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Ten State-Based Exchange Executives Tell Senate Leaders Graham-Cassidy Will Disrupt Insurance Markets and Prove Impossible to Implement

By Jennifer Laudano | September 25th, 2017

For Immediate Release: Sept. 25, 2017
Contact: Jennifer Laudano, 202-507-7584
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WASHINGTON, DC: Today, executive directors from 10 state-operated health insurance marketplaces expressed serious concerns over the financial cuts, drastic policy changes, and dramatically altered insurance funding model proposed in the Graham-Cassidy-Heller-Johnson amendment.

In a Sept. 25, 2017, letter to Senate leadership, state insurance marketplace leaders said the amendment could cause wide-scale market disruption resulting in issuer exits, escalating prices, loss of coverage, and/or elimination of consumer protections.

Drawing on their experiences as front-line implementers of state-based insurance market reforms, the leaders cautioned that implementation of the proposed reforms could be impossible in many states, given the amendment's short-sighted consideration of the policy, administrative, legislative, financial, operational, and regulatory hurdles that each state must navigate to implement the amendment's massive coverage reforms.

"This plan could trigger the collapse of states' entire individual markets, forcing millions to lose their health care coverage," said Peter V. Lee, executive director of Covered California. "The effect would lead not only to more uninsured than before the Affordable Care Act, but cause huge negative impacts on the health care delivery system, the economy, and those with employer-based health care coverage," he said.

"The amendment's financial cuts would force our states and insurers to choose between preserving protections deemed critical to our consumers, such as protecting those with pre-existing conditions, or drastically raising rates and/or minimizing choices in order to maintain a functional market," said Heather Korbulic, executive director of Nevada's Silver State Health Insurance Exchange. "Drawing on our collective experience, we encourage the Senate to return to bipartisan efforts that can benefit from our lessons learned, build on our successes, and bring both short- and long-term improvements to our markets."

The Senate Finance Committee is currently scheduled to hold a hearing on the amendment on Monday, September 25. A vote on the amendment has been tentatively scheduled for Wednesday, September 27.

The full text of the letter is available **here**.

The National Academy for State Health Policy is home to the State Health Exchange Leadership Network, a consortium of state leaders and staff dedicated to operation of the SBMs and SBM-FPs.

Filed under: Front Page , News & Media , Press Release , Affordable Care Act , Cassidy , Covered California , Graham , heather Korbulic , nashp , National Academy of State Health Policy , Peter Lee , pre-existing condition , repeal Obamacare , Senate , silver state health insurance exchange

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September 25, 2017

The Honorable Mitch McConnell, Majority Leader
The Honorable Charles Schumer, Minority Leader
The Honorable Orrin Hatch, Chairman, Senate Finance Committee
The Honorable Ron Wyden, Ranking Member, Senate Finance Committee
The Senate of the United States of America
Washington, D.C., 20510

Dear Leaders McConnell and Schumer and Senators Hatch and Wyden,

As front-line implementers of state-based health insurance marketplaces, the 10 state-based marketplaces write to express our serious concerns about the ramifications of the Graham-Cassidy-Heller-Johnson amendment on our states and the nation. Since opening our doors, the key mission of our marketplaces has been to develop and apply state-based solutions to provide quality and affordable coverage to more than 3.4 million consumers that enable us to bring choice and value to the citizens of our states. Based on our experience and analysis of the funding and structure of Graham-Cassidy-Heller-Johnson we want to highlight two primary areas of concern.

Potential Collapse of Individual Health Care Markets

Over four years of operation, we have learned many valuable lessons about our health insurance markets and the needs of our consumers. We know that two policies provide the predictability that is a necessary component of stable and affordable insurance markets: (1) moving the health insurance markets to ones that no longer screen for pre-existing conditions and promote a common risk pool with a broad mix of enrollees; and (2) providing financial support to consumers to make health care affordable and support a stable risk pool. While we encourage opportunities to innovate within our markets, this proposal dramatically changes current policy and the likelihood that consumers will get financial assistance, which risk wide-scale market disruption, including issuer exits, dramatically escalating prices, loss of coverage, and/or elimination of consumer protections**.** Graham-Cassidy-Heller-Johnson's time–limited and greatly reduced funding for both the current Advanced Premium Tax Credit and states' Medicaid programs will challenge the ability of our states to effectively provide our consumers with sustained, affordable, and value-based coverage options without risking deep cuts in coverage or significant tax increases. With greatly reduced funding, states will confront difficult choices. If they protect low-income residents

through their Medicaid program, the likely reduction of tax credits for the individual market could trigger the collapse of individual markets – health plans will not participate in markets in which they must take all comers without financial protections. This collapse would mean not only that those who currently benefit from subsidies would no longer have coverage, but that the millions in the individual market who pay for their own coverage would face the prospect of losing the possibility of getting any coverage. For states that opt to protect their individual markets, they would do so at the direct expense of those who are enrolled in Medicaid programs. In addition, the broad discretion given to the Secretary of Health and Human Services to adjust the financing formula increases the unpredictability and instability of the market.

Implementation of Effective State-Based Solutions Would Be Impossible in the Two-Year Window Provided

To the extent a state has the resources and wants to support an individual market, Graham-Cassidy-Heller-Johnson requires each state, most of which now operate under the federal marketplace, to convert current programs and policies in just two years. During implementation of our marketplaces, we witnessed firsthand the practical realities and challenges of implementing statewide insurance programs. Drawing from this experience, we know it is critical that any reforms have sufficient time and resources built in for states to develop efficient programs that are informed by evidence and best practices and are transparent to consumers. For us, we had a broad road-map, substantial federal financial support and a four-year lead time to launch our individual marketplaces. Given the great complexities related to information technology systems, eligibility and enrollment processes, developing marketing and outreach and health plan contracting – the struggles in meeting a four-year launch timeframe were huge (as evidenced by the well documented challenges facing healthcare.gov in 2014). The two-year timeline – calling for full state-based responsibility of programs to be created out of whole-cloth by 2020 – does not take into consideration the policy, administrative, legislative, financial, operational and regulatory hurdles that each state would need to navigate. While Graham-Cassidy-Heller-Johnson provides the appearance of state-based autonomy, even those states that have established state-based marketplaces would be greatly challenged to convert to a purely state-operated system absent core federal administrative and technology infrastructure supports, such as the administration of risk adjustment processes and the operation of the "federal hub" for managing eligibility and enrollment processes.

Representing diverse states, consumers, and political leadership, we encourage a return to the development of bipartisan solutions to stabilize our markets. In the short-term, financing of cost-sharing reduction payments and establishment of a federal reinsurance program will accelerate stability and help drive down costs in our markets. We encourage additional flexibility for states under ACA section 1332 waivers, while also ensuring all consumers continue to receive comprehensive and affordable coverage and protection for pre-existing conditions as in the ACA. Additional flexibility could clarify: 1) the ability to meet deficit neutrality requirements over the lifetime of the waiver, not year by year, thus allowing states the flexibility to invest in initial years and ramp up to savings in later waiver years; and 2) flexibility to establish open enrollment periods that are more suitable to meet local needs.

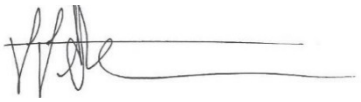
Beyond additional flexibility, we believe that the creation of planning grants and establishment of expedited federal processes for review and approval of waivers (without diminishing public

comment opportunities) could provide states with heightened opportunity to appropriately innovate in consideration of timely and local factors.

Long-term, we are committed to working with you to better understand key cost-drivers of our health insurance markets and develop solutions that will lead to lasting cuts in health care spending across the country.

We would be pleased to provide any additional information to assist in your important deliberations

Sincerely,



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Opinion

Invited Commentary | HEALTH CARE REFORM

Markets and Marketing Matters: Putting a Small Number of Health Care Plan Choices in Perspective

There has been much flux in the health insurance exchange market this year, with more clearly to come. In this issue of *JAMA Internal Medicine*, Zhu et al[1] estimated that 2017 premiums in insurance markets with a single issuer increased 30% compared with 15% in markets having 4 or more issuers.

Related article

Although there are areas of the country where the insurance exchanges have not generated as much competition as desirable, overall the Affordable Care Act both fosters competition and provides vital protections for consumers from potential monopoly pricing.

The Affordable Care Act promotes intense competition for value because if a provided plan is more expensive than the Silver plan with the second-lowest cost, issuers are at risk of having very low enrollment from those who receive federal subsidies-currently at least half of the individual market. The result of this dynamic is that consumers are winning in California: consumers have a choice of plans, with 92% having a choice of 3 or more plans (and all having ≥2 plans to select from) in 2017. Rate increases in California have been held to historically low levels over the past 3 years (increases on year-over-year rates at about 7%), and consumers are doing far better than the "mean" weighted coverage premium increases, since they can and are shopping for value—meaning the ultimate rate that they are getting is more than 11% lower than the weighted coverage increase, because they are shopping and switching plans to get better value.[2]

Not only does the subsidy structure and the prohibition on screening for pre-existing conditions promote value-based competition, the Medical Loss Ratio provision of the Affordable Care Act limits the amount health plans can charge to the amount needed to cover medical expenses, which is not referenced in the article by Zhu et al.[1] Anything more than 20% of the premium collected that is not spent on health care must be returned to consumers. This provides a true consequence to unrestrained price increases.

It is also important to remember that there are additional causes of increased premiums besides single-issuer marketplaces. First, as the authors mentioned, provider consolidation leads to premium increases. As providers consolidate, which is occurring across the nation as hospitals become part of bigger systems and also buy private physician practices, they can demand higher prices from insurance plans. Many of the markets with a single plan are likely to have relatively fewer providers, and those providers are using their market position to charge higher prices.

A second reason that markets with single issuers have higher increases is that the risk mix in these "single-plan" regions is very likely linked to states that did not convert their entire individual market to meet the Affordable Care Act's standard plans in 2014. California and 14 other states made this change—which all states were supposed to have completed by 2018, but with recent regulation by the Trump administration, many will never do. By not making this change, many healthier populations—because they previously underwent medical underwriting—have been excluded from the common risk pool.

Regardless of the number of plans in a marketplace, a key and often forgotten issue in how to keep premiums lower is marketing. By aggressively marketing plans, providers are likely to have a better risk mix, which fosters lower premiums. Two data points support the importance of marketing plans. First, based on recently released data from the Centers for Medicare and Medicaid Services in 2016, markets that were under the federal facilitated marketplace faced a net decline in enrollment of about 15% from the beginning of the year to the end of the year; this compares to a net decline of only 6% for those in state-based marketplaces.[3] This decline matters because declining enrollment is likely to mean that healthier people are leaving to be uninsured. Understanding the reason does require further study, but a key difference between federal and state-based marketplaces is that states have invested more in marketing that supports initial enrollment, enrollment throughout the year during special periods, and retention.

The second data point relates to the core difference in marketing. Zhu and colleagues mention an increase in premiums for single-issuer regions of 25% compared with 7.2% the prior year. Too often, rate analysis looks at too short a window of time and at too few variables. Examining the combined weighted coverage of the second-lowest-cost Silver plan for 2016 and 2017 reveals that, in all of the 38 federal marketplace states, weighted coverage premium rates increased approximately 32.5% over 2 years. Compare this with an increase in the same period in California of 9.9% for the Silver plan with the second-lowest cost. The reason that premiums increased by more than 22.6% in federal marketplace states compared with that in California during 2016 and 2017 surely has multiple factors. However, limited plan competition is likely far less of a reason than the difference in marketing spending. California invests heavily in marketing—a mean annual 1.7% of the premium during 2016 and 2017.

Taken together with the recent data for enrollment year 2017 confirming that Covered California continues to have a strong, stable risk mix, these marketing investments seem to pay off in a big way to reduce premiums.[4,5]

Diagnosing the reason for premium increase variation is important and provides tools to policy makers. Part of this investigation should include looking at factors that contribute to poor performance and, just as important, to the factors that

explain why California and many other health insurance markets have continued to be stable and competitive.

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Conflict of Interest Disclosures: Mr Lee is the executive director of Covered California.

1. Zhu JM, Zhang Y, Wu B, Polsky D. Association between number of issuers and premium rates in the Affordable Care Act Marketplace [published online September 25, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2017.4780

2. Gabel JR, Arnold DR, Fulton BD, et al. Consumers buy lower-cost plans on Covered California, suggesting exposure to premium increases is less than commonly reported. *Health Aff (Millwood)*. 2017;36(1):8-15.

3. Covered California. Executive Director's Report: June 15, 2017. http://board.coveredca.com/meetings/2017/06-15/PPT%20-%20Board%20ED%20Report%20Final%20-%20June%2020172.pdf. Accessed August 16, 2017.

4. Bertko J, Feher A, Watkins J. Amid ACA uncertainty, Covered California's risk profile remains stable. http://healthaffairs.org/blog/2017/05/15/amid-aca-uncertainty-covered-californias-risk-profile-remains-stable/. Published May 15, 2017

5. Covered California. Covered California continues to attract sufficient enrollment and a good risk mix necessary for marketplace sustainability. http://hbex.coveredca.com/data-research/library/CoveredCA_Sufficient_Enrollment_Good_Risk_Mix.pdf. Published May 17, 2017. Accessed August 2, 2017.

MARKETING MATTERS:

Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets

Peter V. Lee, Vishaal Pegany, James Scullary and Colleen Stevens

COVERED CALIFORNIA™

September 2017

Acknowledgements

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Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets

Peter V. Lee, Vishaal Pegany, James Scullary and Colleen Stevens

September 2017

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Lower Costs in National and State Individual Insurance Markets V

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Executive Summary

Marketing and outreach are crucial investments to promote enrollment in the individual health insurance market. They are investments that pay off by fostering a healthier pool of consumers, which in turn lowers premiums for everyone. California has demonstrated that you need to invest money to save money.

Selling health insurance is uniquely difficult. While sick people are motivated to buy health insurance, healthier people need to be reminded, nudged and encouraged; they need to be convinced of the value of having health care coverage. Marketing is necessary to overcome the innate biases that discourage consumers from purchasing something that does not provide an immediate return.

California's experience shows that a stable individual insurance market does not just happen on its own — investments in marketing and outreach attract a healthier risk pool, lower premiums and encourage health insurance companies to participate in the market with more certainty and potential returns.

Effective marketing and outreach require a multifaceted approach grounded in solid research and a critical review of the return on investment. This report provides an overview of California's marketing and outreach experience, strategy and tactics. It also provides evidence of the impact of marketing and the potential application of this evidence to decisions by the Federally-facilitated and state-based marketplaces.

Major findings of this report include:

- Because of Covered California's extensive marketing and outreach, California's individual market — both on- and off-exchange — has one of the best take-up rates and lowest risk scores in the nation. This bigger and healthier enrollment translates to 20 percent lower costs than Covered California would have otherwise had if its risk score were the same as the national average — specifically, on-exchange premiums were $2.6 billion lower for 2015 and 2016. Covered California's marketing and outreach expenses in 2015 and 2016 likely lowered premiums by 6 to 8 percent. The lower premiums resulted in healthier consumers being more likely to enroll because of the reduced price of insurance, which further drives down the premium. (See Table 1: Potential Return on Covered California's Marketing Investment, 2015 and 2016.) Covered California estimates that every marketing dollar likely yields a more than three-to-one return on investment (ROI).
- The federal government is on a path to dramatically underspend on marketing and outreach — with the investment plans for 2018 being one-tenth of Covered California's spend. Lower investments mean less stable markets and higher premiums. The federal government collects a health plan assessment on premiums paid on the Federally-facilitated Marketplace (FFM) that is 3.5 percent of premium. The purpose of this assessment is specifically to pay for marketing and outreach to promote viable marketplaces for consumers, as well as ongoing

operations.[1] The Centers for Medicare and Medicaid Services (CMS) estimates that the federal government will collect $1.2 billion in plan assessments for calendar year 2018.[2] The federal government's planned 2018 spending of $47 million to promote marketing and outreach for 39 states is one-tenth of the $480 million it would be spending if it spent the same percentage of premium on marketing as does Covered California: If the FFM made this investment over three years, it would likely pay off with more than two million more Americans getting insurance, premiums that are 3 percent lower and higher participation of health plans, all with over a 400 percent return on investment. (See "Untapped Potential of Federally-facilitated Marketplace Marketing Expansion" section beginning on page 20.) If the federal government goes ahead with its planned 72 percent reduction in marketing and outreach spending, for a national spend of $47 million, there will likely be one million fewer Americans getting insurance, a less healthy risk pool in premiums that will be over 2.5 percent higher in 2019 (representing a premium increase for those remaining insured of $1.3 billion).

- California's experience and research provide evidence to support nine facts on the importance of making marketing and outreach a priority for federal and state public marketplaces. (See Section III: Facts on the Role of Marketing and Outreach to Promote Enrollment in the Individual Insurance Market.)
- California's experience in promoting enrollment in a large and diverse state can provide a framework to assess the level and nature of federal or other states' investments. (See Section II: Marketing and Outreach "By the Numbers": Data That Inform Marketing Investments; and Section IV: Elements of Effective Marketing, Outreach and Enrollment for the Individual Insurance Market.)

Covered California provides this report in an effort to inform the planning and investments of other marketplaces with the belief that the best path to improvement is transparency and the sharing of best practices. California is not an island. We have much to learn from other parts of the nation and Covered California has a stake in the success of efforts to assure stability in individual markets nationally. Understanding that the combination of strategies and tactics that worked for California may not fully apply to other states or the federal marketplace, nonetheless, the evidence is clear that a combination of marketing and outreach efforts is critical to promoting markets that work for consumers.

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[1] Under 45 CFR §156.50 (https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_150&rgn=div8), a plan assessment fee is charged to participating issuers to recoup the costs for the following federal activities in connection with the operation of the Federally-facilitated Marketplace: provision of consumer assistance tools, consumer outreach and education, management of a Navigator program, regulation of agents and brokers, eligibility determinations, enrollment processes, and certification processes for health plans.

[2] 2018 plan assessment revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document, available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

The federal government, other state-based marketplaces and California have a responsibility to make investments that pay off for Americans and to continually seek to improve operations. California looks forward to continuing to learn from the lessons of others as it seeks to promote enrollment and a stable individual marketplace, and is happy to share links to a range of actual marketing material that are available for use or adaptation by other public exchanges.

An issue brief summary of this report can be found at http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_Issue_Brief.pdf.

Introduction

California and other state-based marketplaces on average have attracted and retained a healthier risk mix than have the 36 states supported by the Federally-facilitated Marketplace (FFM). The Centers for Medicare and Medicaid Services has found that California had the lowest "average plan liability risk score" in the individual market for both 2014[3] and 2015,[4] and continued to have one of the lowest risk scores in the nation for 2016.[5]

While a range of factors contribute to a good risk mix and resulting lower premiums, Covered California understands that "good risk is earned." With that in mind, Covered California makes marketing investments and policy decisions to promote broader enrollment to ensure the best possible risk mix. The lynchpin to a good risk mix is significant, ongoing and effectively targeted investments in marketing and outreach.

Marketing is a critical element to creating a successful business. By building brand value in consumers' eyes, a business is making an investment in its future. Doing marketing and outreach correctly requires:

- Hiring the best subject-matter experts (both staff and contractors).
- Learning from research about consumers' perspectives and their experience.
- Coordinating with partners to execute comprehensive and strategic outreach efforts annually.
- Adapting to changing circumstances and new insights.

Health insurance offered to individuals is no different. In fact, in many ways selling health insurance is harder. Behavioral science shows that health insurance is a product that needs to be explained, promoted and sold because there are innate biases that make individuals skeptical about the need for coverage. (See page 7, Why Selling Health Insurance in the Individual Market is Challenging.)

In 2016, Covered California spent $99 million on marketing and outreach, and in 2017, that number was $122 million. For the upcoming 2018 enrollment year, Covered California has budgeted $111 million — one-third of its 4 percent user fee assessed on health plans or 1.4 percent of on-exchange premiums. The effective cost of Covered California's marketing and outreach investments is approximately 0.9 percent of total individual market premium — in many ways, a more appropriate point of reference to

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[3] Centers for Medicare and Medicaid Services: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year (Sept. 17, 2015) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

[4] Centers for Medicare and Medicaid Services: Appendix A to June 30, 2016 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx

[5] Centers for Medicare and Medicaid Services: Appendix A to March 31, 2017 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-March-31-2017-Interim-RA-Report_5CR_033116.xlsx

compare since the entire individual market benefits from the broad marketing efforts that result in a better risk pool and lower premiums.[6]

California's significant marketing investments are proportionate to the size of the state and the size of its individual insurance market. California has implemented its marketplace in the context of having one of the most culturally, linguistically and geographically diverse markets in the nation. Consumer needs vary among different demographic groups, geographic areas and population centers. To better communicate and encourage enrollment, Covered California's marketing and outreach strategy is informed by data-driven research on potential enrollment populations and their demographic characteristics.

