximums and therefore will not match data as reported by CMS. While all states have reported expenditure data for the January – December 2014 period, California and North Dakota have not reported enrollment data for that same period; DC, Colorado, Nevada New Jersey and Washington had reported some but not all months.

Spending per enrollee data are calculated taking the sum of expenditure data over the 4 quarters over the maximum enrollment level. Expenditure data from California and North Dakota were excluded from national calculations since these states did not report enrollment data. The maximum enrollment figure is intended to better capture all people touched by the program over the calendar year examined; however this figure is likely low and is expected increase over time as data are updated and missing data from states like California are added.

Appendices

- Appendix A: Comparison to Other Available Data Sources
- Appendix Table 2: Total Medicaid Expenditures, CY 2014
- Appendix Table 3: Preliminary Medicaid Enrollment, CY 2014
- Appendix Table 4: Spending per Enrollee in Expansion States, CY 2014

Appendix A: Comparison to Other Available Data Sources

Spending. States have historically reported expenditure data through the MBES for claiming purposes; this is sometimes referred to as CMS-64 data. However, the expenditure data in this report may differ from other data reported from the MBES due to differences in timing as well as adjustments made to the data. For example, expenditure data from the MBES is commonly reported on a Federal Fiscal Year (FFY) basis (October 1 – September 30) whereas the data in this report reflect the calendar year (January 1 – December 31).

Enrollment Data. Since December 2013, CMS has been providing another source of monthly enrollment data for Medicaid and CHIP as part of its Medicaid and CHIP Performance Indicator Project. There are important differences between the Performance Indicator and MBES enrollment data that limit the ability to make comparisons between the two datasets, as discussed below and highlighted in Appendix Table 1:

- **The data vary in their intended purpose.** The MBES enrollment data are collected as part of the claiming process for federal Medicaid matching funds only, not CHIP. The Performance Indicator data are intended to provide timely insight into Medicaid and CHIP eligibility and enrollment trends to support program management and oversight.

- **There are key differences in who is included in the enrollment data.** The MBES enrollment data include all enrollees whose spending is eligible for Medicaid matching funds (including limited benefit waiver enrollees and Medicare enrollees that receive cost-sharing and premium assistance from Medicaid). In contrast, the Performance Indicator enrollment data only include enrollees that receive full benefit coverage. Moreover, the MBES enrollment data only include enrollment in Medicaid and not CHIP; the claiming process for CHIP, which has different matching rates, is done separately. The Performance Indicator data include enrollment for both Medicaid and CHIP.

- **There are differences in the timing of the data**. The MBES data include individuals enrolled in the state's Medicaid program at any time during the month of the reporting period. In contrast, the Performance Indicator data are a point-in-time count based on the number of individuals enrolled as of the last day of the month. The MBES enrollment data cover the period between January and June 2015 (though only data through December 2014 is used in this analysis), while the most recent monthly Performance Indicator report included data through October 2015.

Appendix Table 1: Differences Between CMS MBES and Performance Indicator Enrollment Data

	MBES Data	Performance Indicator Data
Eligibility Groups included	All Medicaid enrollees, including those receiving limited benefits (e.g., limited benefit waiver enrollees and Medicare enrollees receiving cost-sharing and premium assistance from Medicaid). Does not include CHIP enrollees.	Includes enrollees in Medicaid and CHIP enrollment. Does not include enrollees receiving limited benefits.
Enrollment data period	Total number of enrollees ever enrolled during the month. (Data are reported on a quarterly basis.)	Total number of enrollees as of the last day of the month.
Frequency of reporting	Quarterly	Monthly
Most recent data available as of December 2015	June 2015 (only data through Dec 2014 are used in this analysis)	October 2015
Data purpose	Collected as part of the claiming process for federal Medicaid matching funds.	Collected as part of new Medicaid and CHIP Performance Indicator Project to inform program management and oversight.

Appendix Table 2: Total Medicaid Expenditures, CY 2014				
State	Total	New Adult Group	Newly Eligible	Not Newly Eligible
Alabama	$5,309,736,744	N/A	N/A	N/A
Alaska	$1,618,158,522	N/A	N/A	N/A
Arizona	$9,460,028,885	$1,727,768,395	$145,541,925	$1,582,226,470
Arkansas	$5,226,774,523	$967,920,039	$967,920,039	N/A
California	$64,055,189,072	$12,199,943,279	$12,199,943,279	N/A
Colorado	$6,368,524,285	$992,468,785	$968,850,624	$23,618,161
Connecticut	$7,494,388,273	$1,200,936,868	$1,181,124,042	$19,812,826
Delaware	$1,760,894,949	$379,235,466	$32,930,545	$346,304,921
DC	$2,334,112,770	$297,107,909	$282,271,893	$14,836,016
Florida	$21,336,121,602	N/A	N/A	N/A
Georgia	$9,613,091,392	N/A	N/A	N/A
Hawaii	$1,975,301,415	$373,037,821	$242,011,231	$131,026,590
Idaho	$1,683,668,434	N/A	N/A	N/A
Illinois	$16,084,380,996	$1,085,547,824	$1,072,644,820	$12,903,004
Indiana	$9,317,184,653	N/A	N/A	N/A
Iowa	$4,216,928,813	$556,162,683	$531,449,280	$24,713,403
Kansas	$2,842,501,614	N/A	N/A	N/A
Kentucky	$8,595,156,527	$2,176,007,998	$2,176,007,998	N/A
Louisiana	$7,031,732,700	N/A	N/A	N/A
Maine	$2,497,790,662	N/A	N/A	N/A
Maryland	$9,725,772,438	$1,612,599,592	$1,612,599,592	N/A
Massachusetts	$15,033,457,934	$1,554,743,109	N/A	$1,554,743,109
Michigan	$14,116,055,764	$1,503,736,391	$1,444,562,564	$59,173,827
Minnesota	$10,638,087,779	$1,433,646,514	$1,427,247,012	$6,399,502
Mississippi	$4,973,795,953	N/A	N/A	N/A
Missouri	$9,034,749,004	N/A	N/A	N/A
Montana	$1,105,703,601	N/A	N/A	N/A
Nebraska	$1,831,650,567	N/A	N/A	N/A
Nevada	$2,538,887,096	$557,912,077	$557,912,077	N/A
New Hampshire	$1,437,357,944	$50,174,127	$49,928,108	$246,019
New Jersey	$13,422,100,485	$2,077,884,888	$2,077,884,888	N/A
New Mexico	$4,488,133,924	$1,015,477,316	$1,015,477,316	N/A
New York	$55,839,970,423	$6,717,924,807	$446,736,046	$6,271,188,761
North Carolina	$12,049,566,135	N/A	N/A	N/A
North Dakota	$995,053,014	$128,096,920	$125,595,143	$2,501,777
Ohio	$19,867,991,538	$1,955,996,607	$1,842,525,912	$113,470,695
Oklahoma	$5,045,035,311	N/A	N/A	N/A
Oregon	$7,279,593,596	$2,107,572,240	$2,107,572,240	N/A
Pennsylvania	$22,961,627,929	N/A	N/A	N/A
Rhode Island	$2,522,983,052	$457,942,487	$457,942,487	N/A
South Carolina	$5,646,426,012	N/A	N/A	N/A
South Dakota	$781,309,878	N/A	N/A	N/A
Tennessee	$8,763,278,224	N/A	N/A	N/A
Texas	$33,027,788,301	N/A	N/A	N/A
Utah	$2,110,973,692	N/A	N/A	N/A
Vermont	$1,561,688,259	$211,439,523	N/A	$211,439,523
Virginia	$7,633,684,545	N/A	N/A	N/A
Washington	$11,262,917,875	$3,437,117,412	$3,267,848,402	$169,269,010
West Virginia	$3,500,885,440	$420,573,988	$420,573,988	N/A
Wisconsin	$7,547,033,281	N/A	N/A	N/A
Wyoming	$540,533,820	N/A	N/A	N/A
United States	**$486,105,759,645**	**$47,198,975,065**	**$36,655,101,451**	**$10,543,873,614**