California's size and diversity does not mean its experience is exceptional; rather, it makes California's lessons relevant to other states and the federal marketplace because California is a microcosm of the United States. Its experience can provide relevant lessons for other marketplaces to consider, whether those markets are larger, as is the FFM, or smaller in the case of individual states.

With four years of experience in promoting enrollment, Covered California has learned the following lessons about fostering a stable and competitive individual market that works for consumers:

- Health insurance needs to be sold. Consumers need to be convinced to spend their discretionary income on coverage.
- Marketing and outreach have a dramatically positive return on investment (ROI). Covered California estimates that every dollar likely yields a more than three-to-one ROI — with both consumers and the federal government being the beneficiary of those investments.
- Marketing will always be needed because the individual insurance market churns significantly. Consumers enter and leave as their coverage needs change.[7]
- Underinvesting in marketing likely contributes to instability in the marketplace, higher premiums for consumers and less participation by health plans.
- Marketplaces need to hire skilled marketing and outreach staff; ensure sufficient spending; conduct appropriate marketing, communications and outreach functions; and adequately staff vendor management and coordination of agents and navigators.

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[6] Since plans in California must offer "mirrored" versions of on-exchange products outside the exchange at the same price, the assessment in California is effectively spread across the entire individual market. Since the FFM and most state-based marketplaces assess fees only based on on-exchange enrollment and may not have comprehensive off-exchange enrollment or plan-selection data, to compare consistently, most of the data in the "By the Numbers" section compares spending only as a percentage of on-exchange premium for 2018. As described in the By the Numbers section, this high churn has continued.

[7] In the period from 2008 to 2011, prior to major Patient Protection and Affordable Care Act provisions taking effect, only 42 percent of individual market enrollees kept their coverage after 12 months, and 80 percent of them experienced coverage changes to other types of health insurance (the majority obtaining employer-based coverage). Sommers, Benjamin D. "Insurance cancellations in context: stability of coverage in the non-group market prior to health reform." *Health Affairs* 33, no. 5 (2014): 887-894.

Covered California provides this report to share its approach, rationale and detailed marketing and outreach plans because it believes the best path to improvement is transparency, setting benchmarks and learning from the best in private and public spheres. This report aims to help inform federal and state policy-makers about the size and nature of marketing and outreach investments that are needed to help foster stable insurance markets and to promote a good risk mix. At the same time, Covered California provides this report to foster discussion and feedback as it seeks to continually improve its own marketing and outreach efforts.

This report includes the following four sections:

I. **Why Selling Health Insurance in the Individual Market Is Challenging**
Behavioral economics, social psychology and cognitive neuroscience explain that the individual health insurance market is different from selling other products and services because of innate biases that make selling health insurance a challenge. It also contrasts individual health insurance to employer-based coverage, Medicare and other public programs.

II. **Marketing and Outreach "By the Numbers": Data That Inform Marketing Investments**
Provides a review of Covered California's multifaceted approach and financial considerations to making marketing and outreach investments. Further describes why marketing and outreach are investments likely to pay off for federal and state-based marketplaces.

III. **Facts on the Role of Marketing and Outreach to Promote Enrollment in the Individual Insurance Market**
Identifies nine key facts based on early evidence or proven data that can help inform investments in marketing and outreach by policy-makers.

IV. **Elements of Effective Marketing, Outreach and Enrollment for the Individual Insurance Market**
Concrete examples of California's marketing and outreach tactics, with a summary of their costs in dollars and as a percentage of on-exchange premium, as well as links to more examples of materials and research used in California.

Marketing is essential to continually maintain the healthiest possible risk pool. There may be room for debate on what the right mix of marketing investments should be. Only through getting and continually refreshing a large and balanced risk pool can stable premiums in the individual market be assured.

I. Why Selling Health Insurance in the Individual Market Is Challenging

Innate Biases Mean Many People Avoid Buying Insurance: Human bias leads consumers to perceive health insurance as something they do not need and overcoming those barriers requires deep insight and sophisticated marketing.

Selling health insurance in the individual market is not like selling other products and services, such as cars and cellphones. It is far more difficult because it requires overcoming several innate biases that affect most people.

There is significant evidence from behavioral economics, social psychology and cognitive neuroscience that finds humans behave irrationally. This explains why some individuals do not take the rational action of protecting themselves with health insurance. Getting people to change these behaviors requires deep insight and sophisticated marketing — especially to enroll the young and healthy to ensure a large, stable pool of participants.

Individual health insurance is a particularly challenging product to sell, even with substantial subsidies. While individuals with health conditions have high motivation to get insurance, healthy people have biases that discourage them from getting care. In large-group health insurance and programs such as Medicare, these biases are addressed by including certain mechanisms to counter them.

What follows are biases most people harbor that make selling health insurance a challenge:

- **Loss Aversion Bias: Consumers see the initial cost of buying a health insurance policy as a loss. Every day that they do not get "a payoff" from the insurance is considered a loss.** Under the prospect theory, people value avoiding a loss at twice the power of receiving a gain.[8] Healthier people would rather accept the risk of being uninsured than face the absolute certainty of paying premiums compared to the uncertainty of a gain in the form of having care paid for by their insurance.[9]
- **Temporal Discounting: Younger and healthier consumers are more tolerant of risk and are willing to make decisions that may adversely affect them in the future.** Individuals discount the future and put all emphasis on the present.[10]

[8] Kahneman, Daniel, and Amos Tversky. "Prospect theory: An analysis of decision under risk." *Econometrica: Journal of the Econometric Society* (1979): 263-291.

[9] Schneider, Pia. "Why should the poor insure? Theories of decision-making in the context of health insurance." *Health Policy and Planning* 19, no. 6 (2004): 349-355.

[10] Thaler, Richard. "Some empirical evidence on dynamic inconsistency." *Economics Letters* 8, No. 3 (1981): 201-207.

Similar to saving for retirement[11] or dieting,[12] people tend to put off buying health insurance. The combination of a cost today and an uncertain future payoff presents a classic temporal discounting barrier.

- **Optimism Bias: When it comes to buying health insurance, people assume they will not get seriously ill nor fall victim to catastrophic health events.** Eighty percent of the population, across gender, race, nationality and age, consistently and routinely underestimate the risk of negative things happening and overestimate the chances of winning or achieving positive things.[13]
- **Availability Bias: Individuals who have never suffered a serious health issue, or are young and healthy and cannot imagine a time when they will need insurance, suffer from the availability bias.** Humans tend to believe what is "available" to their common experience.[14] The more an idea is abstract, invisible or distant in time or space, the less available it is in imagining. Most people are relatively healthy and do not foresee themselves as being sick or needing care.
- **Status Quo Bias: If individuals currently do not have health insurance, enrolling them is even harder.** The research on the status quo bias reveals that it is difficult to make people take action to change their current status.[15, 16]
- **Self-Efficacy: When signing up, consumers worry about understanding health insurance and making the wrong choice when deciding on their own.** A significant barrier to people doing something new is called self-efficacy. In a study examining insurance decision-making with Medicare patients, it was found that the consumers with greater self-efficacy wanted to make decisions on their own but preferred having advice.[17] Those with less self-efficacy were less knowledgeable about Medicare, in poorer health, and preferred delegating insurance decisions to someone they trust, such as spouse. These findings suggest that education and outreach activities could help build trust with less informed consumers, and support the role of agents, Navigators and others to help consumers with complex decision-making.

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[11] Ersner-Hershfield, Hal, G. Elliott Wimmer and Brian Knutson. "Saving for the future self: Neural measures of future self-continuity predict temporal discounting." *Social Cognitive and Affective Neuroscience* 4, No. 1 (2008): 85-92.

[12] Barlow, Pepita, Aaron Reeves, Martin McKee, Gauden Galea and David Stuckler. "Unhealthy diets, obesity and time discounting: a systematic literature review and network analysis." *Obesity Reviews* 17, No. 9 (2016): 810-819.

[13] Sharot, Tali. "The optimism bias." *Current Biology* 21, No. 23 (2011): R941-R945.

[14] Tversky, Amos, and Daniel Kahneman. "Availability: A heuristic for judging frequency and probability." *Cognitive Psychology* 5, No. 2 (1973): 207-232.

[15] Samuelson, William, and Richard Zeckhauser. "Status quo bias in decision making." *Journal of Risk and Uncertainty* 1, No. 1 (1988): 7-59.

[16] Anderson, Christopher J. "The psychology of doing nothing: forms of decision avoidance result from reason and emotion." *Psychological Bulletin* 129, No. 1 (2003): 139.

[17] Kan, Kathleen, Andrew J. Barnes, Yaniv Hanoch, and Alex D. Federman. "Self-efficacy in insurance decision making among older adults." *The American Journal of Managed Care* 21, No. 4 (2015): e247-54.

The Individual Insurance Market is Different and Requires More Marketing: The individual health insurance market Is different from employer-based or public sources of coverage, such as Medicare — and must be heavily marketed and sold.

The Affordable Care Act includes multiple policy levers to encourage broad-based enrollment in the individual market, including:

- The availability of premium tax credits and cost-sharing reduction subsidies through marketplaces.
- The individual shared-responsibility provision (individual mandate).
- Mechanisms to support marketing for the federal or state-based marketplaces.

The first two policy levers have been critical in achieving coverage gains. However, they are not enough to encourage consumers to purchase and keep insurance.

Some suggest that the relative absence of marketing for health insurance in the employer, Medicare or Medicaid markets should inform efforts of public exchanges in the individual market. However, the individual market is fundamentally different from these sources of coverage, which both serve different populations and have structural features that efficiently maximize enrollment and attract both low- and high-risk consumers.

These major coverage sources do not rely heavily on marketing for the following reasons:

- **Employer-Sponsored Insurance:** Employer-sponsored insurance is the main source of coverage for 150 million nonelderly Americans.[18] Employers offering coverage generally pay for a significant percentage of that coverage so that nearly all employees participate in coverage at the beginning of employment — the take-up rate of 79 percent reflects the fact that the vast majority of those employees eligible for job-based coverage sign up.[19] Marketing to those with employer-based coverage is a critical function of the employer-employee communication, and does not require additional marketing for purposes of "selling." Further, a substantial portion of employers have "auto-enrollment" processes that facilitate higher enrollment.[20]

[18] Kaiser Commission on Medicaid and the Uninsured (2015). "The uninsured: A primer — key facts about health insurance and the uninsured in America. Washington, D.C.: http://kff.org/uninsured/report/the-uninsured-a-primer/. See supplemental tables — Table 1: 270.2 million non-elderly people, 55.5 percent of whom are covered by ESI.

[19] Some of the reasons workers are not covered by their employer include: 1) They are not eligible for benefits, 2) they already have coverage through a spouse or 3) they refuse employer coverage. See Exhibit 3.2 in Kaiser/HRET 2016 "Survey of Employer-Sponsored Health Benefits", available here: http://www.kff.org/health-costs/report/2016-employer-health-benefits-survey/

[20] According to recent national surveys, more than 40 percent of employers automatically enroll workers in health benefits. Kaiser/HRET "Survey of Employer-Sponsored Health Benefits" (2015).

- **Medicare:** Most consumers qualify for Medicare upon turning 65 or when they are under 65 but disabled. Because Medicare Part A (hospital) effectively has no premiums for eligible consumers, they are automatically enrolled if they have contributed their payroll tax. Medicare Parts B (outpatient) and D (prescription drugs) are voluntary and require eligible consumers to pay a monthly premium, with subsidies available on a sliding scale. Unlike younger people, those eligible for Medicare are far less likely to experience innate biases that may impede enrollment — instead those who are eligible for Medicare know they need health care coverage. For those over the age of 65, 90 percent use at least one prescription drug and 39 percent use more than five.[21] Additionally, two-thirds of Medicare beneficiaries live with multiple chronic conditions.[22] Not only are older individuals more aware of their potential need for health care than are younger people, but there are now penalties in the form of increased premiums for consumers who do not sign up.

  The marketing and outreach efforts to promote enrollment in Medicare Advantage and Medicare Part D are also totally different from the individual market. The Center for Medicare and Medicaid Services reports spending only $9.7 million to promote Medicare Part D and Medicare Advantage, but health plans themselves spend what is sure to be billions to promote their plans. The best data available is for 2017, the advertising spend alone of private health plans to promote enrollment was likely more than $350 million.[23] This figure does not include other forms of marketing expenses, such as digital marketing and direct mail. It also does not include health plans' agent commissions to promote enrollment. Medicare Advantage uses extensive marketing to enroll consumers and relies heavily on agents and brand-marketing investments similar to those of Covered California. Agents in California are paid approximately $500 a year for the first year a consumer enrolls in a Medicare Advantage plan. If the ratio of marketing spend to agent commission payments in Medicare is anywhere close to that of the individual market — Medicare Advantage plans and Medicare Part D plans are paying close to $2 billion in commissions to agents. This spending is similar to spending by health plans in public marketplaces which does not promote enrollment itself, but promotes the selection of their plan among all potential plans in a choice environment (see Fact 5: Public Marketplaces Are Best Positioned to Promote Broad Enrollment, starting on page 49).

[21] Kantor, Elizabeth D., Colin D. Rehm, Jennifer S. Haas, Andrew T. Chan, and Edward L. Giovannucci. "Trends in prescription drug use among adults in the United States from 1999-2012." *Jama* 314, no. 17 (2015): 1818-1830

[22] Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD. 2012.

[23] See, Duggan, et al., "Who benefits when the government pays more? Pass-through in the Medicare Advantage program." *Journal of Public Economics* 141 (2016), which found average spend on advertising per Medicare enrollee in Medicare Advantage Plans and Medicare Part D plans of $5.90 a year. This average spend was multiplied by 19.1 enrollees in Medicare Advantage and 41.3 enrollees in Medicare Part D.

- **Medicaid:** Because Medicaid is a public insurance program available at little-to-no cost to the consumer, it is easier to convince eligible consumers to enroll into Medicaid since the financial barrier has been removed. Additionally, because eligible consumers can enroll year-round and in some states[24], at the point of care (when Medicaid-eligible individuals show up needing care at a hospital they can be immediately enrolled), there is less need to market during an open-enrollment period. Even with these enrollment advantages, research has highlighted the importance of marketing and outreach to promote higher take-up rates for those eligible for Medicaid.[25]

[24] Presumptive Medicaid eligibility is a state option under Sec. 2001 of the Patient Protection and Affordable Care Act.

[25] Wright, et al. "Low-Cost Behavioral Nudges Increase Medicaid Take-up Among Eligible Residents of Oregon." *Health Affairs* (May 2017).

II. Marketing and Outreach "By the Numbers": Data That Inform Marketing Investments

Marketing and outreach need to be executed well and be focused on the right target populations. Marketing and outreach investments should generate sufficient offsetting returns in the form of enrollment, better risk mix and lower premiums to justify their "load" on premiums.

The payoff of marketing investments takes multiple forms, including:

- Increased enrollment that leads to a better risk mix and resulting lower premiums.
- Certainty for health plans that they will enroll a healthier mix of consumers, which allows them to price accordingly and decide if participating in the individual market makes financial sense.
- Lower premiums for individuals who do not receive federal tax credits.
- Lower premiums translating into lower federal-subsidy payments.

This section of the *Marketing Matters* report provides some of the data that frames California's investment approach.

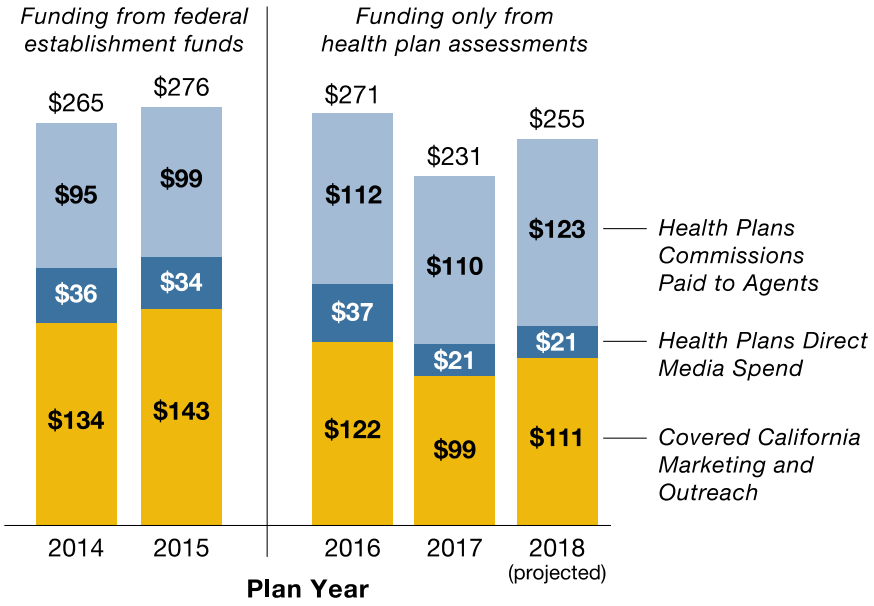
Making the Right Investment: Covered California's Approach

A good risk mix does not just happen. Since its inception, Covered California has consistently invested in substantial marketing and outreach. These investments are grounded in the perspective that such investments lower premiums and attract a healthier risk pool. While there is no magic formula to determine how much marketing is sufficient, Covered California provides a pathway to help each marketplace determine its appropriate level of investment.

Covered California's multi-channel approach has resulted in marketing and outreach budgets that will average more than $120 million annually over its first five years. While the first two years of operations were supported by federal establishment funds, Covered California has continued to make investments in marketing and outreach a priority. These investments complement what health plans pay directly on marketing and commissions to agents. All together, the investments by Covered California and its 11 contracted health plans totaled nearly $1.0 billion over the past four years. Adding planned spending for 2018, the total increases to $1.3 billion and averages to approximately $260 million per year (see Figure 1: California On-Exchange Individual Market Marketing and Outreach Investments, 2014–18).

FIGURE 1

California On-Exchange Individual Market Marketing and Outreach Investments (millions), 2014–18[26]

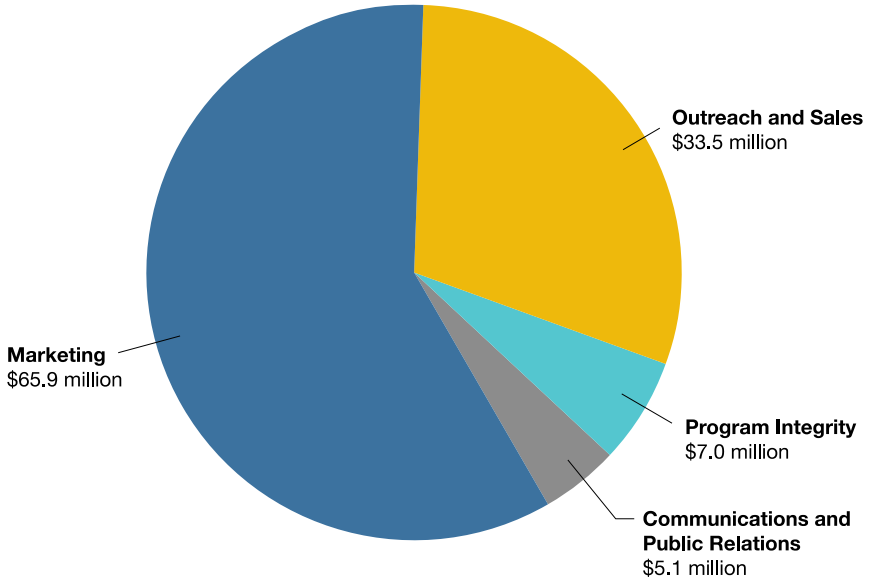


Looking ahead, Covered California has budgeted $111 million for FY 2017–18 which is broken down as follows (see Figure 2: Covered California's 2018 Marketing and Outreach Investments — $111 million):

- **Marketing** ($65.9 million): Includes paid media buys on television, radio, print, digital and out-of-home advertising to promote enrollment and the importance of coverage. Covered California has earmarked more than $43 million of the marketing budget specifically for paid media.
- **Outreach and Sales** ($33.5 million): Support for Covered California's extensive system to support in-person enrollment and enrollment partners such as Certified Insurance Agents, certified enrollers and Navigator grantees.
- **Communications and Public Relations** ($5.1 million): Covered California invests heavily in earned media to encourage enrollment during open and special enrollment. The $5.1 million supports a staff of 15 Covered California media professionals and a contract with the global public relations firm, Ogilvy. During the fourth open-enrollment period Covered California conducted more than 200 interviews with various media outlets, generating 90 million impressions.
- **Other program administrative expenses** ($7 million): Support for consumer protection.

[26] Covered California's health plan agent paid commissions are estimated based on enrollment data and best available information on commission rates, but may not reflect actual health plan spend. 2018 figures are projected using Covered California's proposed 2017–18 budget and direct-media spend is assumed to be the same as 2017. To enable common benchmarks based on a share of on-exchange premium (Figures 1 and 11), Covered California attributed plans' direct-media spending proportionally based on 68 percent of individual market enrollment being on exchange and 32 percent off exchange.

FIGURE 2
Covered California's 2018 Marketing and Outreach Investments — $111 million



Marketing and Outreach Results in California

Covered California's decision to continue to make substantial marketing and outreach investments is rooted in research that shows enhanced marketing improves take-up in the individual market. While it is difficult to establish empirically the precise effects of marketing investment and the specific benefits of each incremental dollar invested in marketing, there is substantial evidence that Covered California's aggressive marketing and outreach have been important contributing factors to California's higher take-up and the healthier risk profile as compared to the experience of the Federally-facilitated Marketplace (FFM).

Two critical pieces of evidence reinforce the hypothesis that Covered California's approach, including marketing as a critical component, results in higher enrollment and a healthier risk mix:

- Covered California has achieved a take-up rate among those who are subsidy eligible that is nearly 25 percent higher than the average for FFM states (see Figure 3: Comparing California and the Federally-facilitated Marketplace Take-Up Rates — 2014-2016). This data indicates that as of 2016, Covered California enrolled about 79 percent of subsidy-eligible individuals compared to the average for FFM states (64 percent).[27]

[27] See Kaiser Family Foundation Analysis of 2016 effectuated enrollment data: http://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/.

- As documented and reported by CMS, Covered California's enrollment reflects a substantially healthier mix of enrollees.[28] The CMS-calculated risk score of California's individual market is approximately 20 percent lower than the national average (see Figure 4: Comparison of FFM, SBM and Covered California Risk Scores). This 20 percent lower risk score means that California's $6.5 billion on-exchange premium for 2016 is roughly $1.3 billion lower than it would have been if the average risk of individual market enrollees in California were the same as the FFM average.[29]

While factors other than marketing and outreach contribute to some of the differences in take-up and risk mix in California, marketing and outreach play a significant role in the higher enrollment and healthier risk mix outlined above.

Further study is needed to better understand the specific return on investment for different levels of incremental spend. Available data provides parameters for modeling the potential return on investment and national benefits if the federal government were to make incremental increases in its marketing and outreach to be on a scale comparable to California. The two central hypotheses that support these investments are:

- Marketing and outreach result in more people signing up; and

FIGURE 3

Comparing California and the Federally-facilitated Marketplace Take-up Rates — 2014–2016

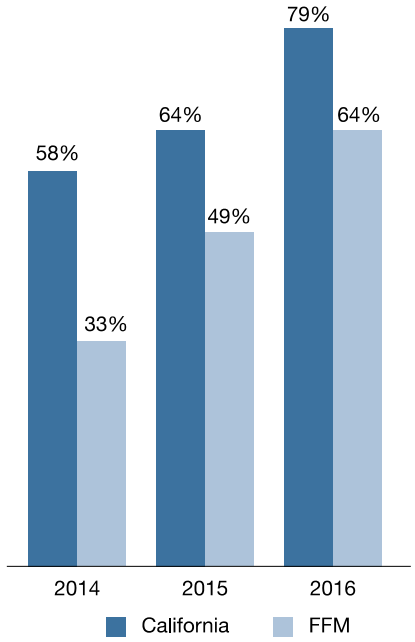
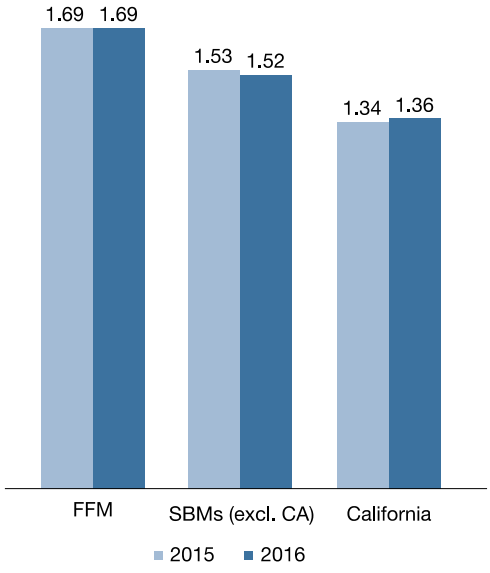


FIGURE 4

Comparison of FFM, SBM and Covered California Risk Scores

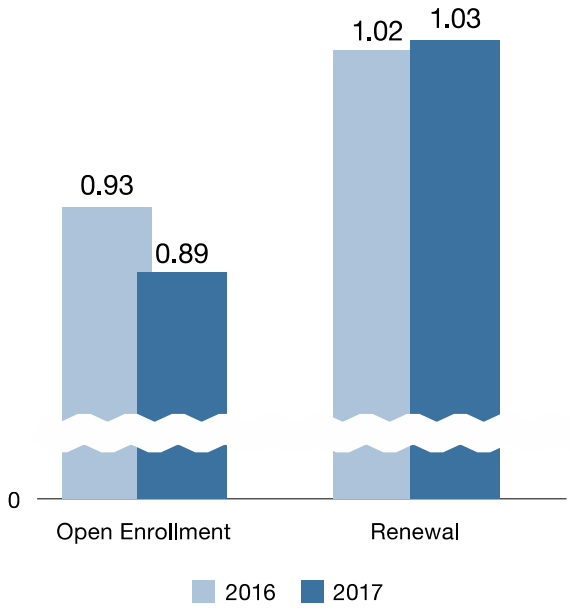


[28] Centers for Medicare and Medicaid Services. (2017) "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year." https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

[29] See Table 1: Potential Impacts of Enhanced Marketing and Outreach — 2018–2002, in the "Return on Investment in California: Marketing has likely delivered California a better than three-to-one return on investment" section, starting on page 17.

- The incremental enrollment from those who sign up due to marketing contribute to a healthier risk mix.

FIGURE 5
Covered California Risk Scores by Enrollee, 2016 and 2017



In 2017, new Covered California enrollment translated to a better risk mix. Using a concurrent risk-score model[30] based on data from the State Office of Statewide Health Planning and Development (OSHPD), Covered California analyzed open-enrollment cohorts to measure its effectiveness in attracting a balanced risk mix.[31] During open enrollment, new consumers obtain coverage for the coming year and existing enrollees renew their coverage.[32] New enrollees in 2017 have a 15.7 percent lower mean risk score than renewing enrollees — an improvement of 4.3 percent between 2016 and 2017. (See Figure 5: Covered California Risk Scores by Enrollee, 2016 and 2017.) At the same time, renewing members have consistently had a mean risk score of ~1.03 from year to year, and the 2017 cohort has fewer chronic conditions than the 2016 cohort. This suggests that Covered California is successfully attracting new healthy enrollees to stabilize the risk pool.

Additionally, Covered California attracted a good risk mix in the context of an average 13.2 percent rate increase in 2017, which suggests that the availability of tax credits to defray the cost of health insurance is a significant driver of enrollment.[33]

[30] The Chronic Illness and Disability Payment System (CDPS) model is used by many states to evaluate their Medicaid program enrollment. CDPS calculates risk scores using an individual's age, gender and chronic-condition diagnoses (e.g., diabetes) listed in the following clinical encounters: hospitalizations, emergency department (ED) visits and ambulatory care. Since ambulatory data is not currently available by OSHPD, Covered California uses hospitalization and ED visits because these two categories have a 70 percent correlation with patient morbidity among Medicaid beneficiaries.

[31] Bertko, John, Andrew Feher and Jim Watkins. "Amid ACA Uncertainty, Covered California's Risk Profile Remains Stable." (2017). http://healthaffairs.org/blog/2017/05/15/amid-aca-uncertainty-covered-californias-risk-profile-remains-stable/, and "Covered California Continues to Attract Sufficient Enrollment and a Good Risk Mix Necessary for Marketplace Sustainability" (2017). http://hbex.coveredca.com/data-research/library/CoveredCA_Sufficient_Enrollment_Good_Risk_Mix.pdf

[32] To simplify year-to-year enrollment, Covered California automatically renews existing consumers into the same coverage, if available, at the end of the renewal period if they do not actively change their health plan. Consumers are notified of their option to change plans during the open-enrollment period should their preferences change.

[33] The premium change for 2017 followed two years of markedly lower premium increases (4.2 percent and 4 percent in 2015 and 2016, respectively). In 2016, 87 percent of Covered California enrollees were eligible for subsidies. Because premium tax credits are benchmarked to the second-lowest-cost Silver plan in an individual's rating region, consumers can purchase a typical plan adjusted to the costs in their local market. Effectively, this regional benchmark insulates subsidy-eligible consumers from rate increases.

Return on Investment in California: Marketing has likely delivered California a better than three-to-one return on investment.

Determining whether marketing investments "pay off" requires analysis of the extent to which incremental spending on marketing and outreach result in a higher take-up rate. Using this simple and limited definition of return on investment, it appears that marketing and outreach have delivered to California a better than three-to-one return, meaning Covered California saved Californians and the federal government anywhere from a low of $853 million to a high of $1.3 billion by having lower premiums in 2015 and 2016 alone.

Return on Investment — More than "just" lower premiums

Measuring return on investment based on lower premiums for those insured is an appropriate metric to assess the value of marketing and outreach spending, but it understates the broader positive impacts. First, more people getting and staying insured. Second, to the extent that marketing provides a better and more stable risk pool, health plans are more likely to see the individual market as a safe place to compete. Fostering greater participation and competition between health plans promotes consumer choice and helps keep premiums low through the market forces of competition.

One way to calculate California's return on investment can be done by looking at: The risk mix relative to the national average and the associated impact on premiums; Covered California's marketing spending; and an attribution of the portion of the premium difference to the marketing efforts.

Covered California has generated a strong take-up rate among healthier enrollees in the individual market, as documented by CMS.[34] The CMS-calculated risk scores of California's individual market enrollees is approximately 20 percent lower than the national average. By and large, this 20 percent lower risk score means that the $6.5 billion in premiums collected in 2016 is roughly $1.3 billion lower than it would have been if the average risk of individual market enrollees in California was actually the same as the FFM average (See Table 1: Potential Return on Covered California's Marketing Investment, 2015 and 2016).

The better risk mix needs to be viewed in the context of an unsurprising companion fact — better enrollment. First, Covered California has achieved a take-up rate among those who are subsidy eligible that is nearly 25 percent higher than the average for FFM states (see Figure 3: Comparing California and the Federally-facilitated Marketplace Take-Up Rates — 2014–2016). The data indicates that as of 2016, Covered California enrolled approximately 79 percent of subsidy-eligible individuals compared to the average for FFM states (64 percent).

Other research has indicated that enhanced marketing improves take-up in the individual market or in public programs, but independent and comprehensive research

[34] Centers for Medicare and Medicaid Services. (2017) "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year" https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

on this topic is sparse.[35] Part of the reason is the difficulty in establishing with precision which enrollees and what elements of a better risk mix result from marketing. For instance, while it is clear that Covered California's aggressive marketing and outreach led to differences in enrollment and the risk mix, other factors surely explain some of the difference in the risk mix resulting in lower premiums.[36]

To account for the potential impact of other factors on enrollment and risk mix, Covered California made several analytic assumptions in calculating the potential return on investment of marketing and outreach spending. First, Covered California's analysis excluded the 2014 plan year — the initial year of the implementation of the Affordable Care Act — because in this first year, there were challenges with the rollout of the FFM and healthcare.gov that may have affected enrollment. Second, rather than base the return on investment on a comparison of enhanced marketing (the relatively higher marketing spending in California compared to the FFM), the analysis used Covered California's entire marketing and outreach spending as the basis to assess possible ROI.[37] Covered California then looked at 2015 and 2016 to model two assumptions relative to what portion of the better risk mix to attribute to marketing and outreach: Applying only one-third of the difference to marketing and outreach and applying half of the difference to marketing and outreach.

If one-third of the difference in gross premiums between California and the FFM is attributed to Covered California's marketing and outreach, then it likely resulted in premium savings of $853 million for 2015 and 2016 (from what premiums might have been without that spending on marketing). When compared to the marketing and outreach investments of $265 million in 2015 and 2016, the return on investment would likely be three-to-one.[38]

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[35] Wright, Bill, Ginny Garcia-Alexander, Margarette Weller and Katherine Baicker. (2017). "Low-Cost Behavioral Nudges Increase Medicaid Take-Up Among Eligible Residents of Oregon." *Health Affairs*. 36(5): 838-845: Karaca-Mandic, Pinar, Andrew Wilcock, Laura Baum, Colleen L. Barry, Erika Franklin Fowler, Jeff Niederdeppe, and Sarah E. Gollust. "The Volume Of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage." *Health Affairs* 36, no. 4 (2017): 747-754, and "Advertising cutbacks reduce Marketplace information-seeking behavior: Lessons from Kentucky for 2018." http://theincidentaleconomist.com/wordpress/advertising-cutbacks-reduce-marketplace-information-seeking-behavior-lessons-from-kentucky-for-2018/.

[36] In addition to the role of marketing and outreach, better risk mix can be potentially attributed to other variables, including: 1) the size and efficacy of marketing efforts by health plans or others 2) whether a state converted all plans to Affordable Care Act-compliant plans in 2014 to create a common risk pool and 3) whether a state expands Medicaid. In California's marketplace, there is the additional factor of the work Covered California does in creating competitive markets. Covered California fosters broad competition while selecting health plans based on their networks, rates, capabilities and consumer-focus. Covered California also negotiates rates and works with health plans, consumer advocates and others to establish patient-centered benefit designs that promote access, retain a healthy risk pool and help consumers shop. To learn more about the key ingredients to California's success in expanding coverage and creating a competitive marketplace, see: http://hbex.coveredca.com/data-research/library/CoveredCA_Key_Ingredients-05-18-17.pdf.

[37] To assess the potential return on investment of enhanced federal spending — detailed in the next section — Covered California considered only potential new federal spending. By applying the entire Covered California marketing and outreach budget to the "return" of the lower costs, this analysis reduces the ROI.

[38] This analysis focused on return on investment for on-exchange enrollees only: however, CMS-calculated risk scores apply to the entire California individual market. In examining the total California individual market, if one-third of the difference in gross premiums between California and the FFM is attributed to Covered California's marketing and outreach, then its marketing efforts resulted in premium savings of $1.3 billion in 2015 and 2016. When compared to the marketing and outreach investments of $265 million in 2015 and 2016, the return on investment would be nearly five-to-one.

TABLE 1
Potential Return on Covered California's Marketing Investment — 2015 and 2016

	2015	2016	Two-Year Impact
Gross Premiums			
Covered California	$6.0 billion	$6.5 billion	$12.5 billion
Average Risk Scores			
FFM States	1.69	1.69	—
California	1.34	1.36	—
Difference	*21% lower*	*20% lower*	—
Estimated Covered California Gross Premiums if California had FFM Risk Scores			
Covered California gross premiums	$7.26 billion	$7.8 billion	$15.1 billion
Difference	*$1.26 billion*	*$1.3 billion*	*$2.56 billion*
***Assumption:* Premium Savings Due to Marketing and Outreach**			
If marketing explains 1/3 of gross premium difference ($1.3 billion)	$420 million	$433 million	$853 million
If marketing explains half of gross premium difference ($1.3 billion)	$630 million	$650 million	$1.3 billion
Covered California Marketing and Outreach Investments			
Covered California	$143 million	$122 million	$265 million
Return on Marketing Investment[39]			
If marketing explains 1/3 of gross premium difference ($1.3 billion)	194%	255%	222%
If marketing explains half of gross premium difference ($1.3 billion)	341%	433%	383%

If marketing explains half of the difference in gross premiums, then potential premium savings of $1.3 billion would be attributed to marketing and outreach, with a likely return on investment of nearly five-to-one.

The benefits of marketing in California, however, go beyond the lower premiums directly attributable to better risk mix. Consumers who gained insurance benefited, and the participation of health plans that saw a stable environment resulted in more competition.

[39] These percentages were calculated as follows: (Premium Savings – Marketing Investment) divided by Marketing Investment. E.g., for 2015: ($420 million - $143 million) divided by $143 million. The percentages displayed reflect the net return after paying back the marketing investment. In the narrative accompanying this table, we describe the return on marketing investment as the total return generated for every dollar invested, such that 194% would translate to nearly three-to-one, i.e., one dollar to pay back the initial marketing investment and two dollars of premium savings.

Untapped Potential of Federally-facilitated Marketplace Marketing Expansion: Resources available from existing federal plan assessments would support enrollment growth, improve stability in the individual markets and lower premiums.

In the years leading up to 2018, the federal government had been on a path of incrementally increasing its investments in marketing and outreach. The Centers for Medicare and Medicaid Services (CMS) spent approximately $118 million to promote enrollment and retention for 2016 (with $51 million for advertising and $67 million for the Navigator program.) (See Table 2: Federal Spending on Marketing and Outreach — 2016 to 2018.) For 2017, this investment was increased to about $165 million ($100 million for advertising and $63 million for the Navigator program).[40] While these investments were far lower than Covered California's as a percentage of premium, in those two years they increased by 22 percent — from 0.36 percent to 0.44 percent of total gross premium collected in the FFM.[41] In addition, the 2017 spending reflected about 13 percent of the reported $1.3 billion in marketplace premium assessments collected for marketing and outreach and other operational supports for the FFM.

TABLE 2
Federal Spending on Marketing and Outreach — 2016 to 2018

	2016 Actual			2017 Actual			2018 Proposed		
Marketing Spend	$ Millions	2015-16 Change	% of Premium	$ Millions	2016-17 Change	% of Premium	$ Millions	2017-18 Change	% of Premium
Advertising	$51.2	—	0.16%	$100	95%	0.27%	$10	-90%	0.03%
Navigators	$67	—	0.20%	$63	-6%	0.17%	$36.8	-42%	0.11%
Total	**$118.2**	**—**	**0.36%**	**$163**	**38%**	**0.44%**	**$46.8**	**-71%**	**0.14%**
FFM Gross Premiums (Estimated)	$33 billion			$37.1 billion			$34.3 billion		
Plan Assessments	$1.15 billion			$1.3 billion			$1.2 billion		
Spend as Share of 3.5 % Plan Assessment	10%			13%			4%		

In August, CMS announced its planned investment of $47 million for marketing and outreach for 2018, with planned advertising spending of $10 million and Navigator program spending of $37 million. This spending is less than one-third of 2017 spending, and is one-tenth of what CMS would be spending if it were to invest in marketing at the same rate as does Covered California. The spending also represents only 4 percent of the estimated $1.2 billion in the federal marketplaces' premium assessments for 2018.

[40] Centers for Medicare and Medicaid Services (2017) "CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment."https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-31-3.html. See also the CMS fact sheet, http://big.assets.huffingtonpost.com/cms-fact-sheet.pdf.

[41] These figures were calculated by dividing the total marketing and outreach spend by total gross premiums for 2016 and 2017. Total gross premiums were derived by dividing publicly reported marketplace premium assessment revenues of $1.15 billion for 2016 and $1.3 billion for 2017 by 3.5 percent. See page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document, available at: https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

For *Marketing Matters*, Covered California modeled the incremental benefits and impacts of increasing the marketing and outreach spending based on the 2017 baseline amount of $165 million. The proposed reduction in marketing and outreach spending announced in August will likely lead to lower enrollment, reduced retention of existing consumers and a worse risk mix — resulting in higher premiums. Covered California's modeling did not contemplate such a significant reduction.