NOTES: Data reflect expenditures for January through December 2014. See Methodology for more details.
SOURCE: KCMU analysis of Medicaid spending and enrollment data collected from the MBES, CMS, accessed December 2015.

Appendix Table 3: Preliminary Medicaid Enrollment, CY 2014				
State	Total	New Adult Group	Newly Eligible	Not Newly Eligible
Alabama	1,050,254	N/A	N/A	N/A
Alaska	121,405	N/A	N/A	N/A
Arizona	1,732,726	359,093	61,709	297,384
Arkansas	871,098	265,032	224,870	40,162
California	Data Not Reported			
Colorado	976,972	211,389	210,013	1,376
Connecticut	851,013	188,969	177,393	11,576
Delaware	205,356	59,841	9,961	49,880
DC	243,852	53,954	53,954	-
Florida	3,954,371	N/A	N/A	N/A
Georgia	1,793,252	N/A	N/A	N/A
Hawaii	333,090	84,838	46,061	38,777
Idaho	290,376	N/A	N/A	N/A
Illinois	2,992,947	590,415	577,455	12,960
Indiana	1,096,804	N/A	N/A	N/A
Iowa	553,661	121,275	112,326	8,949
Kansas	369,784	N/A	N/A	N/A
Kentucky	1,200,615	378,364	378,364	-
Louisiana	1,351,281	N/A	N/A	N/A
Maine	300,720	N/A	N/A	N/A
Maryland	1,160,217	217,282	217,282	-
Massachusetts	1,981,413	343,836	-	343,836
Michigan	2,162,402	504,430	470,828	33,602
Minnesota	1,105,285	185,011	183,824	1,187
Mississippi	736,517	N/A	N/A	N/A
Missouri	840,679	N/A	N/A	N/A
Montana	152,200	N/A	N/A	N/A
Nebraska	237,519	N/A	N/A	N/A
Nevada	556,116	164,906	164,906	-
New Hampshire	167,988	29,406	29,124	282
New Jersey	1,652,548	539,902	539,902	-
New Mexico	753,184	184,942	184,942	-
New York	5,992,264	1,494,419	202,684	1,291,735
North Carolina	1,935,493	N/A	N/A	N/A
North Dakota	Data Not Reported			
Ohio	2,924,123	485,312	448,378	36,934
Oklahoma	765,374	N/A	N/A	N/A
Oregon	1,035,570	492,687	407,990	84,697
Pennsylvania	2,110,761	N/A	N/A	N/A
Rhode Island	267,327	54,126	54,126	-
South Carolina	1,193,222	N/A	N/A	N/A
South Dakota	108,302	N/A	N/A	N/A
Tennessee	1,504,276	N/A	N/A	N/A
Texas	4,330,364	N/A	N/A	N/A
Utah	323,730	N/A	N/A	N/A
Vermont	192,515	51,911	-	51,911
Virginia	931,238	N/A	N/A	N/A
Washington	1,678,876	510,155	492,358	17,797
West Virginia	527,194	155,636	155,636	-
Wisconsin	1,201,672	N/A	N/A	N/A
Wyoming	73,744	N/A	N/A	N/A
United States	**58,891,690**	**7,727,131**	**5,404,086**	**2,323,045**

NOTES: Data reflect preliminary maximum enrollment in calendar year 2014. See Methodology for more details.
SOURCE: KCMU analysis of Medicaid spending and enrollment data collected from the MBES, CMS, accessed December 2015.

Appendix Table 4: Spending per Enrollee in Expansion States, CY 2014		
State	Spending per enrollee for the new adult group (Group VIII)	Spending per enrollee across all groups (Traditional and Group VIII)
Arizona	$4,811	$5,460
Arkansas	$3,652	$6,000
California		
Colorado	$4,695	$6,519
Connecticut	$6,355	$8,806
Delaware	$6,337	$8,575
District of Columbia	$5,507	$9,572
Hawaii	$4,397	$5,930
Illinois	$1,839	$5,374
Iowa	$4,586	$7,616
Kentucky	$5,751	$7,159
Maryland	$7,422	$8,383
Massachusetts	$4,522	$7,587
Michigan	$2,981	$6,528
Minnesota	$7,749	$9,625
Nevada	$3,383	$4,565
New Hampshire	$1,706	$8,556
New Jersey	$3,849	$8,122
New Mexico	$5,491	$5,959
New York	$4,495	$9,319
North Dakota		
Ohio	$4,030	$6,795
Oregon	$4,278	$7,030
Rhode Island	$8,461	$9,438
Vermont	$4,073	$8,112
Washington	$6,737	$6,709
West Virginia	$2,702	$6,641
Expansion State Average	**$4,513**	**$7,371**

NOTES: Data for January through December 2014. Data are limited to the 27 states that had implemented the Medicaid expansion effective December 2014. Data reflect spending per enrollee for each state during this period using expenditures summed across the 4 quarters and the highest level of enrollment reported. Data were not reported for California and North Dakota. All but 2 of these states (MI and NH) implemented the expansion January 2014; MI's expansion became effective April 1, 2014 and NH's expansion became effective August 15, 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of Medicaid spending and enrollment data collected from the Medicaid Budget and Expenditure System (MBES), Centers for Medicare and Medicaid Services, accessed December 2015. http://medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/expenditure-reports-mbes-cbes.html

Endnotes

[1] Additionally, not all states reported enrollment data for all periods. The District of Columbia reported enrollment data for all but the first quarter (January – March 2014). Colorado reported enrollment data for only the first quarter (January – March 2014). Hawaii reported enrollment data for all but the last quarter (October – December 2014). Nevada, New Jersey and Washington reported enrollment data in each quarter, they did not report enrollment data for each month in the 4th quarter of 2014 (data were reported for December only).

[2] Additionally, not all states reported enrollment data for all periods. The District of Columbia reported enrollment data for all but the first quarter (January – March 2014). Colorado reported enrollment data for only the first quarter (January – March 2014). Hawaii reported enrollment data for all but the last quarter (October – December 2014). Nevada, New Jersey and Washington reported enrollment data in each quarter, they did not report enrollment data for each month in the 4th quarter of 2014 (data were reported for December only).