Based on California's experience, if the FFM were to expand its investments in marketing from 2018 to 2020 to be commensurate with Covered California's investments as a percentage of premium — which we estimate to be $480 million, an increase of approximately $315 million over the 2017 spending of $165 million — the benefits from this increased investment would be immediate and profound.[42]

Exact impacts are difficult to project, but based on reasonable assumptions about how much the market would grow, and the health status of new enrollees, a plausible outcome would be that:

- 1.3 million more Americans would gain subsidized insurance.
- Premiums would be reduced an average of 3.2 percent from 2018 to 2020 for all insureds in the individual market. (See Table 3: Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018-2020.)

To model the potential benefits of enhanced marketing spending, this analysis starts with the best available information on a few fronts:

- The president's budget estimates that the plan assessments for FY 2018 will be $1.2 billion. This information is used as the basis for calculating the starting enhanced funding of marketing and outreach for 2018.[43]
- The FFM total marketing and outreach spending for 2017 was $165 million. Although CMS recently announced it will spend $47 million on marketing and outreach for 2018, this analysis assumed spending would continue at the same rate as 2017.

[42] To develop this model, Covered California used the CMS-reported budget (https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf) for health plan assessments of $1.2 billion as the basis for calculating what a 1.4 percent of premium spend would equate to for the FFM. This calculation is used to determine potential 2018 spending with subsequent years' marketing reflecting only an increase of 4 percent spending. Covered California considered a range of increases in the take-up rate based on enhanced marketing spending. The range of potential increases in enrollment was from 5 percent to 25 percent. Similarly, we modeled a range of differences in the health status of the incremental enrollment — ranging from 10 percent healthier and less costly to 40 percent healthier and less costly. Based on California's enrollment and risk mix experience, as well as its return on investment, we model the most likely impact of the enhanced investments to result in a 20 percent enrollment increase from 2017 to 2020 (with net enrollment reflecting a year-over-year increase of 10 percent in 2018 and 4.5 percent in 2019 and 2020), and that those incrementally enrolled individuals would be 25 percent healthier and less costly. Under these two assumptions, Covered California's marketing and outreach investments would have been responsible for the enrollment of more than 350,000 Californians, and lowered premiums by more than 4 percent compared to what they would have been without the enhanced marketing. This is consistent with our return on investment analysis that found a potential return on investment of more than three-to-one if only one-third of Covered California's healthier risk mix were attributed to marketing. For additional details on the modeling and assumptions, see http://hbex.coveredca.com/data-research/MarketingMatters-ModelingMethods-09-13-17.pdf.

[43] 2018 plan assessment revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document, available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

TABLE 3
Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018–2020[44]

	2018			3 Year Total (2018-2020)	
	Baseline (Projected at 2017 level)	**Enhanced** (Hypothetical)	**Difference** (Impact)	**Potential 3 Year Impact Due to Enhanced Marketing**	
Marketing Spend					
Baseline	$165 million	$165 million	—	—	$531 million
Enhanced	—	$315 million	—	—	$968 million
Total	$165 million	$480 million	$315 million	—	$1.5 billion
Enrollment					
				End of Period Enrollment	Difference from Baseline
On-Exchange Subsidized	6,622,133	7,284,347	662,213	7,946,560	1,324,427
On- and Off-Exchange Unsubsidized	3,773,076	4,150,384	377,308	4,527,691	754,615
Total	10,395,209	11,434,730	1,039,521	12,474,251	2,079,042
Premiums (Individual)					
Per Member Per Year	$5,374	$5,252	– $122	Average Premium Decrease (2018–2020)	
Percent Change	– 2.3%			– 3.2%	
Total Premiums (Aggregate)					
Core Group				Total Cumulative Premiums (3 Years)	Difference from Baseline
On-Exchange Subsidized	$35.6 billion	$34.8 billion	-$809 million	$110.7 billion	– $3.8 billion
On- and Off-Exchange Unsubsidized	$20.3 billion	$19.8 billion	– $461 million	$63 billion	– $2.1 billion
Subtotal	$55.9 billion	$54.6 billion	– $1.3 billion	$173.7 billion	– $5.9 billion
Marketing-Induced Group					
On-Exchange Subsidized	—	$3.5 billion	$3.5 billion	$16.8 billion	$16.8 billion
On- and Off-Exchange Unsubsidized	—	$2 billion	$2 billion	$9.6 billion	$9.6 billion
Subtotal	—	$5.5 billion	$5.5 billion	$26.4 billion	$26.4 billion
TOTAL					
On-Exchange Subsidized	$35.6 billion	$38.3 billion	$2.7 billion	$127.5 billion	$13.1 billion
On- and Off-Exchange Unsubsidized	$20.3 billion	$21.8 billion	$1.5 billion	$72.6 billion	$7.4 billion
Subtotal	$55.9 billion	$60.1 billion	$4.2 billion	$200.1 billion	$20.5 billion
Potential Return on Investment of Enhanced Marketing (return is lowered premiums for original group)					
Potential ROI	303%			508%	

Assumption: Enhanced marketing leads to 20 percent increase in enrollment of consumers who are 25 percent loss costly to insure.

[44] The baseline spending for 2018 is FFM total marketing and outreach spending of $165 million for 2017. Although CMS recently announced it will spend $47 million on marketing and outreach for 2018, this analysis assumed spending would continue at the same rate as 2017. Baseline enrollment for 2018 uses 2017 effectuated enrollment for the FFM. The $480 million marketing and outreach spend for 2018 under enhanced was calculated by applying California's benchmark of 1.4 percent of premium to the FFM's projected $34.3 billion in total gross premiums. FFM total gross premiums is derived by dividing CMS' reported $1.2 billion in plan assessment revenue for 2018 by the 3.5 percent user fee on plans. The $480 million then grew by 4 percent (instead of medical inflation) for each year thereafter.

If the FFM were to increase its marketing and outreach spending to be 1.4 percent of on-exchange premium for 2018, and then increase that spending by 4 percent per year (rather than increasing it to keep pace with the growth of premium), total marketing and outreach investments over three years would be approximately $1.5 billion — an increase of nearly $1 billion over the 2017 spending rate. Over three years, this investment would represent only 1 percent of total FFM on-exchange gross premiums from 2018 to 2020.

As previously mentioned, the results from these federal investments include the following potential benefits under Covered California's assumptions of 20 percent enrollment growth of enrollees that are 25 percent less costly to insure:

- 2.1 million *more* Americans would enroll in or keep their health insurance over this three-year period. This would include covering 1.3 million more subsidy-eligible Americans, increasing take-up of subsidy-eligible consumers by 20 percent, from 58 percent in 2017 to 70 percent in 2020.
- Premiums over the three years would be on average 3.2 percent *less* than they would be absent the enhanced marketing investments because of the better health of the additional enrollees.
- After a three-year phased enrollment growth of 20 percent, the enhanced federal marketing spending would have a better than 400 percent return on investment, based *only* on looking at lower premiums for those who would have had insurance under a baseline (not the enhanced marketing scenario).

The biggest beneficiaries of these investments would be:

- Individuals who get insurance because of the effective marketing; and,
- Unsubsidized individuals who were already insured and are now paying lower premiums — saving them more than $2.1 billion in premiums over the three years.

The proposed federal spending on marketing and outreach for 2018 is neither supported by the evidence nor a rational application of good business principles. The evidence so far is clear — marketing is a potentially effective and efficient mechanism for both improving take-up *and* lowering premiums. The benefits, however, go beyond these impacts by fostering marketplaces that insurance carriers see as stable and competitive. In addition, all insured consumers in the FFM would benefit from expanded and more certain participation of health plans, which fosters greater competition.

Potential Decreased Enrollment and Higher Premiums Resulting From Lower Federal Marketing Spending

In light of the recent announcement by CMS to reduce planned marketing and outreach to $47 million, Covered California also analyzed the potential impact of reduced marketing and outreach spending. This analysis examines possible impacts on enrollment and the financial impacts to those remaining insured in the individual market when fewer consumers enroll or maintain their coverage because of reduced marketing spending. Based on a scenario in which enrollment declines by ten percent in 2018, which is likely a conservative estimate, the impact on reduced enrollment, worse risk mix and higher premiums would impact some consumers immediately and likely lead to higher costs and less market stability in 2019 (see Table 4. Potential Impacts of Reduced Marketing and Outreach for Federally-facilitated Marketplace States [2018]).

Based on the assumption of 10 percent loss in enrollment of consumers who are 25 percent less costly to insure, the potential impacts of the proposed reduced marketing investment include:

- One million fewer Americans enrolled in health insurance. This would include 660,000 subsidy-eligible consumers, which would reduce take-up of subsidy-eligible consumers by 10 percent, from 58 percent in 2017 to 52 percent in 2018.
- Premiums for 2019 would be, on average, 2.6 percent more than they would be because of the smaller consumer pool and less healthy risk profile of the remaining group. This would translate to $1.3 billion higher premiums in 2019 for the remaining 9.4 million insured consumers in the individual market. Of this group, unsubsidized consumers would pay $465 million more in premiums.

If the same reduced spending were to lead to a decline in enrollment by 20 percent, which is easily in the range of the possible, this would lead to 2.1 million fewer insured Americans, of whom 1.3 million would have been subsidy-eligible. Under this scenario, the number of insured consumers in the individual would shrink from 10.4 million to 8.3 million and would be less healthy overall. Premiums would likely increase by 5.3 percent, meaning insured consumers remaining in the individual market would pay $2.4 billion in higher premiums — of which $850 million is borne by unsubsidized consumers.

TABLE 4
Potential Impacts of Reduced Marketing and Outreach for FFM States — 2018[45]

	2018		
	Baseline (Projected with 2017 Marketing Spend)	**Reduced** (Projected Based on Announced Spending)	**Difference** (Impact)
Marketing Spend			
Baseline	$165 million	$47 million	—
Enhanced	—	—	—
Total	$165 million	$47 million	– $118 million
Enrollment			
On-Exchange Subsidized	6,622,133	5,959,920	– 662,213
On- and Off-Exchange Unsubsidized	3,773,076	3,395,768	– 377,308
Total	10,395,209	9,355,688	– 1,039,521
Premiums (Individual): Impact on Premium for 2019 Based on Health Status Change Only			
Per Member Per Year	$5,374	$5,512	$138
Percent Change	—	2.6%	2.6%
Total Premiums (Aggregate)			
Remaining Insured After Reduced Enrollment (Premium Difference is Estimated Impact on 2019 Premiums Based on Health Status Change Only)			
On-Exchange Subsidized	$32 billion	$32.8 billion	$821 million
On- and Off-Exchange Unsubsidized	$18.2 billion	$18.7 billion	$468 million
Total	$50.3 billion	$51.6 billion	$1.3 billion
Reduced Enrollment Group (Premium Difference is Gross Reduction in Premium for 2018 Based on Non-Coverage)			
On-Exchange Subsidized	$3.6 billion	—	– $3.6 billion
On- and Off-Exchange Unsubsidized	$2 billion	—	– $2 billion
Total	$5.6 billion	—	– $5.6 billion

Assumption: Enhanced marketing leads to 20 percent increase in enrollment of consumers who are 25 percent loss costly to insure.

[45] The baseline spending for 2018 is FFM total marketing and outreach spending of $165 million for 2017. The reduced marketing spend for 2018 is based on the recent CMS announcement that proposed $47 million in marketing and outreach spending. Baseline enrollment for 2018 uses 2017 effectuated enrollment for the FFM. Reduced enrollment is modeled based on a 10 percent reduction.

Covered California's Benchmarks for Spending: Marketing and outreach spend provides a benchmark to inform federal and other SBM spending.

Based on public reports, the federal investment in marketing and outreach for 2017 was $165 million and the planned spending for 2018 is $47 million.[46] If the FFM spent the same percentage of on-exchange premium on marketing and outreach as does Covered California (1.4 percent), the FFM would invest approximately 10 times its planned 2018 spending amount ($480 million) on marketing and outreach. Given the FFM's current level of health plan assessments of $1.2 billion, the $480 million would represent 40 percent of the assessment collected (compared to California's rate of about 35 percent).[47]

To provide a benchmark for potential federal marketing investments, Covered California conducted a "what if" scenario for potential FFM spending across major elements of a multi-channel marketing and outreach effort if it spent the same proportion of premium to promote enrollment as does Covered California (see Table 5: California 2018 Marketing Spend as a Benchmark for the Federal Marketplace).

Regarding potential allocation among marketing and outreach areas, it is likely that in most instances the FFM spends far less proportionately than does Covered California. There may be two areas where the FFM is spending as much or more proportionally as Covered California:

- The FFM has operated a significant and sophisticated outreach program to individuals who have initiated their application. Similarly, Covered California conducts email outreach and follows up with these individuals in other ways. The direct costs of these efforts are relatively low, however, and are reflected in Covered California's information technology budget.
- The FFM has historically made significant investments in its support for the Navigator program. This was the only area of spending where it appeared that CMS was spending at a higher rate as a percentage of premium than was Covered California. Covered California's Navigator program, with grants totaling $6.5 million, reflects an investment of 0.08 percent of premium. CMS recently announced a reduction of federal support for the Navigator program from $62.5 million in 2017 to $37 million for 2018. With the reduction in spending, CMS is on track to spend about one-tenth of one percent of on-exchange premium in support of the Navigator program. What is striking is not the fact that CMS might adjust particular tactics, but that it cut Navigator funding in half in one-year and at the same time reduced all other marketing expenditures by 90 percent, from $100 million in advertising for 2017 to $10 million for 2018.

[46] Centers for Medicare and Medicaid Services. (2017) "CMS Announcement on ACA Navigator Program and Promotion for Upcoming Open Enrollment." https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-31-3.html. See also CMS fact sheet, http://big.assets.huffingtonpost.com/cms-fact-sheet.pdf.

[47] The other major spending areas funded by health plan assessments is the maintenance and updating the healthcare.gov enrollment site and the support for the call center. Covered California does not have data on the amount of federal spending on these two functions, nor is it within the scope of this report to assess the efficiency of the website and call center functions and the amount spent on them.

TABLE 5
California 2018 Marketing Spend as a Benchmark for the Federal Marketplace[48]

	Covered California Marketing and Outreach as 1.4% of Premium (35% of Plan Assessment)		WHAT IF" SCENARIO **FFM Spends 1.4% of Premium on Marketing and Outreach** (40% of Plan Assessment)	
Projected Gross Premium (billions)	$7.8 billion		$34.3 billion	
Projected Enrollment	1.4 million		7.7 million	
Total Plan Assessment Dollars	$314.4 million		$1.2 billion	
Marketing and Outreach	$111.5 million		$480 million	
MARKETING — Select Breakdown for Benchmarking Purposes			Federal Allocation by Channel *if* Same as Covered California	
	$ Millions	**% of Premium**	**$ Millions**	**% of Premium**
PAID MEDIA				
Television	$18.1	0.23%	$79.6	0.23%
Digital Display	$9.7	0.12%	$42.8	0.12%
Radio	$8.3	0.11%	$36.4	0.11%
Paid Search	$2.3	0.03%	$10.2	0.03%
Paid Social	$1.9	0.02%	$8.5	0.02%
Print	$3.1	0.04%	$13.6	0.04%
Out-of-Home	$1.5	0.02%	$6.7	0.02%
TOTAL	**$45.0**	**0.58%**	**$197.8**	**0.58%**
NON-PAID MEDIA				
Collateral, Printing, Fulfillment, Postage	$11.0	0.14%	$48.4	0.14%
Marketing Operations	$4.9	0.06%	$21.4	0.06%
Personnel Services	$2.9	0.04%	$13.0	0.04%
Research	$2.1	0.03%	$9.2	0.03%
TOTAL	**$20.9**	**0.27%**	**$92.0**	**0.27%**
OUTREACH & SALES				
Covered California for Small Business	$18.9	0.24%	$83.1	0.24%
Navigators	$6.5	0.08%	$34.3	0.10%
Personnel Services	$6.3	0.08%	$27.7	0.08%
Other Enrollers Program Administration	$1.8	0.02%	$2.2	0.01%
TOTAL	**$33.5**	**0.43%**	**$147.2**	**0.43%**
EARNED MEDIA				
TOTAL	**$5.1**	**0.07%**	**$22.4**	**0.07%**

[48] Notes related to considering Covered California's marketing and outreach expenditures to set benchmarks:

- The projected gross premium and enrollment would likely be substantially higher for the FFM with increased marketing and outreach expenditures.
- Support for agents to enroll in Covered California programs, such as: a statewide storefront program, agent referral program, management of Covered California for Small Business and an agent-focused program.
- Earned media includes staff and contractual public relations and the consumer-facing website (before the application).

For additional details on Covered California's budget, see its 2017–18 budget (http://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2017-18_Budget_final.pdf).

Promoting Retention: Marketing and outreach investments are linked to better retention, which helps mitigate the high turnover in the individual market.

Covered California's experience is that 40 percent of its enrollees leave the marketplace each year, which is a "natural" part of the individual market (see Figure 6: Covered California Health Coverage Transitions in 2016). Not only is churn natural,[49] but Covered California's survey data finds that, in California, the vast majority of those leaving do so for other coverage.

This churn means that continual outreach is needed to maintain enrollment and to newly enroll people who lose employer-based insurance, parental coverage, or coverage from public programs.

For California, the turnover means that while Covered California was providing coverage to about 1.4 million people (as of April 2017), since the first open-enrollment period in January 2014, more than 2.9 million unique Californians have had both subsidized and unsubsidized coverage through Covered California. Some of these people had coverage for as short as a month while others for as long as the entire three years. Looking at subsidy-eligible consumers only, Covered California has enrolled 2.35 million unique individuals since 2014. (See Figure 7: Covered California: Continuous and New Subsidized Insureds, 2014–2016.)

FIGURE 6
Covered California Health Coverage Transitions in 2016

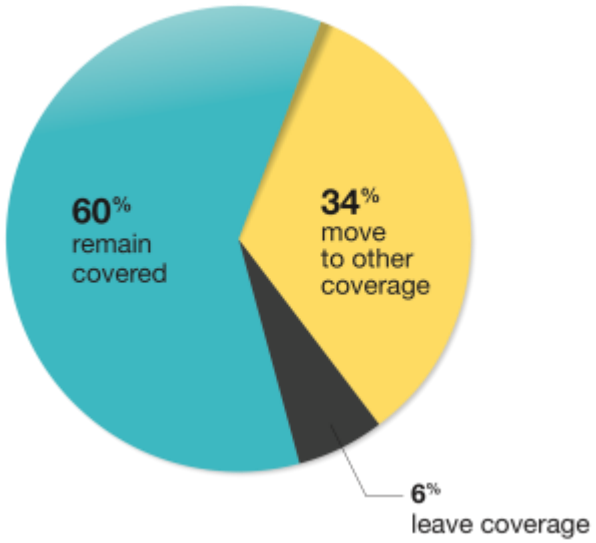
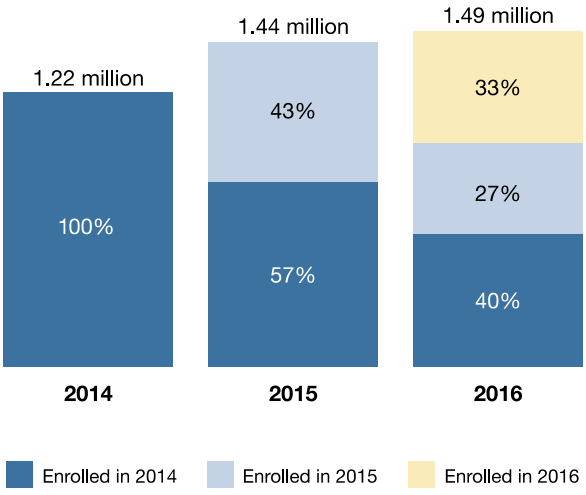


FIGURE 7
Covered California: Continuous and New Subsidized Insureds, 2014–2016



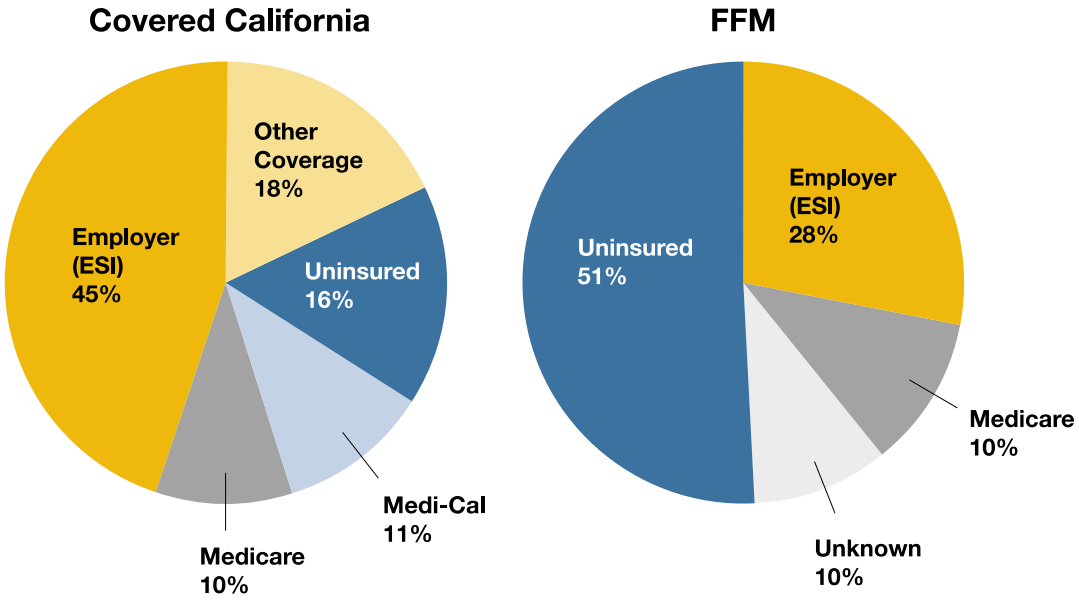
[49] In the period from 2008 to 2011, prior to major Patient Protection and Affordable Care Act provisions taking effect, only 42 percent of individual market enrollees kept their coverage after 12 months, with 80 percent of those experiencing coverage changes to other types of health insurance (the majority obtaining employer-based coverage). Sommers, Benjamin D. "Insurance cancellations in context: stability of coverage in the non-group market prior to health reform." *Health Affairs* 33, no. 5 (2014): 887-894.

When comparing Covered California and the federal marketplace's experience on where consumers go once they leave the exchange, there is evidence that marketing helps those enrollees who might churn stay insured. The vast majority of Covered California's enrollees who leave coverage (84 percent) move on to another form of insurance coverage (e.g., employer-based coverage from new employment or aging into Medicare), and only 16 percent become uninsured. By contrast, the latest data from CMS indicates that consumers who leave the FFM are more than three times as likely to become uninsured as are those leaving Covered California (see Figure 8: Coverage Transitions in 2016: Comparing Covered California to FFM Survey Data).[50]

While some of the higher rate of people leaving FFM coverage to be uninsured may be attributable to the fact that many states in the federal marketplace did not expand Medicaid, it is important to note that only 11 percent of Covered California consumers left the marketplace and enrolled in Medi-Cal (California's Medicaid program). If that same proportion held true on the federal marketplace, at least 40 percent of consumers

FIGURE 8

Coverage Transitions in 2016: Comparing Covered California to FFM Survey Data[51]



[50] For Covered California, the 6 percent uninsured number in Figure 6: Covered California Health Coverage Transitions in 2016 is based on the entire 2016 enrollment while the 16 percent uninsured number for Covered California in Figure 8: Coverage Transitions in 2016: Comparing California to FFM Survey Data is based on the subset of Covered California enrollees that leave the marketplace.

[51] Survey data reflect respondents who paid at least one month's premium but ultimately left coverage. Covered California's value of "other coverage" includes consumers who reported Medicaid, individual market off-exchange health insurance and other sources (e.g., TRICARE). FFM survey results (https://downloads.cms.gov/files/cost-disruptions-trends-report-06-12-17.pdf) do not explicitly report on Medicaid or uninsured statuses following marketplace enrollment, the "unknown" category represents individuals who CMS does not report have either employer-sponsored insurance or Medicare, CMS did not release any details about this group, but it could include similar categories of individuals who transitioned to Medicaid or other sources of coverage.

leaving the FFM would still be dropping coverage to be uninsured. This means that the FFM would still have nearly three times as many consumers leaving to become uninsured than does Covered California (hypothetical 40 percent versus 16 percent).

Marketing and outreach are part of what makes coverage "sticky." These efforts encourage those with coverage who do not use medical services to stay covered by reinforcing that decision through marketing and outreach. Given the natural churn in the individual market, keeping existing consumers insured is a key function of marketing. Just as Chevrolet invests billions in marketing even though the "Chevy brand" is very well known and millions drive their cars, marketing of insurance promotes retention of individuals who have already enrolled. Since relatively few who get insurance actually use their insurance for expensive services, there is the risk that they may either drop coverage — as appears to be happening at high rates in the FFM — or not renew. Marketing and outreach efforts are important to reinforce the ongoing value of having insurance, especially for those who only use the health care system occasionally. These enrollees are precisely the people an individual insurance market needs to enroll and retain to maintain a good risk mix.

State-Based Marketplaces Attract and Retain a Better Risk Mix

While it is not possible to say with certainty how much marketing and outreach contribute to improved retention, there is a clear pattern that Covered California and other state-based marketplaces that spend on marketing and outreach and focus on retention have a better risk mix and lower premiums than the FFM. Covered California believes this is an issue that warrants more research, but the early indication is that marketing does make a difference and matters not only for promoting initial enrollment, but also to foster retention.

The Centers for Medicare and Medicaid Services (CMS) has previously found that California had the lowest "state liability risk score" in the individual market for both 2014[52] and 2015[53], and continued to have one of the lowest risk scores in the nation in 2016.[54] The CMS report shows the "average risk score" across federal marketplace states, state-based marketplaces and California was nearly the same from 2015 to 2016. Because California's individual market had a risk profile that was 20 percent better than the national average (21 percent better in 2015 and 20 percent better in 2016), this means health care costs would be about 20 percent lower based on health status. (See Figure 4: Comparison of FFM, SBM and Covered California Risk Scores.)

Further, the report found that other state-based marketplaces collectively had a healthier risk mix than the national average (10 percent better in 2015 and 11 percent

[52] Centers for Medicare and Medicaid Services: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year (Revised: Sept. 17, 2015) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

[53] Centers for Medicare and Medicaid Services: Appendix A to June 30, 2016 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx

[54] Centers for Medicare and Medicaid Services: Appendix A to March 31, 2017 Risk Adjustment and Reinsurance: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-March-31-2017-Interim-RA-Report_5CR_033116.xlsx

better in 2016), which meant that health care costs in those 10 states would be 10 percent lower than the national average.[55]

Covered California, in an analysis of those rates, cites three reasons that it, and other state-based marketplaces, was relatively successful in attracting and retaining a healthier mix of consumers than the national average:[56]

- Covered California and state-based marketplaces appear to be investing proportionately more in marketing and outreach than is the federal government.
- State-based marketplaces, like California, were more likely to convert all health coverage in the individual market into Affordable Care Act-compliant plans and created one common risk pool as of 2014.
- California and other states with state-based marketplaces were more likely to expand their Medicaid program, which has a positive impact on the health status of the individual market.[57] Of the 12 state-based marketplaces, 11 expanded their Medicaid programs.[58]

The positive impact on the risk mix is continuing into 2017. Generally, the risk profile of a group gets less healthy over time, and the fact that California's risk mix is holding steady is clear evidence that relatively healthier individuals are continuing to sign up for insurance.

While *Marketing Matters* does not include a full review and analysis of all state-based marketplace marketing efforts, as a group, they clearly do a better job of attracting and retaining consumers than does the Federally-facilitated Marketplace (FFM).[59]

The number of effectuated consumers for both the federal and state-based marketplaces peaks in March every year. An analysis of the latest data from CMS shows that state-based marketplaces retained a higher percentage of those consumers, whether through more enrollment during the special-enrollment period or by retaining a higher rate of existing consumers than the federal marketplace, or both (see Figure 9: Comparing FFM and State-Based Marketplaces' Retention and Special Enrollment Performance). By November, state-based marketplaces — including California — had an effectuated enrollment that was approximately 94 percent of their peak figure, while the federal marketplace had about 85 percent of its peak enrollment total at that time.

[55] The analysis excludes Massachusetts and Vermont because risk-score data was not available for these states.

[56] Covered California press release "New Federal Report Shows the Individual Markets Across the Nation Are Stable (July 6, 2017): http://news.coveredca.com/2017/07/new-federal-report-shows-individual.html

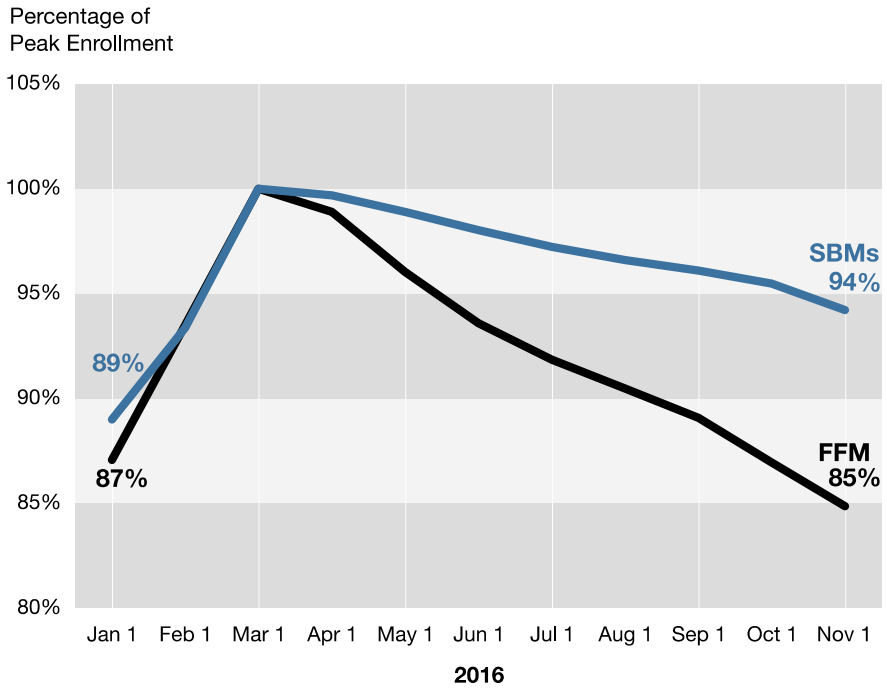
[57] Sen, Aditi P. and Thomas DeLeire. The Effect of Medicaid Expansion on Marketplace Premiums. 2016. https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf

[58] Kaiser Family Foundation "Current Status of State Medicaid Expansion Decisions (Jan. 1, 2017): http://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/

[59] Centers for Medicare and Medicaid Services: 2017 Effectuated Enrollment Snapshot (June 12, 2017): https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

FIGURE 9

Comparing FFM and State-Based Marketplaces' Retention and Special-Enrollment Performance



Marketing is about getting people covered, but it is also about keeping them covered. State-based marketplaces appear to do more marketing that is targeted to their communities than the federal marketplace does, which helps them maintain a healthier risk mix (see Figure 4: Comparison of FFM, SBM and Covered California Risk Scores).

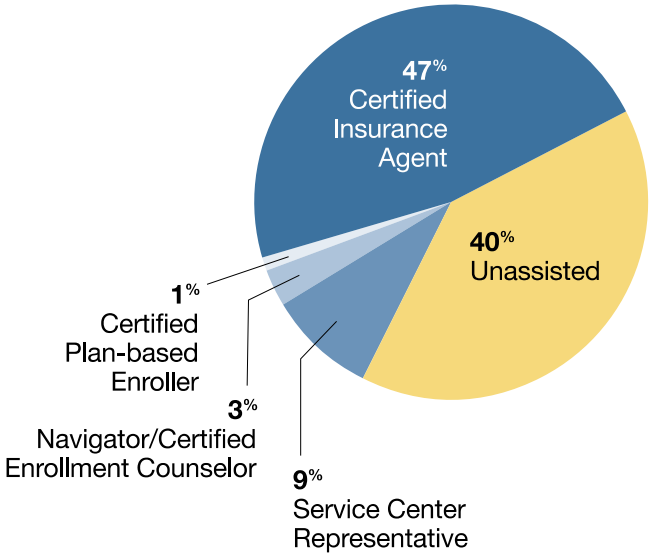
As discussed earlier, in California, exit surveys have found that 84 percent of consumers who leave Covered California move onto other sources of coverage, and only 16 percent become uninsured. While data on where consumers go when they leave other state-based marketplaces is not available, the latest data from CMS[60] shows that consumers who leave the federal marketplace are three times more likely to become uninsured. This provides additional evidence of the potential positive impact of marketing investments. (See Figure 8: Coverage Transitions in 2016: Comparing California to FFM Survey Data.)

[60] FFM survey results (https://downloads.cms.gov/files/cost-disruptions-trends-report-06-12-17.pdf) do not explicitly report on Medicaid or uninsured statuses following marketplace enrollment; the "unknown" category represents individuals who CMS does not report have either employer-sponsored insurance or Medicare: CMS did not release any details about this group, but it could include similar categories of individuals who transitioned to Medicaid or other sources of coverage.

Person-to-Person Assistance, Especially Through Agents, Is Vital to Promoting Enrollment.

Most of Covered California's enrollment comes from a range of channels that provide person-to-person assistance to help people enroll. At Covered California, about 40 percent of all enrollment is from consumers who enroll directly through the website (CoveredCA.com) (see Figure 10: Covered California 2017 Enrollment by Service Channel), but most consumers want and need personal assistance with enrolling.

FIGURE 10
Covered California 2017 Enrollment by Service Channel



The biggest single channel for enrollment is through Certified Insurance Agents who are paid directly by health plans through commissions. Agents enroll 47 percent of Covered California's consumers. These are trained and licensed professionals who operate storefronts and do in-person retail sales. It also includes web-based entities. All agents must be certified by Covered California.

Some health plans have decades of experience funding agent channels to attract and enroll consumers. Covered California has successfully established a variety of programs to promote and partner with agents.

After agents, the next most common way that consumers enroll is through Covered California's Service Center, which in 2017 enrolled about 9 percent of all those who got insurance through Covered California. The Service Center also helps many more consumers by answering questions about their coverage. The FFM and all state-based marketplaces operate service or call centers, which represent a substantial functional area and cost center for marketplaces.

Covered California's Navigators — funded directly by Covered California through a performance-based competitive grant — generate about 3 percent of enrollment. Navigators in California reflect a diverse mix of community-based organizations that provide particularly important support for enrolling potentially hard-to-reach populations. As is described in more detail in the description of Covered California's Navigator program in the next two sections, Covered California's investment over the past four years has been substantially reduced while on a relative basis funding for other channels has increased.

Actively Collaborating With Health Plans and Agents Works: Marketing and outreach are about the combined efforts of health plans and marketplaces (health plan marketing and agent commissions, plus marketplace spending on marketing and outreach).

Marketing and outreach to promote enrollment in the individual market is a combination of what is done directly by health plans — in both marketing and commission payments to agents — and what is funded and done by public marketplaces. Covered California recognizes the critical need to complement the marketing activities of the health plans it contracts with by actively collaborating with them to promote enrollment. Each Covered California health plan shares its detailed marketing plan and budget with Covered California as a required element of the health plan's contract.[61]

Prior to the passage of the Patient Protection and Affordable Care Act, marketing, enrollment and acquisition costs in the individual market were high. The high acquisition costs were a central rationale for the medical loss ratio for the individual market being set at 80 percent — compared to 85 percent for the group insurance markets. Not only were direct marketing costs high, but agent commissions were substantial and medical underwriting (the cost of screening applicants to either exclude or charge higher premiums to those with pre-existing health conditions) was a significant cost.

PricewaterhouseCoopers (PwC), in an analysis conducted for Covered California, found that the average acquisition cost for health plans in the pre-Affordable Care Act individual market was 7.6 percent of premium.[62] The plans that generally participated in the individual market were those with deep experience in medical underwriting and extensive agent sales strategies, since the bulk of the individual market sales were through agents. Before the Affordable Care Act agents were paid an average 6.3 percent of premium for their efforts to enroll and retain individuals and families.

Since the launch of the Affordable Care Act, there have been big changes in the individual market, resulting in far lower acquisition costs and hence smaller increases on premiums. Among the changes:

- Health plans no longer have any medical underwriting expenses.
- While overall enrollment, including enrollment done through agents, has increased dramatically, agent commissions on a per-case basis have dropped significantly and a larger percentage of enrollment is not subject to commissions. Commissions in California have dropped from 6.3 percent of total individual market premium pre-Affordable Care Act to about 1.5 percent in 2017 (inclusive of on- and off-exchange commissions).
- The portion of consumers enrolling without an agent, which used to be very low, is now substantial. Health plans are not paying agent commissions for these

[61] See Covered California's contractual terms related to marketing, see pp. 18–22 of the Qualified Health Plan Issuer Contract: http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf.

[62] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning: http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

individuals, which in California represent about 47 percent of on-exchange enrollment and an estimated 10 percent of the off-exchange enrollment.

- Enrollment through public marketplaces like Covered California, state-based marketplaces or the Federally-facilitated Marketplace generates large new and healthier enrollment because the subsidies make coverage affordable to millions of Americans.
- Public marketplaces charge health plan assessments to cover their costs.[63]
- There have also been additional costs to health plans, such as: interfacing with marketplaces and the federal government, billing and reconciling membership and financial information.
- In many other states, the entry of many new plans that did not have experience in selling in the individual market (many of which did not know how to price or market effectively) resulted in their leaving after a few years.

In California, as in the rest of the nation, health plan investments in marketing primarily promote the individual health plan, rather than broadly inform the public about the marketplace or open enrollment. Because of the potential that consumers coming to the marketplace may pick any plan, individual plans do not have the same incentive as the marketplace itself to promote enrollment generally. Health plan marketing that targets their off-exchange products encourages consumers to enroll directly through them rather than through a marketplace. Shopping through a marketplace allows consumers to review all coverage options in the market.

Based on discussions with leaders of other state-based marketplaces and with national health plans, California's experience appears to be similar to that occurring nationally in three areas:

- Commissions to insurance agents have dropped significantly as a percentage of premiums, but total payments have continued to be high with the growth in enrollment.
- Health plan direct-marketing expenses vary dramatically by health plan. Some health plans spend very little and rely entirely on marketing conducted by public marketplaces, and a few plans make relatively large investments that come close to matching their pre-Affordable Care Act marketing investments.
- Health plan marketing spending is often focused on "selling the plan" and promoting the brand. Few plans promote open enrollment and provide information about the marketplace to consumers who may be subsidy eligible.

State-based marketplaces generally report that their own investments in marketing and outreach have been reduced significantly since federal establishment funds were exhausted. Boards or legislative bodies have not been sympathetic to raising the premium assessment to support expanded or continued marketing.

[63] California's assessment for 2018 is 4 percent of premium; the FFM is 3.5 percent of premium.

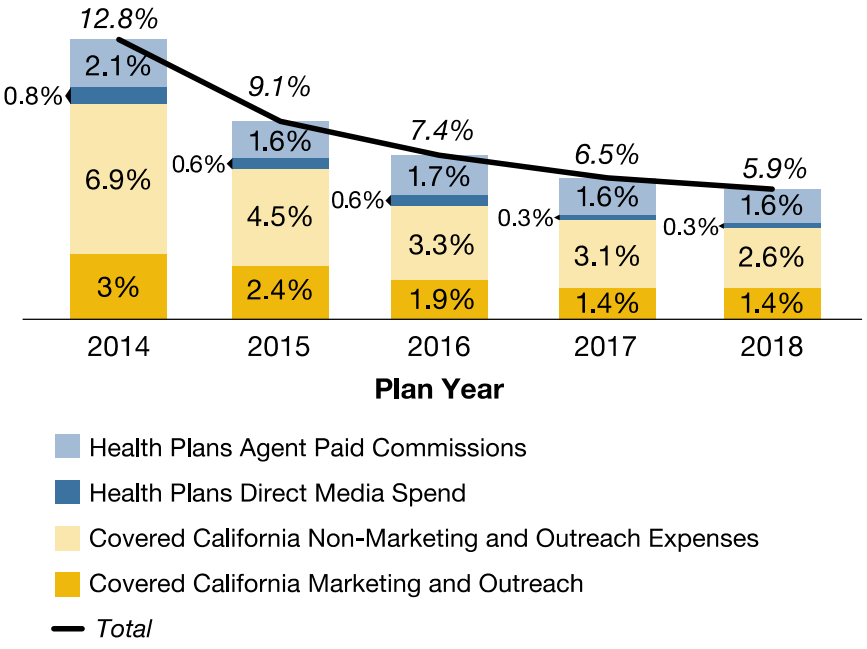
The picture of health plan marketing in states using the federal marketplace is even more opaque. The federal government has no requirements to spend on marketing and outreach and does not request data related to the type, scope and nature of health plans' marketing and outreach efforts. The one exception is that plans in the FFM are prohibited from discriminating and employing marketing practices or benefit designs that discourage the enrollment of consumers with significant health needs.[64]

Investments in Marketing Are a Declining Percent of Premium.