[3] 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.

[4] Robin Rudowitz, "Understanding How States Access the ACA Enhanced Medicaid Match Rates", Kaiser Family Foundation, September 2014. http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

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National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending

ABSTRACT **US health care spending increased 5.3 percent to $3.0 trillion in 2014. On a per capita basis, health spending was $9,523 in 2014, an increase of 4.5 percent from 2013. The share of gross domestic product devoted to health care spending was 17.5 percent, up from 17.3 percent in 2013. The faster growth in 2014 that followed five consecutive years of historically low growth was primarily due to the major coverage expansions under the Affordable Care Act, particularly for Medicaid and private health insurance, which contributed to an increase in the insured share of the population. Additionally, the introduction of new hepatitis C drugs contributed to rapid growth in retail prescription drug expenditures, which increased by 12.2 percent in 2014. Spending by the federal government grew at a faster rate in 2014 than spending by other sponsors of health care, leading to a 2-percentage-point increase in its share of total health care spending between 2013 and 2014.**

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The National Health Expenditure Accounts Team is recognized in the acknowledgments at the end of the article.

Total spending for health care in the United States increased 5.3 percent and reached $3.0 trillion in 2014, or $9,523 per person (Exhibit 1). This was faster than the rate of growth in 2013 (2.9 percent), which was the lowest in the fifty-five-year history of the National Health Expenditure Accounts. The acceleration in health spending growth in 2014 followed five consecutive years of historically low growth, which averaged 3.7 percent. Health care spending grew 1.2 percentage points faster than the overall economy in 2014 (when the nominal gross domestic product [GDP] increased 4.1 percent), resulting in a 0.2-percentage-point increase in the health spending share of GDP—to 17.5 percent. By comparison, the health spending share of GDP remained between 17.3 percent and 17.4 percent from 2009 to 2013.

The acceleration in health spending growth in 2014 was primarily driven by faster growth in private health insurance and Medicaid spending in 2014, compared to 2013, as well as by rapid growth in spending on retail prescription drugs (Exhibit 2). Total private health insurance spending growth accelerated from 1.6 percent in 2013 to 4.4 percent in 2014, driven in part by the expansion of health insurance coverage under the Affordable Care Act (ACA), which contributed to faster growth in 2014 benefit spending for prescription drugs, physician and clinical services, and hospital care, compared to 2013. Enrollment in private health insurance increased by 2.2 million in 2014, or 1.2 percent, largely as a result of the net effect of enrollment in health insurance Marketplace plans (Exhibit 3).

Medicaid spending growth also accelerated in 2014, increasing at a rate of 11.0 percent, compared to a growth rate of 5.9 percent in 2013 (Exhibit 3). The acceleration in 2014 was primarily due to provisions in the ACA that expanded eligibility (while providing full federal financing for all newly eligible enrollees) and enhanced

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EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts, Share Of Gross Domestic Product (GDP), And Annual Growth, By Source Of Funds, Calendar Years 2008–14

Source of funds	2008[a]	2009	2010	2011	2012	2013	2014
EXPENDITURE AMOUNT							
NHE, billions	$2,402.6	$2,496.4	$2,595.7	$2,696.6	$2,799.0	$2,879.9	$3,031.3
Health consumption expenditures	2,254.6	2,357.5	2,452.9	2,547.1	2,645.8	2,727.4	2,877.4
Out of pocket	295.8	294.6	299.5	309.7	318.7	325.5	329.8
Health insurance	1,697.8	1,796.3	1,876.3	1,955.1	2,027.6	2,087.9	2,216.9
Private health insurance	804.7	832.7	863.1	902.5	934.1	949.2	991.0
Medicare	467.0	498.8	520.5	546.1	569.2	586.3	618.7
Medicaid	344.2	374.5	397.2	406.4	422.0	446.7	495.8
Federal	203.1	247.3	266.3	247.0	242.8	257.7	305.1
State and local	141.1	127.1	130.8	159.4	179.2	189.0	190.6
Other health insurance programs[b]	81.9	90.3	95.6	100.1	102.2	105.6	111.4
Other third-party payers and programs and public health activity	261.0	266.6	277.1	282.3	299.5	314.0	330.7
Investment	148.0	139.0	142.7	149.5	153.2	152.5	153.9
Population (millions)	303.8	306.4	309.0	311.2	313.6	315.9	318.3
GDP, billions of dollars	$14,718.6	$14,418.7	$14,964.4	$15,517.9	$16,155.3	$16,663.2	$17,348.1
NHE per capita	$7,909	$8,147	$8,402	$8,666	$8,927	$9,115	$9,523
GDP per capita	$48,449	$47,053	$48,436	$49,869	$51,523	$52,741	$54,502
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	97.7	100.0	102.7	105.1	106.9	108.3	110.2
GDP price index	99.2	100.0	101.2	103.3	105.2	106.9	108.7
Real spending							
NHE, billions of chained dollars	$2,460	$2,496	$2,529	$2,565	$2,619	$2,660	$2,750
GDP, billions of chained dollars	$14,830	$14,419	$14,784	$15,021	$15,355	$15,583	$15,962
NHE as percent of GDP	16.3	17.3	17.3	17.4	17.3	17.3	17.5
ANNUAL GROWTH							
NHE	4.6%	3.9%	4.0%	3.9%	3.8%	2.9%	5.3%
Health consumption expenditures	4.5	4.6	4.0	3.8	3.9	3.1	5.5
Out of pocket	1.8	−0.4	1.6	3.4	2.9	2.1	1.3
Health insurance	5.5	5.8	4.5	4.2	3.7	3.0	6.2
Private health insurance	3.6	3.5	3.6	4.6	3.5	1.6	4.4
Medicare	7.9	6.8	4.3	4.9	4.2	3.0	5.5
Medicaid	5.7	8.8	6.1	2.3	3.8	5.9	11.0
Federal	9.5	21.8	7.7	−7.2	−1.7	6.1	18.4
State and local	0.6	−9.9	2.9	21.8	12.4	5.5	0.9
Other health insurance programs[b]	9.9	10.1	5.9	4.7	2.2	3.3	5.5
Other third-party payers and programs and public health activity	1.3	2.1	4.0	1.9	6.1	4.9	5.3
Investment	6.9	−6.1	2.7	4.7	2.5	−0.5	0.9
Population	0.9	0.9	0.8	0.7	0.8	0.8	0.7
GDP, billions of dollars	1.7	−2.0	3.8	3.7	4.1	3.1	4.1
NHE per capita	3.7	3.0	3.1	3.1	3.0	2.1	4.5
GDP per capita	0.7	−2.9	2.9	3.0	3.3	2.4	3.3
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	2.0	2.4	2.7	2.4	1.7	1.3	1.8
GDP price index	1.9	0.8	1.2	2.1	1.8	1.6	1.6
Real spending							
NHE, billions of chained dollars	2.6	1.5	1.3	1.4	2.1	1.6	3.4
GDP, billions of chained dollars	−0.3	−2.8	2.5	1.6	2.2	1.5	2.4

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found in Centers for Medicare and Medicaid Services. National Health Accounts methodology paper, 2014: definitions, sources, and methods [Internet]. Baltimore (MD): CMS; 2015 [cited 2015 Dec 2]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-14.pdf. Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2007–08. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI, Department of Defense, and Department of Veterans Affairs.