In California the aggregate spending of health plans and Covered California to promote enrollment has remained relatively constant over the past four years, with on-exchange spending ranging from $231 million to $265 million (see Figure 1: California On-Exchange Individual Market Marketing and Outreach Investments [millions], 2014–18), but while California's total marketing and outreach spending has remained consistent, it has fallen dramatically as a percentage of premium (see Figure 11: California On-Exchange Total Acquisition Costs as a Share of Premium, 2014–18).

FIGURE 11

California On-Exchange Total Acquisition Costs as a Share of Premium, 2014–18[65]



[64] See 45 CFR §147.104(e): https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.147_1104&rgn=div8, §156.200(e): https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_1200&rgn=div8, and §156.225(b): https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_1225&rgn=div8.

[65] Covered California's health plan agent paid commissions are estimated based on enrollment data and best available information on commission rates, but may not reflect actual health plan spend. 2018 figures are projected using Covered California's proposed 2017–18 budget and direct-media spend is assumed to be the same as 2017. To enable common benchmarks based on a share of on-exchange premium (Figures 1 and 11), Covered California attributed plans' direct-media spending proportionally based on 68 percent of individual market enrollment being on exchange and 32 percent off exchange.

While health plans have decreased their average commission to agents,[66] they have increased their year-over-year total dollar investment in agent commissions because of higher enrollment. In the period of four years, from 2014 to 2017, health plans' on-exchange commission payments to agents in California have risen by 16 percent (from $95 million to $110 million) (see Figure 1: California On-Exchange Individual Market Marketing and Outreach Investments [millions], 2014–18). These payments reflect 1.6 percent of total on-exchange premium and 1.5 percent of total individual market premium (inclusive of off-exchange commissions) as of 2017. (This compares to the national pre-Affordable Care Act figure of 6.3 percent of total individual market premium.)

For 2017, Covered California represents about 40 percent of aggregate marketing and outreach investment for the individual market and is 0.9 percent of total individual market premium for 2017. Covered California's investments in marketing and outreach also benefited those consumers who enrolled off-exchange — roughly 650,000 Californians. Premiums paid by off-exchange consumers in California represent about $3.6 billion in 2017.

The initial years of any product or service require investing to promote brand recognition. Covered California's initial two years of marketing expenses (FY 2013–14 and FY 2014–15) were paid for with federal establishment funds. The average Covered California marketing and outreach annual investment in its first two years was about $138 million. While aggregate on-exchange marketing spend as a share of premium has declined since 2014, Covered California's marketing and outreach investments represent between 40 and 50 percent of the total marketing and outreach investment in California's individual market from 2014 to 2018.

Measuring Lifetime Value: Measuring the lifetime value of a member helps assess appropriate returns on marketing and outreach investments.

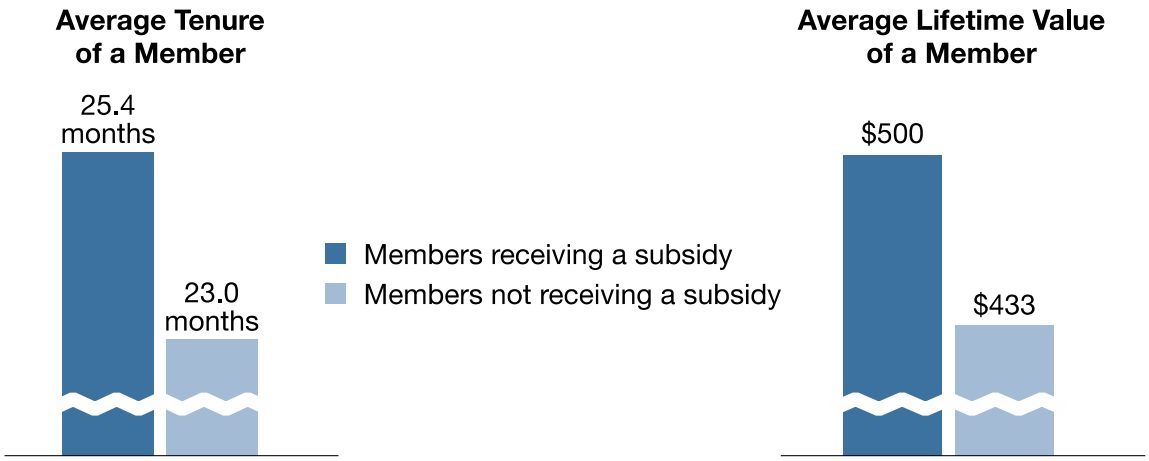
As a longitudinal measure, the lifetime value of a member is the amount of revenue earned by Covered California on each enrollee. Since Covered California is totally reliant on its plan assessments for revenue — receiving no direct state or federal funding — understanding how much revenue is generated by each enrollee is a vital business question. The lifetime value is the total revenue earned for each enrollee that must support all of Covered California's operations. The average member tenure for subsidy-eligible enrollees is 25.4 months and 23 months for non-subsidy-eligible enrollees, which translates to an average of $492 lifetime value ($500 lifetime value for each subsidized member and $433 for non-subsidy member) enrolled in 2018.[67]

[66] The average commission paid to agents in California has been cut four-fold from the pre-Affordable Care Act rate of more than 6 percent to about 1.5 percent of premiums for their business.

[67] For the FFM, based on an average monthly premium of $433 for the 2017 and 2018 enrollment years and assuming an average tenure of 24 months, the lifetime value to the FFM of Americans enrolled is $364 — which is collected in the form of a 3.5 percent plan user fee to support marketing, enrollment and retention efforts and other marketplace functions. If the FFM allocated the same 35 percent of the lifetime value to marketing and outreach as does Covered California, it would spend about $127 per person enrolled directly on marketing and outreach that supports new enrollment and retention.

FIGURE 12

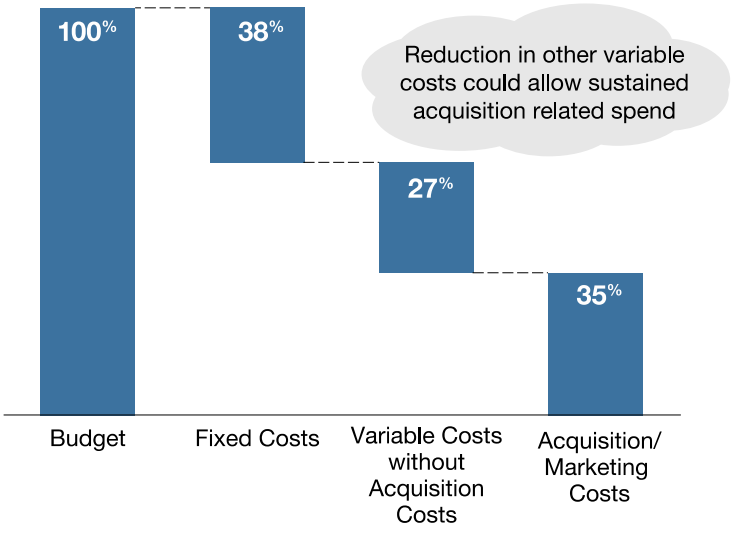
Average Member Tenure and Lifetime Value for Covered California Enrollees



For 2018, Covered California will allocate about 35 percent of its 4 percent user fee — 1.4 percent of premium — for marketing and outreach; the other 65 percent will be used for information technology, the service/call center, plan management, and administration (see Figure 13: Covered California's Revenue and Cost Breakdown). For planning purposes, Covered California allocates one-third of an average enrollee's lifetime value to marketing and outreach, which equates to roughly $164 per person. When taking this long-range perspective of the lifetime value of a member, it helps provide the basis of assessing what investments in marketing and outreach generate sufficient returns to warrant their investment.

FIGURE 13

Covered California's Revenue and Cost Breakdown[68]



[68] Plan Management, the information technology to support CoveredCA.com, and Covered California Administration are considered fixed costs. Covered California's Service Center and Marketing and Outreach are considered a mix of fixed and variable costs.

Marketing Must Be Adequately Funded: Health plan assessments (user fees) are part of California's path to adequately fund marketing to ensure a good risk mix and long-term sustainability.

Since marketing is integral to having a good risk mix and lower premiums, if policy-makers do not ensure it is adequately resourced, underfunded marketing will result in smaller and less-healthy enrollment and higher premiums. States that operate state-based marketplaces are free to establish their own assessment or funding structure, but since exchanges are required to be self-sustaining, the most common source of funding for marketing is derived from a "user fee," an assessment levied on participating plans for each covered enrollee.

Covered California has collected an assessment on health plan premiums since January 2014. Initially, the fee was set at a fixed per-member, per-month (PMPM) assessment of $13.95. In 2017, the assessment was converted to a percent of premium, with the initial assessment set at 4 percent. Covered California will keep the same assessment level for 2018 and has shared projections that detail decreases in the assessment level in future years.[69] Since the assessment was initiated during the early years when Covered California was supported by federal establishment funds, these assessments have built a substantial reserve that Covered California can use, along with new revenue, to fund future activities.

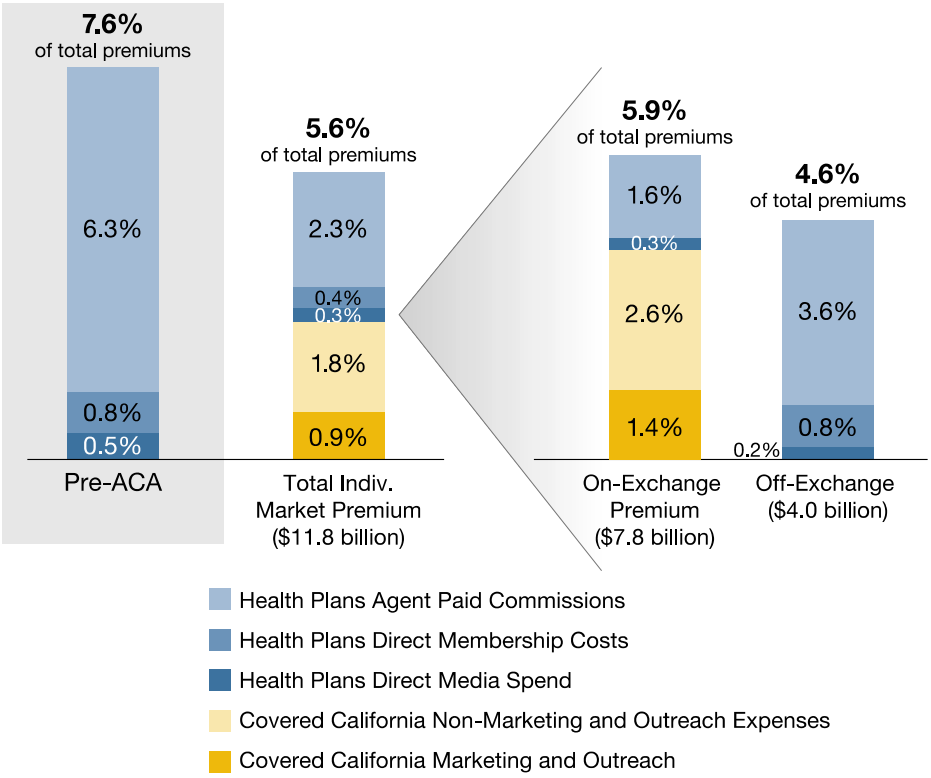
Covered California has structured its 2018 budget such that 1.4 percent of premium is dedicated for marketing and outreach while the remaining 2.6 percent is for non-marketing exchange expenditures. For "on-exchange" enrollment, when loading the entire Covered California plan assessment as an "acquisition cost," and taking into account health plans' agent-paid commissions (1.6 percent of premium) and direct-media spend (0.3 percent of premium) total member acquisition costs are 5.9 percent of premium for 2018 (see Figure 14: Comparing California's Individual Market Total Marketing, Acquisition and Retention Costs as a Share of Premium, Pre- and Post-Affordable Care Act (2018)). These acquisition costs are also represented as a share of the total individual market premium, which would be 5.6 percent of premium. This illustrates that direct expenses for marketing and acquisition are far lower than before the Affordable Care Act.[70]

[69] See page 17 of Covered California's 2017-18 budget (http://hbex.coveredca.com/financial-reports/PDFs/CoveredCA_2017-18_Budget_final.pdf)

[70] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

FIGURE 14

Comparing California's Individual Market Total Marketing, Acquisition and Retention Costs as a Share of Premium, Pre- and Post-Affordable Care Act (2018)[71]



Collectively, the 2018 acquisition costs for health plans in the individual market has dropped from the pre-ACA rate of 7.6 percent of premium to 5.6 percent in California. This 2 percent reduction equals to an annual cost saving of $236 million for consumers and the federal government.[72]

Federal regulations currently define two fee structures for states that use the federal infrastructure: 3.5 percent of premium for the FFM, and 3 percent of premium for marketplaces on the federal platform.[73] Neither the Affordable Care Act nor federal regulations clearly define the portion of the federal marketplace user fee that should be dedicated to fund marketing and outreach. However, as discussed in the next sections, the federal government has an obligation to fund and support marketing and outreach.

[71] The expense category of "direct membership costs" reflects management and data-related expenses for enrollment of members and costs for medical underwriting (in pre-ACA period). For pre-ACA and off-exchange, all values shown are based on a PricewaterhouseCoopers analysis. The category for direct membership costs also came from the PwC analysis and are based on post-ACA health plan cost benchmarks of 0.8 percent of premium for off-exchange and 0.4 percent of premium for the total individual market. Other values were calculated using available data on agent commission rates and the 2017-18 Covered California budget.

[72] This was calculated by multiplying 2 percent by $11.8 billion (total individual market gross premium).

[73] See 45 CFR §156.50 (https://www.ecfr.gov/cgi-bin/text-idx?SID=92e241490966e0b1b87f14d3683ca144&mc=true&node=se45.1.156_150&rgn=div8) and the annual HHS Notice of Benefit and Payment Parameters for 2018 (https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-30433.pdf).

III. Facts on the Role of Marketing and Outreach to Promote Enrollment in the Individual Insurance Market

Just as health care should be "evidence-based," so too should the assessment, planning and investments in ensuring enrollment in the individual market promotes stability and a good risk mix. Informed by Covered California's experience, this section contains evidence related to the role of marketing and outreach and public exchanges.

Fact 1: Marketing Lowers Premiums.

Marketing lowers premiums by attracting a better risk mix, a larger and more stable risk pool and more participation by health plans that see a more profitable market. While some believe that reducing marketing and outreach efforts will lower premiums, well-targeted marketing fosters a better risk mix and lowers premiums far more than the direct expense of marketing.

Getting consumers insured in the individual health insurance market has historically been a costly proposition,[74] but evidence from California shows that the Affordable Care Act has helped lower acquisition costs as a portion of premiums and marketing may have driven enrollment. A recent analysis by PricewaterhouseCoopers (PwC) examined the implementation of Covered California and its impact on member-acquisition costs in the individual market, both on and off exchange.[75] The PwC analysis found that in California the Affordable Care Act contributed to a 26 percent reduction in the costs of signing up new insureds in the individual market ("member acquisition costs"), from 7.6 percent to 5.6 percent of total premium, pre- and post-Affordable Care Act (See Figure 14: Comparing California's Individual Market Total Marketing, Acquisition and Retention Costs as a Share of Premium, Pre- and Post-Affordable Care Act [2018]). This reduced acquisition cost reflects attributing the entire Covered California plan assessment as an acquisition cost. PwC found that even after incorporating the entire user fee levied on participating Covered California plans, and including additional costs for health plans, the overall California individual market benefited from a lower share of total premium paid to agent and broker commissions. These lower acquisition costs mean that consumers are saving over $236 million[76] annually compared to pre-Affordable Care Act acquisition costs spent on the individual market in California.

Since marketing is integral to the business case of generating a good risk mix and lower premiums, if policy-makers do not ensure it is financed with a dedicated funding source, it runs the risk of being chronically underfunded. Total marketing and outreach investment by the Federally-facilitated Marketplace (FFM) was $165 million, which represents about 0.44 percent of the 2017 FFM premium and a spending on marketing

[74] The high cost of member acquisition was the central factor in the Medical Loss Ratio being set at 80 percent for the individual market compared to 85 percent for employer groups. See "Actively Collaborating With Health Plans and Agents Works" beginning on page 34.

[75] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

[76] This was calculated by multiplying 2 percent by $11.8 billion (total individual market gross premium).

at about one-third of California's rate of investment for 2017 (see Table 2: Federal Spending on Marketing and Outreach — 2016 to 2018). The planned spending for 2018 of only $47 million represents a very risky underfunding of marketing and outreach. For 2018, Covered California plans to spend the equivalent of approximately 1.4 percent of on-exchange premium for marketing and outreach, which would translate to $480 million spend for the FFM, using its planned assessment as the basis for calculating its total assessment of $1.2 billion. [77]

California's experience shows that marketing investments are associated with a more balanced risk mix, lower rate increases and higher enrollment. Federal data shows the healthier risk mix of those enrolled in California, with a risk mix that means health care costs are about 20 percent lower than in FFM states. (See "By the Numbers" for more discussion of California's risk mix.) Based on Covered California's enrollment and the good risk mix that has been generated as a result, the weighted average rate change for Covered California plans in 2015 was 4.2 percent and in 2016, it was 4.0 percent. While the 2017 rate change averaged 13.2 percent, the majority of that increase was a reflection of the expiration of the federal transitional reinsurance program. In addition to promoting a more balanced risk mix, lower rate changes and increased enrollment, marketing investments benefit those in the individual market who do not get any subsidy by lowering their premium and improving the value of the Advance Premium Tax Credits.

[77] 2016 and 2017 plan-assessment ("user fee") revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' fiscal year 2018 budget-justification document, available at: https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

Fact 2: Awareness of the Affordable Care Act Does Not Translate to Enrollment: Consumers still need to know about the availability of financial help.

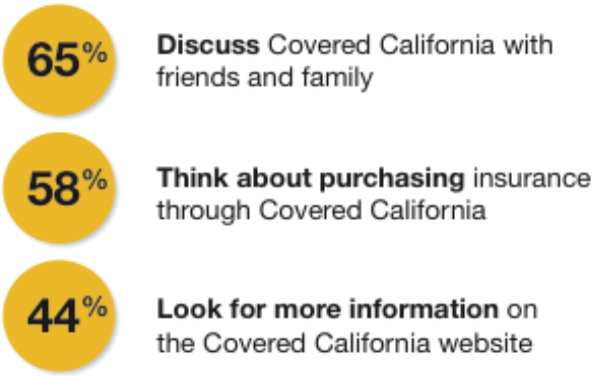
Research shows education and tailored marketing on the availability of financial help is still important, relevant and needed. While there have been substantial increases in the overall awareness of Covered California and support of the Affordable Care Act over the last five years, one of the key drivers of consumers seeking insurance is their understanding that they can get financial help. As late as 2017, 73 percent of uninsured and subsidy-eligible consumers surveyed were not sure if they were eligible for financial help or incorrectly assumed they were not. Increasing awareness of subsidy eligibility leads to stronger enrollment, higher retention rates, healthier consumer pools and lower premiums.

The Affordable Care Act was the most significant piece of health reform in the past 50 years and has garnered significant news coverage and paid media about it over the past five years. While there have been dramatic increases in the general knowledge and support for the Affordable Care Act, knowledge is *not* the primary catalyst for enrollment. The key to enrollment in the individual market is affordability. Consumers need to know that there are subsidies available to them. Research shows that significant resources are still required to encourage consumers who are subsidy-eligible to research the options available to them.

In California, awareness and support for both the Affordable Care Act and Covered California has increased dramatically over the past five years and marketing has been a key contributor to that awareness. Research shows that a consumer's overall awareness of marketing by Covered California is a key factor in them actively talking to friends and family about Covered who had seen marketing by Covered California were 50 percent more likely to have purchased a Covered California plan when they were aware of marketing messaging than those who were not aware of marketing messaging. These same respondents reported very high rates of seeking additional information, talking about Covered California and considering buying insurance. (See Figure 15: Exposure to Marketing Leads Consumers to Shop and Talk).