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EXHIBIT 2

National Health Expenditures (NHE) Amounts And Annual Growth, By Spending Category, Calendar Years 2008–14

Spending category	2008[a]	2009	2010	2011	2012	2013	2014
EXPENDITURE AMOUNT							
NHE, billions	$2,402.6	$2,496.4	$2,595.7	$2,696.6	$2,799.0	$2,879.9	$3,031.3
Health consumption expenditures	2,254.6	2,357.5	2,452.9	2,547.1	2,645.8	2,727.4	2,877.4
Personal health care	2,013.9	2,115.9	2,194.1	2,280.4	2,371.8	2,441.3	2,563.6
Hospital care	727.6	778.1	817.6	853.2	902.7	933.9	971.8
Professional services	649.4	669.5	691.3	721.2	749.5	767.5	801.6
Physician and clinical services	483.7	500.5	516.4	540.9	563.0	576.8	603.7
Other professional services	63.7	66.6	69.9	73.3	77.6	80.3	84.4
Dental services	101.9	102.3	105.0	107.1	108.9	110.4	113.5
Other health, residential, and personal care	114.5	123.3	129.0	131.8	137.9	144.5	150.4
Home health care	62.3	67.4	71.1	73.6	76.9	79.4	83.2
Nursing care facilities and continuing care retirement communities	131.5	136.9	140.9	146.8	148.3	150.2	155.6
Retail outlet sales of medical products	328.6	340.9	344.2	353.8	356.5	365.8	401.0
Prescription drugs	241.4	252.7	253.0	258.7	259.1	265.3	297.7
Durable medical equipment	37.7	37.8	39.9	42.3	43.7	44.9	46.4
Other nondurable medical products	49.5	50.3	51.2	52.8	53.7	55.6	56.9
Government administration	29.2	29.6	30.2	32.4	33.5	36.3	40.2
Net cost of health insurance	140.0	137.9	153.2	160.3	164.4	173.2	194.6
Government public health activities	71.5	74.1	75.4	74.0	76.0	76.6	79.0
Investment	148.0	139.0	142.7	149.5	153.2	152.5	153.9
Noncommercial research	44.3	45.4	49.2	49.6	48.4	46.5	45.5
Structures and equipment	103.7	93.6	93.5	99.8	104.8	106.0	108.3
ANNUAL GROWTH							
NHE	4.6%	3.9%	4.0%	3.9%	3.8%	2.9%	5.3%
Health consumption expenditures	4.5	4.6	4.0	3.8	3.9	3.1	5.5
Personal health care	4.9	5.1	3.7	3.9	4.0	2.9	5.0
Hospital care	5.2	6.9	5.1	4.3	5.8	3.5	4.1
Professional services	5.6	3.1	3.3	4.3	3.9	2.4	4.4
Physician and clinical services	5.5	3.5	3.2	4.7	4.1	2.5	4.6
Other professional services	7.9	4.6	4.9	4.8	5.9	3.5	5.2
Dental services	5.1	0.4	2.7	2.0	1.6	1.5	2.8
Other health, residential, and personal care	5.7	7.7	4.6	2.2	4.6	4.7	4.1
Home health care	8.4	8.1	5.5	3.6	4.4	3.3	4.8
Nursing care facilities and continuing care retirement communities	4.1	4.1	2.9	4.2	1.0	1.3	3.6
Retail outlet sales of medical products	2.5	3.7	1.0	2.8	0.8	2.6	9.6
Prescription drugs	2.5	4.7	0.1	2.2	0.2	2.4	12.2
Durable medical equipment	1.6	0.4	5.6	5.8	3.4	2.8	3.2
Other nondurable medical products	3.6	1.7	1.8	3.1	1.7	3.5	2.4
Government administration	0.3	1.4	2.2	7.2	3.3	8.5	10.7
Net cost of health insurance	−2.4	−1.5	11.1	4.6	2.6	5.3	12.4
Government public health activities	8.5	3.5	1.8	−1.8	2.7	0.7	3.1
Investment	6.9	−6.1	2.7	4.7	2.5	−0.5	0.9
Noncommercial research	4.0	2.5	8.5	0.9	−2.4	−4.1	−2.0
Structures and equipment	8.3	−9.8	−0.1	6.7	5.0	1.2	2.2

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2007–08.

payments to primary care providers. Medicaid enrollment grew by 7.7 million in 2014, an increase of 13.2 percent (compared to growth of 1.7 percent in 2013), as twenty-six states plus the District of Columbia expanded coverage. Expansion in eligibility and enrollment resulted in faster growth for almost all Medicaid benefit categories in 2014 compared to 2013—most notably, physician and clinical services—and led to additional spending on government administration and the net cost of insurance associated with Medicaid managed care plans.

A rapid increase in prescription drug spending growth—from 2.4 percent in 2013 to 12.2 percent in 2014 (Exhibit 2)—also contributed to the acceleration in overall health expenditure growth

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EXHIBIT 3

National Health Expenditures (NHE) And Health Insurance Enrollment, Aggregate And Per Enrollee Amounts, And Annual Growth, By Source Of Funds, Calendar Years 2008–14

Source of funds	2008[a]	2009	2010	2011	2012	2013	2014
PRIVATE HEALTH INSURANCE							
Expenditure (billions)	$804.7	$832.7	$863.1	$902.5	$934.1	$949.2	$991.0
Expenditure growth	3.6%	3.5%	3.6%	4.6%	3.5%	1.6%	4.4%
Per enrollee expenditure	$4,108	$4,390	$4,646	$4,878	$4,972	$5,056	$5,218
Per enrollee expenditure growth	4.5%	6.9%	5.8%	5.0%	1.9%	1.7%	3.2%
Enrollment (millions)	195.9	189.7	185.8	185.0	187.9	187.7	189.9
Enrollment growth	−0.8%	−3.2%	−2.1%	−0.4%	1.5%	−0.1%	1.2%
MEDICARE							
Expenditure (billions)	$467.0	$498.8	$520.5	$546.1	$569.2	$586.3	$618.7
Expenditure growth	7.9%	6.8%	4.3%	4.9%	4.2%	3.0%	5.5%
Per enrollee expenditure	$10,520	$10,971	$11,173	$11,439	$11,456	$11,434	$11,707
Per enrollee expenditure growth	5.2%	4.3%	1.8%	2.4%	0.1%	−0.2%	2.4%
Enrollment (millions)	44.4	45.5	46.6	47.7	49.7	51.3	52.8
Enrollment growth	2.6%	2.4%	2.5%	2.5%	4.1%	3.2%	3.1%
MEDICAID							
Expenditure (billions)	$344.2	$374.5	$397.2	$406.4	$422.0	$446.7	$495.8
Expenditure growth	5.7%	8.8%	6.1%	2.3%	3.8%	5.9%	11.0%
Per enrollee expenditure	$7,293	$7,372	$7,316	$7,277	$7,376	$7,676	$7,523
Per enrollee expenditure growth	2.1%	1.1%	−0.8%	−0.5%	1.4%	4.1%	−2.0%
Enrollment (millions)[b]	47.2	50.8	54.3	55.9	57.2	58.2	65.9
Enrollment growth	3.5%	7.6%	6.9%	2.9%	2.4%	1.7%	13.2%
UNINSURED AND POPULATION							
Uninsured (millions)	42.2	45.9	48.1	45.6	44.8	44.2	35.5
Uninsured growth	2.7%	8.9%	4.7%	−5.1%	−1.9%	−1.3%	−19.5%
Population (millions)	303.8	306.4	309.0	311.2	313.6	315.9	318.3
Population growth	0.9%	0.9%	0.8%	0.7%	0.8%	0.8%	0.7%
Insured share of total population	86.1%	85.0%	84.4%	85.3%	85.7%	86.0%	88.8%