FIGURE 15

Exposure to Marketing Leads Consumers to Shop and Talk

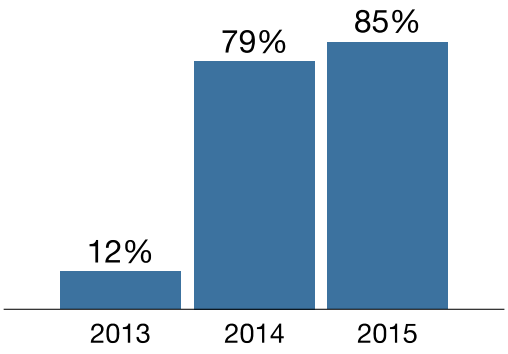


A 2015 study by NORC at the University of Chicago found that unaided awareness of Covered California stood at 12 percent in 2013, the year before the exchange began

offering coverage. Over the next two years, awareness improved to 79 percent in 2014 and 85 percent in 2015.[78] (See Figure 16: Awareness of Covered California.)

A recent survey,[79] shows awareness remains strong with 89 percent of survey respondents saying they were aware of the Affordable Care Act and/or Covered California. A majority of survey respondents (57 percent) said they knew "a fair amount" or "a lot" about Covered California.

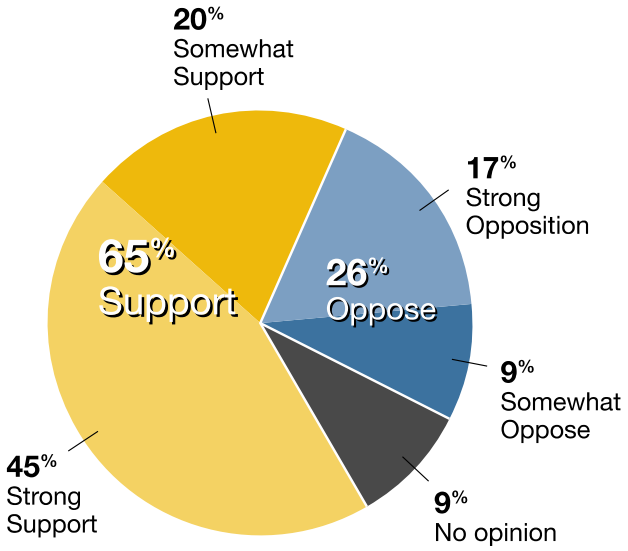
FIGURE 16
Awareness of Covered California



In addition, a 2017 study found supporters of the Affordable Care Act outnumbered opponents by more than two to one in California.[80] When Californians were asked whether they support or oppose the Affordable Care Act, two out of three (65 percent) said they support the law, with 45 percent strongly supporting the law. By comparison, just 26 percent opposed the law, while another 9 percent were undecided.

This represents a record level of public support for the Affordable Care Act, exceeding measures found in prior annual statewide surveys. (See Figure 17, Support for the Affordable Care Act in California.).

FIGURE 17
Support for the Affordable Care Act in California



Despite this widespread awareness and support of Covered California and the Affordable Care Act, research shows that general knowledge does not translate into people knowing about whether they personally qualify for financial help. In 2017, nearly three-quarters of uninsured Californians who were specifically screened as uninsured and eligible for subsidies, did not realize they could receive financial help in the form of subsidies or assumed they were not eligible, even though they were. (See, Figure 18: Understanding of Subsidy Eligibility Among Subsidy-Eligible Californians (2017).

[78] NORC at the University of Chicago. (2015). "Covered California Overview of Findings from the Third California Affordable Care Act Consumer Tracking Survey."

[79] A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage (September 2017).

[80] Berkeley IGS Poll. 2017. "Over Half of Californians Worry that They or a Family Member Will Lose Health Coverage if the Affordable Care Act is Repealed."

Knowledge of subsidy eligibility is critical. Studies show that awareness of financial help is what motivates consumers to seek out information and enroll in coverage. The research has been confirmed in California, where 88 percent of those who signed up for subsidized coverage say that financial help is an important motivator (see, Figure 19: Importance of Subsidy as a Motivator for Covered California Enrollment). A consumer's personal knowledge of subsidy eligibility makes the marketing messages personal and relevant, increasing their likelihood of enrollment and renewal of their coverage.

Among the uninsured, expectations of future subsidy eligibility is strongly associated with future enrollment or renewal intent. Those who expect to be eligible for subsidies next year are twice as likely to plan to enroll in Covered California (71 percent) as those who do not know if they will be eligible (34 percent).[81] Renewal intent of members is also higher among those who expect to be eligible for subsidies next year (94 percent) than among those who do not expect to be eligible for subsidies (70 percent).

This data from consumer surveys is reinforced by the many focus groups that Covered California has conducted over the past five years. Marketing is never "one and done." The data also supports the current theme in Covered California's messaging, which encourages people to check their eligibility (e.g., "check with our experts to find out if you qualify for help paying for health coverage" and "financial help is available, so check for yourself to see what savings you qualify for").

FIGURE 18
Understanding of Subsidy Eligibility Among Subsidy-Eligible Californians (2017)

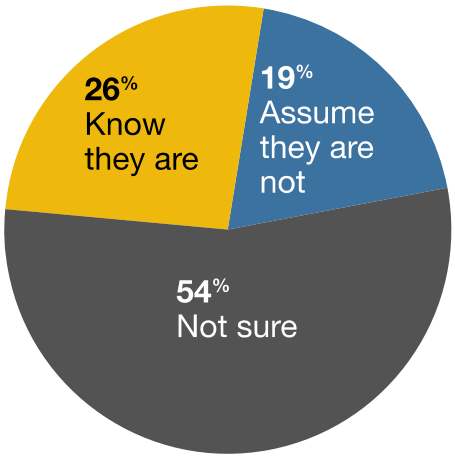
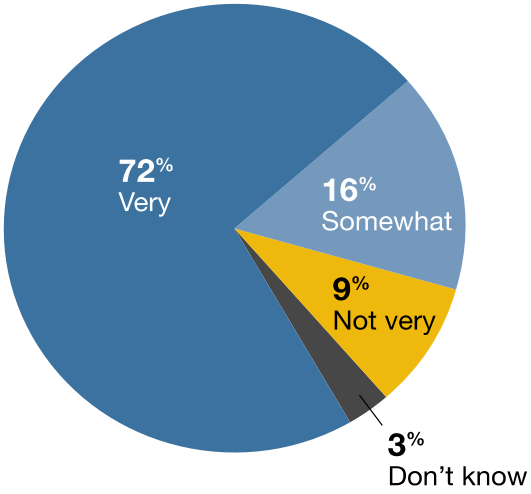


FIGURE 19
Understanding of Subsidy Eligibility Among Subsidy-Eligible Californians (2017)



[81] Greenberg Research. (2017). "A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage."

Fact 3: The High Churn in the Individual Market Requires Significant Ongoing Marketing Investments.

There is high churn in the individual market because consumers frequently leave when they obtain coverage from other sources (e.g., employers, Medicare). This means significant and ongoing marketing investments are required to convince newly eligible consumers to purchase insurance and promote retention of healthy consumers.

The launch of a new path to insurance entailed substantial marketing and outreach investments in the early years of the Affordable Care Act. Covered California invested $134 million in 2013–14 and $143 million in 2015 in marketing and outreach. The significant investment garnered high brand awareness and was a key ingredient to California having the best risk mix in the nation in 2014, when an enrollment of 1.4 million consumers during open enrollment.

The need to convince consumers to purchase or keep existing insurance, however, is not a "one-and-done" proposition. The individual market is notable for its high turnover. For some people, the individual market is an important coverage pathway as consumers transition between different coverage types. Covered California's experience is that 40 percent of its enrollees leave its marketplace each year (see Figure 6: Covered California Health Coverage Transitions in 2016.)

"Churning" of enrollees is a natural part of the individual market.[82] This churn means that continual outreach is required to maintain enrollment. Covered California's survey data finds that the vast majority (85 percent) of its churn reflects consumers leaving for other coverage such as employer-based coverage from new employment or aging into Medicare. This means that while Covered California was providing coverage to about 1.4 million Californians (as of April 2017), more than 3 million Californians have enjoyed coverage through Covered California since it opened its doors in 2014.[83] In striking distinction, it appears that in FFM states, more than half of those leaving coverage become uninsured.

The high rate at which FFM enrollees leave coverage to go without insurance appears to mean that not only do states served by the FFM experience the "natural" churn resulting from consumers transitioning to other coverage, but there is substantial loss of enrollment from those deciding to go without insurance. At least some of this loss can be attributed at least in part to the failure to invest in marketing that promotes retention. The direct impact is a worse risk mix and higher premiums, since those leaving to go without insurance will virtually always be "healthier" than those who maintain coverage.

[82] From 2008 to 2011, prior to major Patient Protection and Affordable Care Act provisions taking effect, only 42 percent of individual market enrollees kept their coverage after 12 months, with 80 percent of those experiencing coverage changes to other types of health insurance (the majority obtaining employer-based coverage). Sommers, Benjamin D. "Insurance cancellations in context: stability of coverage in the non-group market prior to health reform." *Health Affairs* 33, no. 5 (2014): 887-894.

[83] Coverage could be as short as a month or as long as three years.

Fact 4: Federal Law Requires Marketing.

Public marketplaces are mandated by federal law and regulations to perform various marketing and outreach activities to encourage participation and target broad and diverse communities. As part of long-term self-sustainability, federal law and regulation permit marketplaces to levy an assessment on participating plans to recoup the costs for exchange functions, including marketing and outreach. California's projected plan assessment revenue for 2018 is estimated to be $314.4 million while the federal marketplace is estimated to collect $1.2 billion.

Public marketplaces are mandated by federal law and regulation to perform various marketing and outreach activities to encourage participation and target broad and diverse communities.[84] Marketplaces' broad-based enrollment strategies further two key goals in improving coverage and affordability: (1) increasing the number of Americans with insurance, and (2) improving the risk mix and lower premiums for everyone.

State-based marketplaces and state partnership exchanges are expressly required to conduct marketing and outreach to comply with implementing the Affordable Care Act's requirements. In the required exchange "Blueprint" application for federal establishment funds, state-based marketplaces and state partnership exchanges were required to describe how they perform various consumer and stakeholder engagement and support activities.[85] For states on the Federally-facilitated Marketplace, the Department of Health and Human Services carries out the exchange functions on their behalf. The consumer and stakeholder engagement and support activities include developing a stakeholder consultation plan, conducting outreach and education, implementing Navigator and in-person assistance programs and supporting agents and brokers.

During the first two years, all marketplace functions for California, including those for marketing and outreach, were paid for with federal establishment funds. California marketing and outreach investments of $134 million and $143 million in 2014 and 2015 represent 26 percent of its federal establishment funds. During the initial launch years, other state-based marketplaces also heavily invested in marketing and outreach and likely spent a similar share of establishment funds as California. Nationally, if the same proportion of establishment funds nationally were spent on marketing and outreach as in California, this would equate to $1.05 billion invested in marketing and outreach out of $4.04 billion in aggregate federal establishment funds (excluding California).[86]

As part of long-term self-sustainability, federal law and regulation permit marketplaces to levy an assessment on participating health plans to recoup the costs for exchange functions, including marketing and outreach.[87] California's projected plan assessment revenue for 2018 is based on 4 percent of premium and is estimated to be $314.4

[84] Sections 1311(d)(6), 1311(i), 1312(e) of the Affordable Care Act and 45 CFR 155.205(e), 155.210 and 155.220.

[85] Other parts of the application required a description of how the state-based marketplace or state partnership marketplace would implement various functions, including: legal authority and governance, eligibility and enrollment, and privacy and security.

[86] The dollar amount presented here was calculated using publicly reported data on federal establishment funds (https://www.cms.gov/cciio/resources/marketplace-grants/index.html).

[87] Section 1311(d)(5)(A) of the Affordable Care Act and 45 CFR 155.160.

million. For the federal marketplace, the Centers for Medicare and Medicaid Services (CMS) collects an assessment based on 3.5 percent of premium and estimates that it will collect $1.2 billion in plan assessments for fiscal year 2018.[88]

CMS understood that it would need to spend a significant amount on marketing to ensure that the shorter open enrollment period would be well-understood and not result in lower enrollment.[89] For 2018, CMS had previously noted in the proposed rule that it intended "to conduct extensive outreach to ensure that all consumers are aware of this change and have opportunity to enroll in coverage within this shorter time frame."[90] In the final rule, CMS noted that it agreed with commentators that "because of the compressed timeframe, consumers may require additional assistance with submitting requested documents in choosing the plan that works best for them."[91] The final rule also states that "many Navigators already focus on the populations who may require this additional help, such as consumers with limited English proficiency and low-income and rural communities."

As policy-makers consider future investments in marketing and outreach, there are two potential funding sources: through a user fee assessed on participating plans, or budget appropriations. Due to the challenging political environment, it seems a special appropriation is unlikely.

If funded through the state or the federal budget process, or both, there is concern that other budget priorities will crowd out funding for marketing and outreach, resulting in disruption to long-term strategic planning and volatility in the risk mix. A clear advantage of dedicating a specific percentage of the user fee for marketing and outreach is that it would not depend on the politically volatile budget processes and would allow marketplaces to have greater year-to-year certainty.

[88] 2018 plan assessment revenue for the FFM is found on page 10 of the Centers for Medicare and Medicaid Services' FY 2018 budget justification document available at https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf.

[89] The federal government adopted a shorter open enrollment period for 2018 — from Nov. 1 through Dec. 15, 2017. Covered California has opted to keep the full three-month enrollment period — from Nov. 1, 2017 through Jan. 31, 2017.

[90] See proposed market stabilization rule issued February 10, 2017: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-03027.pdf.

[91] See final market stabilization rule issued April, 13, 2017: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf.

Fact 5: Public Marketplaces Are Best Positioned to Promote Broad Enrollment.

Public marketplaces are well positioned to support and coordinate an "umbrella" strategy that promotes enrollment and competition. Many health plans have relatively little expertise in direct-to-consumer marketing, and others have scaled back on marketing because investments could lead consumers to pick other plans.

Health plans in the individual market have incentives to foster enrollment for their own plans, but public marketplaces — whether state-based or the federal marketplace — have incentives to promote broad enrollment regardless of the health plan selected. Broader enrollment, irrespective of which carrier gains from it, promotes the mission of public marketplaces of expanding coverage and promotes a better risk mix that saves consumers money in lower premium.

Prior to the Affordable Care Act, selling insurance in the individual market was a niche business. Those insurers that were successful were good at risk selection through benefit design and medical underwriting which allowed them to select consumers based on risk, charge higher premiums depending on applicants' health status and deny coverage due to a pre-existing condition. Before the Affordable Care Act, the primary marketing expense for carriers in the individual market was in the form of payments to insurance agents. PricewaterhouseCoopers (PwC), using national data reports that payments to agents represented approximately 6.3 percent of premium prior to the implementation of the Affordable Care Act.[92] With the advent of the Affordable Care Act and the elimination of medical underwriting, health plans dramatically reduced their payments to agents. At the same time they generally have not increased their direct non-agent marketing spending. The reason appears to be that in a "choice" environment, health plans do not want to encourage consumers to come to the marketplace where they are one of multiple offerings. Because of the potential that consumers coming to the marketplace may pick any plan, individual plans do not have the same incentive as the marketplace itself to promote enrollment generally. Rather, they seek to promote marketing and outreach efforts that are more narrowly focused on enrolling consumers into their plans. This often means health plans either invest in "search engine" marketing, which seeks to grab shoppers already looking for coverage, or promoting their off-exchange plans so that consumers enroll directly rather than through the marketplace that presents all coverage options to consumers.

Beyond having an incentive to invest in marketing, public marketplaces are uniquely positioned to create umbrella strategies that complement and reinforce health plans' marketing and agent commission spending. Over the past three years, marketing spending by health plans in California collectively has declined both in total dollars and as a percentage of premium. While the spending in California by particular plans varies

[92] See PricewaterhouseCoopers analysis: Covered California 2016-2022 Market Analysis and Planning http://board.coveredca.com/meetings/2016/5-12/Covered CA and PwC Market Planning and Analysis_Board Draft.pdf (page 4).

dramatically, with some spending virtually nothing while others spend as much as 2 percent of premium, the aggregate marketing spend as a share of premium has declined since the 2014 launch (see Figure 11: California On-Exchange Total Acquisition Costs as a Share of Premium, 2014–18). Covered California's marketing and outreach have consistently represented half of the total spend for 2014–17. Given Covered California's substantial contribution to aggregate marketing spend, one way in which Covered California executes an umbrella strategy is by actively coordinating with its contracted plans to complement their media advertising and agent commission payments. All contracted plans are required to provide full and detailed marketing plans, which Covered California uses to identify gaps and opportunities.[93]

One example of using information shared with Covered California to foster better enrollment is in the area of targeting subsidy-eligible Asian Americans. California's diversity is reflected in those eligible for subsidies — 22 percent of whom are Asian Americans, with the biggest populations being Chinese, Korean and Vietnamese. Many of these individuals prefer to receive information in their native language. For open enrollment in 2016, Covered California found that collectively the health plans spent 87 percent of their marketing and advertising on material that was in English, 12 percent on material in Spanish and roughly 1 percent on in-language marketing for major communities speaking Chinese, Korean, Vietnamese and other Asian languages. Based on this information, Covered California prioritized Asian-language advertising targeting Asian-language-dominant populations and English-language advertising targeted at bilingual Asians. Covered California better targeted these channels and achieved very positive results — the enrollment in Covered California closely matches the demographic profile of those eligible for subsidies — with about 23 percent of enrollment consisting of Asian Americans.

[93] To see Covered California's contractual terms related to marketing, see pp. 18-22 of the Qualified Health Plan Issuer Contract: http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf.

Fact 6: Ensuring a Stable Individual Market Requires Engaging Agents and a Multi-Channel Enrollment Strategy.

Agents and web-based entities are funded by health plan commissions and do not have an incentive or the resources to promote the overall marketplace. The marketing and outreach "umbrella" strategy can and should support in-person enrollment through agents (such as through developing a brand, collateral material and "storefronts") but agents cannot fill the gap left from underinvestment by the public exchange or health plans.

Enrollment comes from a wide range of channels and requires a wide range of efforts to educate consumers and sign them up for the plan that best fits their needs. While approximately 40 percent of Covered California consumers enroll directly through the website at www.CoveredCA.com (see Figure 10: Covered California 2017 Enrollment by Service Channel), the majority of consumers want and need personal assistance with enrolling. In addition, consumers enrolling online without any help may do so after receiving in-person assistance.

Since opening its doors in 2014, Covered California has enrolled more than 3 million individuals cumulatively, an accomplishment that builds on significant investments in marketing and strong relationships with Certified Insurance Agents, Navigators and other enrollment assisters; its contracted health plans; as well as robust choice-architecture tools that help enrollees make informed health plan selections.

As important as a good website is to promoting self-service, many people want and need person-to-person assistance. What follows are the elements of a broad multi-channel enrollment support structure.

Certified Insurance Agents

Covered California partners with approximately 15,000 Certified Insurance Agents across the state. Many of them are small-business owners who are trusted voices in their communities. These agents have invested significantly to promote Covered California's brand and enthusiastically work to enroll consumers. Agents make investments in web-based marketing, television advertising, call centers, enrollment centers and events, direct mail and canvassing, all of which complement Covered California's efforts.

Since agents pay for marketing through the commissions they receive from health plans, Covered California believes a marketplace should support agents and brokers by complementing and supplementing their marketing efforts. The results of these efforts are evidenced by the fact that Certified Insurance Agents represent Covered California's largest sales channel, accounting for 47 percent of all enrollees.

Covered California has cultivated relationships with the agent community by actively working with them on branding, promotion and coordination. Building these relationships has led to the development of approximately 800 "storefronts" (i.e., enrollment centers)

— the vast majority of which are owned, operated and entirely supported by agents — that all use common branding and promotion rules developed by Covered California. These storefronts allow Covered California to be on hundreds of "Main Streets" across the state and promote enrollment in both on-exchange and off-exchange plans, which benefits the overall risk mix.