SOURCES Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2007–08. [b]Based on an unpublished analysis by the CMS Office of the Actuary of the following sources: (1) enrollment data from the Medicaid Statistical Information System state summary database: Medicaid.gov. MSIS Medicaid Statistical Information System [Internet]. Baltimore (MD): CMS; [cited 2015 Nov 13]. Available from: http://medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/msis/medicaid-statistical-information-system.html; and (2) CMS-64 quarterly state reports: CMS.gov. CMS-64 quarterly expense report [Internet]. Baltimore (MD): CMS; [last modified 2012 Mar 28; cited 2015 Nov 13]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/CMS-64-Quarterly-Expense-Report.html.

in 2014. This rapid increase, which was the highest rate since 2002, was in part due to the introduction of new drug treatments for hepatitis C as well as of those used to treat cancer and multiple sclerosis.[1]

In 2014 the number of uninsured individuals fell by 8.7 million, a decline of 19.5 percent (Exhibit 3). As a result, the insured share of the total population increased from 86.0 percent in 2013 to 88.8 percent in 2014—the highest share since 1987.

The federal government's share of health care spending increased from 26 percent in 2013 to 28 percent in 2014 as federal expenditures grew 11.7 percent, or 8.2 percentage points faster than in 2013 (discussed below). A 100 percent federal match rate for newly eligible Medicaid enrollees, as well as health insurance premium tax credits and cost-sharing subsidies paid by the federal government, accounted for much of the increased share. In contrast, the shares of spending by households (28 percent) and state and local governments (17 percent) each fell by 1 percentage point from 2013 to 2014. The private business share of health care spending remained steady in 2013 and 2014, at 20 percent.

The Affordable Care Act

Since its enactment in 2010, numerous provisions of the ACA have affected the health sector. However, the most significant provisions took effect in 2014, including major coverage expansions through private health insurance and Medicaid. In 2014 Medicaid coverage expanded in some states to most people under age sixty-five with incomes of up to 138 percent of the federal poverty level,[2] and enhanced federal matching

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payments were provided for newly eligible enrollees. This change in the eligibility criteria is estimated to have led to an additional 6.3 million enrollees in 2014.[3] As a result of this expanded coverage, enrollment in Medicaid increased 13.2 percent in 2014 (up from growth of 1.7 percent in 2013), and spending increased 11.0 percent (up from growth of 5.9 percent in 2013) (Exhibit 3).

Health insurance was also expanded through private insurers, including health plans purchased in the health insurance Marketplaces. The Marketplaces allow individuals and small businesses (those with fewer than 100 employees) to purchase policies that by law must guarantee availability of coverage, prohibit annual dollar limits on coverage received, and create an essential health benefits package that provides comprehensive health benefits. Marketplace average monthly enrollment was 5.4 million in 2014.[4,5] Additionally, the ACA provides health insurance premium tax credits and cost-sharing subsidies to eligible individuals and imposes new fees on the health insurance sector.[6]

Other provisions of the ACA that took effect before 2014 continued to affect overall health spending. These include changes to Medicare and Medicaid provider payments, increased Medicaid prescription drug rebates, reductions to the size of the Medicare Part D coverage gap, prescription drug industry fees, and implementation of the medical loss ratio requirement for private insurers.[7]

Factors Accounting For Growth

Aggregate national health spending grew 5.3 percent in 2014, or 4.5 percent per capita (Exhibit 1). This per capita growth can be examined further by analyzing the impact of medical price inflation (which includes overall economywide price inflation and medical-specific price inflation) and nonprice factors, such as shifts in the age and sex mix of the population and residual use and intensity of services. Of the 4.5 percent increase in per capita health spending in 2014, changes in the age and sex mix of the population accounted for 0.6 percentage point, medical price inflation accounted for 1.8 percentage points, and the change in residual use and intensity accounted for the remaining 2.1 percentage points (Exhibit 4).

There was a substantial increase in the portion of health spending growth attributed to residual use and intensity of services in 2014. In 2013 the growth rate for this factor was just 0.2 percent, but it accelerated to 2.1 percent in 2014 and accounted for almost half of per capita health spending growth. As Medicaid and private health insurance coverage expanded, faster growth in residual use and intensity of services occurred for almost all health care goods and services in 2014 compared to 2013, particularly for hospital care, physician and clinical services, and prescription drugs.

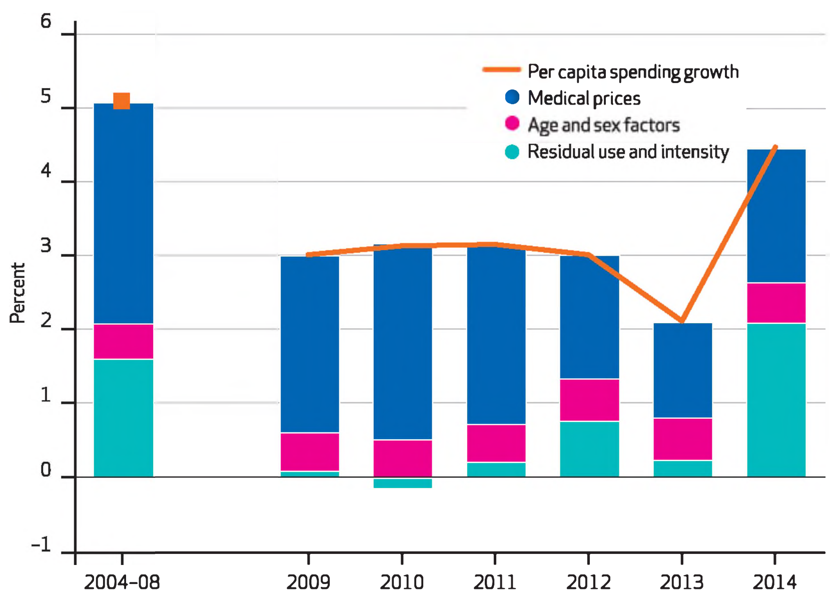
Medical price growth increased at a rate of 1.8 percent in 2014, following growth of 1.3 percent in 2013. Economywide inflation (as measured by the GDP price index) increased 1.6 percent in both 2013 and 2014, while medical-specific price growth increased 0.1 percent after a decline of 0.3 percent in 2013. Faster price growth for expenditures outside of personal health care (such as the net cost of insurance and investment in structures and equipment) more than offset a slight deceleration in overall prices for personal health care services, such as for hospital care and other professional services.

Revisions To The National Health Expenditure Accounts

The health spending estimates in this article differ in two ways from those released December 3, 2014.[7] First, these estimates reflect new and revised source data that were unavailable for previous vintages of the National Health Expendi-

EXHIBIT 4

Factors Accounting For Growth In Per Capita National Health Expenditures, Selected Calendar Years 2004–14



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTE** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted national health expenditures (NHE) deflator for NHE. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

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ture Accounts. In particular, the 2013 growth rate for national health spending was revised down from 3.6 percent to 2.9 percent, mainly because of downward revisions to the estimates for physician and clinical services and hospital spending.

Second, every five years the National Health Expenditure Accounts undergo a comprehensive review and revision process that ensures that the concepts, definitions, methods, and data sources used in the accounts reflect the most current and complete information available. Most revisions prior to 2013 largely reflect this comprehensive review. Notable revisions include the incorporation of data from the 2012 Economic Census[8] and other "benchmark" data sources, as well as shifts within payer and service categories to more accurately align the estimates, such as a new method for estimating Medicaid managed care spending by service.

In total, changes due to the comprehensive and routine revisions resulted in a downward revision of $18.3 billion in 2012, or 0.7 percent of national health expenditures, compared to last year's report. In addition, the GDP was revised down by $7.9 billion for 2012.[9] As a result, the health spending share of GDP for 2012 is now reported as 17.3 percent, down from the previously reported share of 17.4 percent.[7]

Sponsors Of Health Care

The main sponsors of health care are households, private businesses, the federal government, and state and local governments that finance the nation's health care bill. In 2014 households and the federal government accounted for the largest shares of spending (28 percent each), followed by private businesses (20 percent), and state and local governments (17 percent) (Exhibit 5). Overall, total government expenditures accounted for a larger share of health spending in 2014 (45 percent) than in either 2012 or 2013 (44 percent). The

EXHIBIT 5

National Health Expenditures (NHE) Amounts, Annual Growth, And Percent Distribution, By Type Of Sponsor, Calendar Years 2008–14

Type of sponsor	2008[a]	2009	2010	2011	2012	2013	2014
EXPENDITURE AMOUNT							
NHE, billions	$2,402.6	$2,496.4	$2,595.7	$2,696.6	$2,799.0	$2,879.9	$3,031.3
Businesses, household, and other private revenues	1,411.5	1,412.1	1,444.6	1,505.6	1,581.0	1,618.3	1,672.6
Private businesses	513.8	514.6	518.8	546.7	571.9	581.9	606.4
Household	724.6	729.8	751.2	777.5	811.7	827.4	844.0
Other private revenues	173.1	167.8	174.6	181.5	197.4	209.1	222.2
Governments	991.1	1,084.3	1,151.1	1,190.9	1,218.0	1,261.6	1,358.7
Federal government	581.1	680.0	731.1	730.8	730.0	755.5	843.7
State and local governments	409.9	404.3	420.0	460.2	488.0	506.0	515.0
ANNUAL GROWTH							
NHE	4.6%	3.9%	4.0%	3.9%	3.8%	2.9%	5.3%
Businesses, household, and other private revenues	2.9	0.0	2.3	4.2	5.0	2.4	3.4
Private businesses	1.3	0.1	0.8	5.4	4.6	1.7	4.2
Household	4.4	0.7	2.9	3.5	4.4	1.9	2.0
Other private revenues	1.7	−3.1	4.1	4.0	8.8	5.9	6.3
Governments	7.1	9.4	6.2	3.5	2.3	3.6	7.7
Federal government	10.0	17.0	7.5	−0.1	−0.1	3.5	11.7
State and local governments	3.3	−1.4	3.9	9.6	6.1	3.7	1.8
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	59	57	56	56	56	56	55
Private businesses	21	21	20	20	20	20	20
Household	30	29	29	29	29	29	28
Other private revenues	7	7	7	7	7	7	7
Governments	41	43	44	44	44	44	45
Federal government	24	27	28	27	26	26	28
State and local governments	17	16	16	17	17	18	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Exhibit 1 Notes). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2007–08.

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shift toward more government spending was influenced mainly by strong growth in federal government spending, along with continued low growth in household expenditures in 2014.

Growth in federal government spending outpaced growth in expenditures for all other sponsors of health care in 2014, increasing 11.7 percent, compared to 3.5 percent in 2013. This faster growth led to a 2-percentage-point increase in the federal government's share of total health spending—from 26 percent in 2013 to 28 percent in 2014. The acceleration was mainly the result of provisions of the ACA, such as Medicaid enrollment expansion and health insurance premium tax credits. Medicaid spending by the federal government increased 18.4 percent in 2014, compared to 6.1 percent in 2013.

Households continued to be the largest sponsor of health care in 2014 at 28 percent, although their share was down from 29 percent in 2013. Compared to growth of 4.4 percent in 2012, household health spending growth was slower in 2013 and 2014, increasing 1.9 percent and 2.0 percent, respectively. Household health spending includes out-of-pocket payments, household payments for private health insurance and Medicare premiums, and payroll taxes dedicated to the Medicare program. Household contributions to private health insurance premiums (representing a 38 percent share of total household expenditures) increased just 0.1 percent in 2014 after growing 1.4 percent in 2013, mainly as a result of health insurance premium tax credits paid by the federal government. These credits reduced the premiums that households with eligible individuals paid for Marketplace plans. Out-of-pocket spending (which accounted for 39 percent of total household expenditures) grew at a slightly slower rate in 2014, increasing 1.3 percent following growth of 2.1 percent in 2013.

Health spending by private businesses, which includes employers' contributions to private health insurance premiums and other health care programs, increased 4.2 percent in 2014, compared to a growth rate of 1.7 percent in 2013. Despite the accelerated growth in 2014, private businesses continued to account for 20 percent of total health spending—a share that has remained stable since 2010. The major driver of growth in private business spending in 2014 was employer contributions to private health insurance premiums, which accounted for a 76 percent share of this category and increased 3.7 percent, compared to growth of 1.1 percent in 2013.

State and local governments accounted for 17 percent of health spending in 2014, a 1-percentage-point decline from their share in 2013. Growth in health expenditures for state and local governments slowed to 1.8 percent in 2014, compared to 3.7 percent in 2013. The deceleration was driven by slower growth in state and local Medicaid spending, which grew 5.5 percent in 2013 but only 0.9 percent in 2014, mostly as a result of slow enrollment growth in the nonexpansion population.

Private Health Insurance

Total private health insurance spending increased 4.4 percent and reached $991.0 billion in 2014, accounting for one-third of total national health care expenditures. This was a faster growth rate than in 2013 (1.6 percent), when private health insurance spending grew at the slowest pace since 1967. In 2014 numerous ACA provisions became effective, including the implementation of Marketplace plans, the introduction of health insurance premium tax credits, new health insurance industry fees, and mandated changes to benefit designs, all of which created upward pressure on 2014 private health insurance spending growth.

The number of people in the United States covered by private health insurance reached 189.9 million in 2014, up from 187.7 million in 2013—an increase of 1.2 percent. Private health insurance enrollment grew primarily because of individuals who gained coverage under the new Marketplace plans. Per enrollee private health insurance spending increased 3.2 percent in 2014, following a smaller increase of 1.7 percent in 2013.

Expenditures for private health insurance medical benefits grew 4.1 percent in 2014, accelerating from growth of 1.5 percent in 2013. This acceleration was driven by faster growth in spending for retail prescription drugs, physician and clinical services, and hospital care in 2014, compared to 2013. Rapid growth in retail prescription drug spending in 2014 was due in part to the introduction of new drug treatments for hepatitis C.[1] Faster growth in private health insurance expenditures for physician and clinical services and hospital care in 2014, compared to 2013, was driven by increased use mainly due to enrollment growth.

Although spending for private health insurance benefits increased in 2014, their share of total private health insurance spending was down slightly, from 87.9 percent in 2013 to 87.7 percent in 2014. Growth in the net cost of insurance, or the difference between revenue and benefits, was 6.6 percent in 2014 and primarily reflected fees associated with the ACA, as well as other administrative costs related to increased private health insurance enrollment.

12.2%

Growth

A rapid increase in prescription drug spending growth, from 2.4 percent in 2013 to 12.2 percent in 2014, contributed to the acceleration in overall spending growth seen in 2014.

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Medicaid

Total Medicaid spending by the federal government and state and local governments reached $495.8 billion in 2014 and accounted for 16 percent of total national health expenditures. Following growth of 5.9 percent in 2013, Medicaid spending increased 11.0 percent in 2014—the fastest rate of growth since 2001.

The primary driver of faster Medicaid spending growth in 2014 was enrollment in Medicaid resulting from the eligibility expansion under the ACA. After growing 1.7 percent in 2013, enrollment jumped an estimated 13.2 percent in 2014—the fastest rate of growth since 1991, when Medicaid enrollment increased 13.8 percent. This growth rate was also faster than during the two most recent recessions in 2002 and 2009, when enrollment growth peaked at 9.8 percent and 7.6 percent, respectively.

Per enrollee Medicaid spending declined at a rate of 2.0 percent in 2014 after growing 4.1 percent in 2013, as the newly insured tended to be lower-cost individuals.[2] The share of total Medicaid enrollees who were adults and children (groups that are generally less expensive than the aged and disabled) increased in 2014, compared with 2013.[2]

Faster growth in spending for government administration and the net cost of insurance was also a contributor to the overall acceleration in Medicaid spending growth in 2014, with expenditures increasing 30.4 percent after growing 13.8 percent in 2013. This faster rate of growth in 2014 was driven primarily by increased enrollment, particularly for managed care, as new enrollees tended to join Medicaid managed care plans.

Medicaid spending for physician and clinical services, hospital care, and prescription drugs increased at a faster rate in 2014 than in the previous year. Expenditures for physician and clinical services grew 22.8 percent, up from growth of 11.0 percent in 2013, because of both increased enrollment and ACA provisions that required states to pay fees to primary care providers that were at least equal to the fees that Medicare paid to primary care providers in 2013 and 2014.[10] After growing 4.0 percent in 2013, Medicaid hospital spending increased 7.6 percent in 2014, largely reflecting increased enrollment. Medicaid prescription drug expenditures grew 24.3 percent in 2014, up from growth of 4.2 percent in 2013, as a result of increased enrollment and spending for drugs that treat hepatitis C.[10]

Federal Medicaid expenditures grew at a much faster rate than did state and local Medicaid spending in 2014. Federal Medicaid expenditures increased 18.4 percent—compared to growth of 6.1 percent in 2013—since expenditures for newly eligible enrollees under the ACA were fully financed by the federal government. State and local Medicaid spending grew just 0.9 percent (compared to 5.5 percent in 2013), primarily as a result of the low enrollment growth of the nonexpansion population.

Medicare

Total Medicare spending reached $618.7 billion in 2014 and accounted for 20 percent of total health expenditures. After growing 3.0 percent in 2013, Medicare spending grew 5.5 percent in 2014. This was the fastest rate of growth since 2009 (when spending increased by 6.8 percent) and was primarily attributable to faster growth in spending for prescription drugs, physician and clinical services, and government administration and the net cost of insurance.

Fee-for-service Medicare expenditures, which accounted for 70 percent of total Medicare spending in 2014, increased 3.1 percent compared to growth of 1.3 percent in 2013. Medicare Advantage spending accounted for the remaining 30 percent of total Medicare expenditures, and in 2014 these expenditures increased 11.6 percent, following growth of 7.7 percent in 2013.

Total Medicare enrollment increased 3.1 percent in 2014, similar to the increase of 3.2 percent in 2013. Continued strong enrollment growth in Medicare Advantage plans helped offset slower enrollment growth in traditional fee-for-service plans in 2014. Medicare Advantage enrollment increased 10.0 percent in 2014 (compared with growth of 9.4 percent in 2013). This was considerably faster than growth in fee-for-service enrollment, which increased only 0.4 percent (compared with 1.0 percent in 2013).

Medicare per enrollee spending growth accelerated in 2014, increasing 2.4 percent after increasing just 0.1 percent in 2012 and declining 0.2 percent in 2013.[11] In the two years prior to 2014, slower and declining per enrollee expenditures were influenced by a combination of one-time payment reductions and policies put in place by the ACA and budget sequestration.

Faster growth in per enrollee spending in 2014 was also affected by increased use of health care goods and services, especially prescription drugs and physician services. Following growth of 9.5 percent in 2013, Medicare prescription drug spending increased 16.9 percent in 2014, primarily because of the use of new and expensive specialty drugs, including those used in treating hepatitis C.[12] Additionally, growth in Medicare spending for physician and clinical services accelerated in 2014—increasing 5.0 percent from

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The return to faster growth and an increased share of GDP in 2014 was largely influenced by the coverage expansions of the Affordable Care Act.

2.9 percent in 2013—because of a larger increase in the physician fee schedule payment update and an increase in the volume and intensity of services.

Also contributing to the increase in total Medicare expenditures in 2014 was faster spending growth for government administration and the net cost of insurance, which increased 8.1 percent in 2014 after growing 2.1 percent in 2013. The net cost of Medicare Advantage accounted for just over half of all Medicare administration spending in 2014, with expenditures increasing 9.7 percent, compared to 1.6 percent in 2013. These Medicare Advantage net cost expenditures increased mainly as a result of health insurance industry fees that were imposed on Medicare Advantage plans in 2014, as mandated by the ACA.[13]

Out-Of-Pocket Spending

Total out-of-pocket spending—which includes direct consumer payments such as copayments, deductibles, coinsurance, and any spending on noncovered services—increased 1.3 percent in 2014, reaching $329.8 billion, and accounted for 11 percent of total health care expenditures. Following growth of 2.1 percent in 2013, the slightly slower growth in out-of-pocket spending in 2014 was affected by changes in health care coverage, most notably fewer out-of-pocket payments by those without insurance and more by those with Medicaid and directly purchased coverage.[14]

Compared to 2013, faster out-of-pocket spending growth in 2014 for prescription drugs (particularly because of increased use of high-cost specialty drugs) and other professional services was more than offset by a decline in out-of-pocket spending for hospital services and slower growth in such spending for physician and clinical services (both of which were due to increased insurance coverage).

Retail Prescription Drugs

In 2014 growth in total retail prescription drug expenditures accelerated sharply, increasing 12.2 percent to $297.7 billion. This rate compares to growth of 2.4 percent in 2013 and 0.2 percent in 2012 and represents the largest annual increase since 2002. The strong growth in prescription drug expenditures in 2014 was caused by increased spending on new medicines (particularly for specialty drugs such as those used to treat hepatitis C), a smaller impact from patent expirations than in previous years, and price increases for brand-name drugs.[1] The single largest driver of growth in specialty drug spending in 2014 was the impact of new treatments for hepatitis C, which contributed $11.3 billion in new spending.[1]

Prescription drug price growth continued to be affected by faster growth in 2014 (compared to 2013) in prices for brand-name medications and declines in prices for generic drugs.[15] Because generic drugs cost substantially less than their brand-name counterparts,[16] it is not uncommon to see increases in the generic dispensing rate, especially when blockbuster drugs lose their patent protection. In 2014 the generic dispensing rate was 81.7 percent, up from 80.1 percent in 2013 and 77.3 percent 2012.[17]

Nonprice factors also grew at a faster rate in 2014. The number of retail prescriptions dispensed increased 1.8 percent in 2014 (compared to growth of 1.2 percent in 2013), primarily because the number of Medicaid prescriptions dispensed grew dramatically—a result of the ACA's enrollment expansion.[1]

The growth rate for prescription drug expenditures increased in 2014 for private health insurance, Medicare, and Medicaid. Private health insurance spending on prescription drugs increased 11.3 percent, following growth of 1.0 percent in 2013. Medicare spending on prescription drugs also accelerated, growing 16.9 percent in 2014 compared to 9.5 percent in 2013, while growth for Medicaid prescription drug spending accelerated from 4.2 percent in 2013 to 24.3 percent in 2014.

Hospital Care

Expenditures for hospital care increased 4.1 percent in 2014, accelerating from growth of 3.5 percent in 2013, and reached $971.8 billion. The faster growth in hospital spending in 2014 re-

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flected a resurgence in growth of nonprice factors, such as the use and intensity of services. For example, the number of inpatient days and hospital discharges increased by 0.8 percent and 0.7 percent, respectively, in 2014,[18,19] following slower or declining growth in inpatient admissions, inpatient surgeries, and outpatient visits in 2013.[20] In contrast, price growth, as measured by the Hospital Producer Price Index, increased at a slower rate in 2014 than in 2013—1.3 percent and 2.2 percent, respectively.[21]

For Medicaid, private health insurance, and Medicare, spending growth for hospital services accelerated in 2014. Following growth of 4.0 percent in 2013, Medicaid spending for hospital services increased 7.6 percent in 2014, primarily as a result of expanded Medicaid coverage.[2] Private health insurance spending for hospital care increased 3.5 percent in 2014, following growth of 2.7 percent the year before—the slowest rate since 1996. Similar to Medicaid, private health insurance spending for hospital services was influenced by increased private health insurance enrollment. Compared to the hospital spending growth rates for Medicaid and private health insurance, growth in Medicare hospital expenditures experienced a smaller acceleration, increasing 2.9 percent in 2014, compared to 2.2 percent in 2013.

Out-of-pocket spending on hospital services, which includes expenditures for copayments and deductibles, declined 4.1 percent in 2014, down from a growth rate of 4.7 percent in 2013. This decline was influenced by expanded coverage through Medicaid and private health insurance.

Physician And Clinical Services

Spending for physician and clinical services grew 4.6 percent in 2014, reaching $603.7 billion. This was an acceleration from 2013, when spending grew at a historically low rate of 2.5 percent.

As with hospital services and retail prescription drugs, expenditure growth for physician and clinical services accelerated in 2014 for Medicaid, private health insurance, and Medicare. Spending for Medicaid physician and clinical services—which increased 22.8 percent in 2014, compared to 11.0 percent in 2013—was influenced by expanded Medicaid enrollment eligibility under the ACA and increased primary care provider fees that affected growth in 2013 and, to a greater extent, in 2014.[10] Private health insurance spending also contributed to the acceleration in expenditure growth for total physician and clinical services, increasing 1.2 percent in 2014 after a decline of 0.1 percent in 2013. Finally, Medicare spending for physician and clinical services increased 5.0 percent in 2014, following a smaller increase of 2.9 percent in 2013.

Physician expenditures accounted for 80 percent of spending for total physician and clinical services in 2014. Over the past decade the physician share declined, as spending for clinical services continued to increase more rapidly than physician expenditures. In 2014 spending for physician services increased 4.6 percent (accelerating from growth of 1.7 percent in 2013), while spending for clinical services increased 5.0 percent (slowing from 5.5 percent in 2013). Continued strong growth in spending for clinical services in 2014 resulted from rapid spending growth in outpatient care centers, such as community health centers, and in kidney dialysis centers. However, for overall clinical services, expenditure growth was moderated by a decline in spending for freestanding ambulatory surgical centers.

For physician and clinical services, growth in both price and nonprice factors, such as residual use and intensity, accelerated in 2014 compared to 2013. Prices increased 0.5 percent in 2014 (up slightly from growth of 0.1 percent in 2013),[22] influenced in part by a Medicare physician payment update of 0.5 percent compared to an update of 0.0 percent in 2013.[12] Nonprice factors also grew faster in 2014—driven, in part, by coverage expansions resulting from the ACA, particularly for Medicaid.[23]

Conclusion

The expansion of insurance coverage, particularly through Medicaid and private health insurance, and rapid growth in retail prescription drug spending fueled a 5.3 percent increase in total national health care expenditures in 2014. This increase compares to historically low health spending growth from 2009 to 2013, when growth averaged only 3.7 percent. Health expenditures grew faster than the overall economy in 2014, as the GDP increased 4.1 percent. As a result, the health spending share of GDP increased from 17.3 percent in 2013 to 17.5 percent in 2014. The return to faster growth and an increased share of GDP in 2014 was largely influenced by the coverage expansions of the Affordable Care Act. But how the health sector responds to the evolving access and incentive landscape, as well as underlying economic conditions, will determine the future trajectory of health spending growth. ■

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