Beyond promoting storefronts and an array of promotional tools that support agents, as a matter of contract with its health plans, Covered California has established a "floor" of engagement by all of them. Since agents are required to fairly and equally present all health plan options to consumers — regardless of their commission arrangement — Covered California has been concerned that some plans may seek to "ride on the coat tails" of other plans commissions. In addition, some plans proposed to alter their commission structures to only pay commissions for enrollments during the open enrollment period and not during special enrollment. Covered California exercised its role in promoting fair competition and a level playing field for consumers by requiring all health plans to pay the same amount of commissions throughout the year.[94] While Covered California has not established a specific floor on commission rate, it actively monitors each plan's agent commissions as part of the annual rate negotiation process between Covered California and its plans.

Agents That Are Web-Based Entities

While some consider web-based entities as possible substitutes for public marketplaces, it is important to note that web-based entities are agents paid on commission. The main distinction between web-based entities and other agents is web-based entities are online and often more narrowly focus on the "point of sale." Like retail agents, they do not have an affirmative duty or financial incentive to develop and direct an umbrella marketing and outreach strategy for the individual market. A marketplace should consider web-based entity services in the context of the value they add by increasing enrollment and reducing costs to the service center — value that is paid for out of the commission payment made by contracted plans and incorporated in plans' overall premium. Covered California has many web-based entities among its Certified Insurance Agents and some of these are significant sources of enrollment. What follows are strategic considerations for assessing web-based entities in the context of the broader marketing and member retention effort:

- When a marketplace is examining partnerships with agents that are web-based entities, it should consider them through the lens of the marketplace's overall marketing and sales-channel distribution strategy. This requires closely examining the way web-based entities harmonize or conflict with existing relationships with health plans and other agents, as well as the downstream impacts to consumers. Not all web-based entities' business models are the same. As marketplaces assess opportunities to increase enrollment, a key value proposition for collaborating with web-based entities is based on the extent to which certain models can reach consumer segments at the point of decision-

[94] See Section 2.2.6 (http://hbex.coveredca.com/insurance-companies/PDFs/2017-2019-Individual-Model-Contract.pdf.)

making that complements an exchange's own marketing efforts, such as individuals experiencing job transitions. In this capacity, a web-based entity might complement the efforts of a marketplace by providing additional membership, maximizing enrollment and ensuring a diverse risk mix.

- There is the potential for conflict with a marketplace if a web-based entity cannibalizes sales that would have otherwise occurred directly through the marketplace. Such a scenario could result in higher acquisition costs for the marketplace and potential sales channel conflicts with health plans and other agents. Web-based entities may compete with the marketplace for members who would have enrolled through the marketplace under any circumstances, with the web-based entities paying for the same search engine marketing on Google and other search engines. This could drive up marketing costs for the marketplace that is attempting to reach the same customer. The net effect is that the marketplace could potentially end up paying more in online marketing and competing for members it would have enrolled anyway. In addition, if these same individuals would have enrolled directly with the exchange, the health plans may be incurring unwarranted agent commission expenses.
- Finally, to the extent web-based entities undertake any role in determining eligibility for tax credits there needs to be clear processes to ensure program integrity and detect fraud. Covered California has a robust consumer protection and fraud review process that receives substantial dedicated resources as part of its marketing and outreach investments.

Service/Call Center and Website

Covered California's website and service/call center are the second and third most popular enrollment channels, accounting for 40 percent and 9 percent of all sign ups respectively.

An effective website is essential to delivering a positive consumer experience, which brings in new enrollment and retains existing consumers. Websites can be accessed at any time and as of 2018 Covered California's website (CoveredCA.com) is optimized to allow for enrollment on mobile devices. For consumers preferring customer service by phone, the quality of a call center is also critical to delivering superior customer service in enrolling and retaining members. This involves staffing and service-level thresholds and standards so consumers can receive trained and competent telephone support in enrolling or managing their account.

While a marketplace's website and service/call center are important enrollment channels, their success depends on inducing consumers to shop for health insurance. Consumers with greater health care needs will seek out the marketplace on their own, but marketing and outreach are needed to balance the risk pool with healthier individuals and continuously refresh it with new enrollees. This requires marketing and outreach to raise awareness of the marketplace and encourage the value of health insurance.

Navigators

The Navigator program is federally mandated for all state health exchanges and has been an important component of the overall strategy to promote enrollment in the FFM and state-based marketplaces.

At the federal level, Navigator funding has been a consistently major recipient of the FFM's marketing and outreach investments. Since the launch of the Affordable Care Act, federal support for Navigators in FFM states amounted to $67 million for 2014[95] $60 million for 2015,[96] $67 million for 2016[97] and $63 million for 2017.[98] The $63 million for 2017 supported 103 grant recipients in 34 states. For each year, these costs do not include the management and oversight of the Navigator program.

The Navigator grant funding for 2017 reflected about 0.17 percent of the FFM premium, which appears to be nearly 40 percent of all federal investments in promoting enrollment. In this area, the federal government was investing substantially more than was Covered California, which spent about half the federal amount as a percentage of premium, about 0.08 percent of premium on its Navigator program (for additional details, see the "By the Numbers" section on benchmarking investing on page 26). CMS has announced plans to reduce Navigator funding significantly for 2018, to $37 million. Informal reports are that many state-based marketplaces continue to invest a high proportion of their marketing and outreach budgets on Navigator programs.

Covered California made a significant investment in community-based outreach education and enrollment during its first two years, developing important relationships with community organizations across the state that had experience in both reaching and assisting California's diverse populations, and proven success with enrolling consumers in health care programs. In 2013–2014, the first year of enrollment efforts, Covered California funded outreach and enrollment grantees and paid community organizations on a per-enrollment basis, with total payments of $47.8 million. For 2014, this level of support reflected 1.1 percent of premium, or about six times higher than the 2017 FFM premium percentage.

Covered California has looked closely at the return on that investment and examined enrollment totals, demographic breakdowns and retention levels generated by these efforts. The data showed that while navigators were a key contributor to Covered

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[95] Centers for Medicare and Medicaid Services: Navigator Grant Recipients (Oct. 18, 2013) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013_2.pdf

[96] Centers for Medicare and Medicaid Services: Navigator Grant Recipients for States with a Federally-facilitated or State Partnership Marketplace (Oct. 18, 2013) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-09-08-2014.pdf

[97] Centers for Medicare and Medicaid Services press release: CMS awards $67 million in Affordable Care Act funding to help consumers sign-up for affordable Health Insurance Marketplace coverage for 2016 (Sept. 2, 2015) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-09-02.html

[98] Centers for Medicare and Medicaid Services press release: CMS awards consumer assistance funding to support 2017 Health Insurance Marketplace enrollment (Sept. 9, 2016) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-09-06.html

California's outreach, over the first three years (2014–2016) they represented only 3 percent of the overall enrollment.

Based on Covered California's review of the efficacy of the Navigator program, the funding for the program has been decreased significantly since the first two years. Covered California has committed to supporting Navigators with $6.5 million in grant funding for fiscal year 2017–2018. This represents 6 percent of the marketing budget and is about 40 percent less than the $10.9 million in grant funds distributed in 2014–2015.

While Covered California has decreased its support for Navigators and they do not enroll as many consumers as other channels do, Covered California does not evaluate their impact based solely on volume of enrollment. Navigators enroll a higher proportion of key demographic populations, which are often more difficult and expensive to reach, including Latino and African-American communities and those speaking languages other than English.

As an example, during the most recent open-enrollment period, Navigators signed up 7,405 consumers who identified as Latino, which was 52 percent of the total enrollment by Navigators. By comparison, Latinos only represented 16 percent of the consumers whom agents signed up, even though the overall total was much larger, at 29,428.

TABLE 6
Covered California's 2017 Ethnicity by Enrollment Channel

Race / Ethnicity	Agents Enrolled		Navigators Enrolled	
	Percent	Total	Percent	Total
(non-respondent)	47%	86,077	19%	2,756
American Indian/Alaska Native	0%	169	0%	32
Asian	17%	31,168	12%	1,703
Black or African American	1%	2,289	3%	408
Latino	16%	29,428	52%	7,405
Multiple Races	1%	1,360	1%	105
Native Hawaiian or Pacific Islander	0%	215	0%	30
Other	3%	5,941	2%	344
White	15%	27,216	10%	1,366
Total	100%	183,863	100%	14,149

Covered California has developed a data-driven methodology for selecting grantees that is consistent with its goal of both ensuring hard-to-reach consumers have access to in-person enrollment assistance while ensuring it builds an organization that is self-sustaining. Based on Covered California's use of lifetime value as a framework for assessing marketing and outreach investments, it has sought to ensure that the cost per acquisition of consumers through the Navigator grant program does not exceed $200 per enrollee. In 2016–17 the cost per acquisition averaged $175 per person. Not only is this well below the cost per acquisition during Covered California's initial years, when

some Navigators spent several times that amount, but it closely mirrors both the marketing attribution for lifetime value and the average agent commission.

TABLE 7
Covered California's 2017 Navigator Enrollment Cost per Acquisition

Sample of Organizations	Enrollment and Retention for FY 2016–2017	Funding for FY 2016–2017	Cost per Acquisition
Alameda Health Consortium	3,254	$500,000	$153.66
AltaMed Health Services Corporation	3,829	$500,000	$130.58
Council of Community Clinics	3,157	$500,000	$158.38
Redwood Community Health Coalition	2,710	$500,000	$184.50
Asian Americans Advancing Justice	1,805	$300,000	$166.20
All Other Grantees	25,808	$4,800,000	$185.99

As Covered California considers its Navigator program for future years, it is evaluating how to continue to reward performance and assure all communities have effective vehicles to support their enrollment. Covered California continues to look at how funding is tied directly to assessment of the effectiveness of the effort to promote enrollment and retention. Investments in community-based organizations to support enrollment need to be held to the same level of accountability and validation as are all marketing and outreach investments.

As the federal government and other state-based marketplaces examine their own Navigator grants and enrollment results, Covered California looks forward to better understanding their assessment of the ROI that these channels garner and how that return relates to other marketing investments.

While there has been a clear commitment at the federal and state level to funding the Navigator programs, more research needs to be done to examine how effective those programs have been in each market. Moving forward, a crucial element to building stable marketplaces will be for each market to determine the efficacy of their efforts and whether navigator funding is at an appropriate level.

Fact 7: Marketing Investments Can Be Tiered to Meet a Wide Range of Market Sizes.

Marketing is crucial and is a central function of any marketplace. While some marketing functions benefit from a big scale (e.g., developing creative TV content), in most areas the scope and nature of investments can be tiered to meet a wide range of market sizes.

Right-sizing marketing and outreach investments is critical for promoting enrollment and retention. California has found a successful formula for marketing and outreach for the individual market — combining the efforts of the marketplace, health plans and agent commissions for member acquisition — which would reflect 5.9 percent of on-exchange premiums for 2018. Out of this amount, Covered California has structured its user fee such that it invests 1.4 percent of exchange premiums directly in marketing and outreach. This formula has proven successful given California's multi-year ability to create a stable market by attracting sufficient enrollment and a balanced risk mix.

Covered California makes significant investments in dedicated staffing in the areas of paid media, support for agents and ongoing earned media efforts. With paid media including $18.1 million in television advertising, the development and creative costs are easier to spread. California is a large state and these are examples of some of the economies of scale in conducting marketing.

Smaller states, however, can still make investments with fewer dedicated staff, focusing on those marketing investments that require less overhead, such as radio and search engine marketing. Digital marketing, on the Web and through social media, can be efficiently pursued by health exchanges of any size. Because these channels are lower cost than traditional media outlets, they can be scaled and measured far more easily. They can also be rapidly turned on and off and are particularly effective at reaching defined population segments.

Covered California believes that when the Federally-facilitated Marketplace (FFM) or state-based marketplaces spend less proportionally on marketing and outreach, they jeopardize their respective risk pools and negatively affect the premium trend in future years.

Fact 8: Marketing Needs to Lead People to Products That Meet Their Needs.

The success of marketing and outreach is critically reliant on the quality and price of the insurance products being offered. Consumers in California benefit from having patient-centered plan designs that are readily understandable and provide access to needed care.

Covered California has 11 health plans competing for enrollment, but Covered California's patient-centered plan designs[99] mean insurers compete with one another based on premium, network, quality, consumer tools and service. The benefits of the common patient-centered benefit designs are significant, including:

- Californians seeking coverage through the marketplace can easily compare health plans knowing that every health plan has the same cost-sharing levels and benefits. The more-important factors for differentiation used by consumers in making plan selections (price being the most important) are readily understandable and include the total price of both premium and out-of-pocket potential costs and other factors (e.g., provider networks and plan quality).
- The patient-centered plan designs are constructed to minimize financial barriers to access for consumers, reduce confusion and reinforce efforts to promote higher-value care delivery, such as better use of primary care.
- Standardization simplifies both the "sales" and the enrollment process to boost enrollment and the delivery of services in clinician offices. The simplification is especially important to previously uninsured individuals or those who are otherwise new to the purchase of individual coverage. In addition, it appears that simplified and standard designs mean that consumers are more likely to select "higher-value" products. In particular, lower-income consumers who are eligible for the cost-sharing subsidy are more apt to understand the relative value of their Silver cost-share reduction plan in contrast to the Bronze alternative.
- Promoting better value at the point consumers select a health plan should promote retention and have positive effects on the risk pool.

Covered California believes its efforts to promote true consumer competition, in which shelf space is devoted to a limited number of products in each tier, is a substantial benefit to consumers. The continuing improvement of benefit designs should be based on evidence of the implications of respective designs with regard to consumer understanding, access to services, cost and other factors. Covered California has begun additional work to evaluate the impact of different benefit designs and design features and how those impacts may differ by the characteristics of the consumers using them (e.g., income level, subsidy level, education, language, and race and ethnicity).

[99] Covered California's patient-centered plan designs for 2017 are available for reference (http://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf)

Fact 9: Marketing Is Politically Neutral and Is an Economic Necessity.

Marketing is politically neutral and is an economic necessity to creating and maintaining stable insurance markets.

While there are widely varied opinions about the Affordable Care Act, the economic reality is that ensuring that the individual market remains as stable as possible, with affordable premiums for those who do and do not receive subsidies, is a basic business proposition.

Marketing is one of the key ways to promote the enrollment that is essential to having stable markets. Covered California, as well as other state-based marketplaces, has engaged in vigorous and robust marketing since day one to create and maintain stable insurance markets. The marketing campaigns, as well as the outreach and education programs, promote the value of coverage, not a particular political approach or perspective. As part of its community outreach, Covered California has worked with both Democratic and Republican elected officials to make sure their constituents understand the benefits available to them.

With Covered California's efforts, California's market is more stable than are those in the Federally-facilitated Marketplace. In addition, Californians have more knowledge and a better understanding of Covered California than they do of the Affordable Care Act — evidence that effective marketing can transcend the political rhetoric.[100]

Marketing should not be about the politics. The singular goal of marketing should be about creating a stable individual market. The formula is simple: Marketing and promoting enrollment improve the risk mix, which helps protect consumers and meets their needs.

[100] Greenberg Research. (2017) "Covered California Sentiment Research. Wave 2: A Quantitative Study on Current Attitudes of Uninsured and Select Insured Californians Toward Health Insurance Coverage."

IV. Elements of Effective Marketing, Outreach and Enrollment for the Individual Insurance Market

Building a stable individual insurance market requires that public exchanges undertake a multi-faceted approach grounded in a thorough understanding of the needs of consumers shopping for health insurance, the individual market itself and the needs of key players operating in that market. Covered California's strategy, since opening its doors in 2014, has been to create robust multi-channel, multi-lingual and ethnically diverse outreach efforts to promote the value of the product that is being offered and to help educate consumers about their options and benefits. In addition, Covered California has worked in partnership with health plans, agents and community groups to reach consumers on multiple fronts with the support and services they need.

Covered California never takes for granted a key principle: *health insurance needs to be sold*. This principle is as true today as it was when the marketplace first launched since 40 percent of Covered California consumers "churn" out of the exchange each year for other forms of coverage.

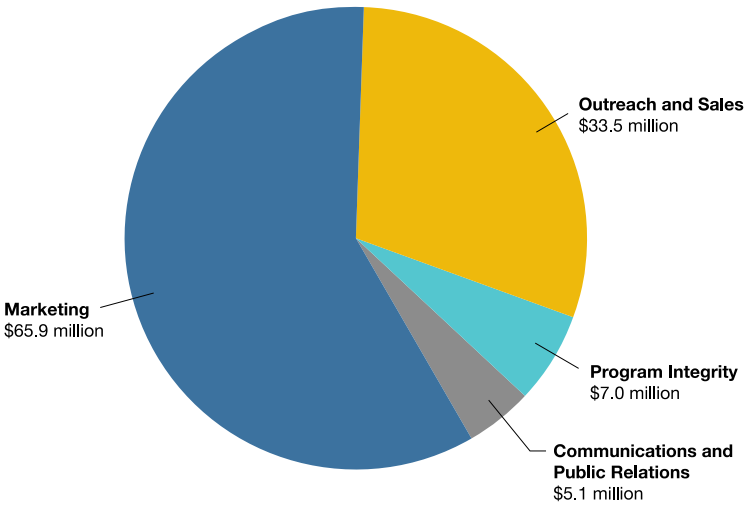
Marketing and outreach are an investment. Marketing is about more than slick television ads or a well-functioning website; it entails a commitment to hire the best experts, learn from their research and hear their outreach advice; it requires coordinating with community partners, agents and health plans; and investing in skilled teams to execute comprehensive and strategic outreach efforts, year after year. Marketing and outreach must adjust along the way to adapt to the changing needs and understanding of consumers, and recognizing new opportunities and ways to improve each year.

While the bulk of *Marketing Matters* provides an analysis of the rationale behind making marketing investments, the section that follows offers a look at the wide-ranging efforts that Covered California has undertaken to promote enrollment in health insurance.

Each of the investments described contributes to an overall marketing, outreach and enrollment assistance spend of more than $111 million (see Figure 20: Covered California's 2018 Marketing and Outreach Investments — $111.5 million).

FIGURE 20

Covered California's 2018 Marketing and Outreach Investments — $111.5 million



Covered California Marketing Assets are Available for Use

Covered California will make available shareable assets to be used by others, including other state-based marketplaces. These will include key messaging, TV and radio scripts and completed creative assets such as digital and social ads. The variety of creative assets will highlight key motivational and informational message points, such as the value of health insurance, availability of financial help, preventive care, the choice of plans and health insurance companies, how to get help and the enrollment deadlines.

The marketing assets are available at: http://www.coveredca.com/marketing-toolkit/

Each section includes in-depth information and examples of marketing, outreach and enrollment assistance efforts used by Covered California to promote and maintain broad enrollment and a healthy risk mix. The sections include:

- **Paid Media**: Covered California invests significantly in marketing on television, radio, in print and on digital platforms to promote enrollment by conveying the value of coverage. Covered California spent $39 million on television, radio, print, digital advertisements and billboards during the fiscal year 2016–17. The average Californian was exposed to one of its ads an average 50 times during the 2016–17 open-enrollment period, generating nearly 2 billion impressions statewide. Covered California plans to increase its paid media in fiscal year 2017–18 to $45 million.
- **Earned Media**: During the fourth open-enrollment period, Covered California conducted 200 interviews with newspapers, radio, television and online news sources. These interviews generated nearly 90 million impressions and were worth an ad value of nearly $2.4 million.
- **Supporting in-Person Enrollment and Enrollment Partners**: Covered California works with partners in the public as well as private sector in every community, including approximately 15,000 independent insurance agents, 5,000 certified enrollers and 46 Navigator grantees. More than 50 percent of all consumers enroll with the support of person-to-person assistance from agents and other enrollers. Covered California supports these enrollers with a field-based outreach support staff, training and communications programs and a certified agent and enroller service center. Opportunities are also provided through special programs, including storefront and events programs; “Help on Demand,” the mobile-enhanced agent consumer-referral tool; and by providing access to branded collateral. Covered California’s brand is represented in approximately 800 storefronts operated by insurance agents and Navigator grantees, which support enrollment in cities and towns across the state. For fiscal year 2016–17, Covered California has 57 full-time employees in outreach and sales, with a total budget of $34 million, including $7.1 million to fund 46 Navigator enrollment entities. In addition, Covered California service centers

handled more than 2.7 million phone calls in the last year, with a staff of 843 and a budget of $92 million.[101]

- **Targeted Outreach**: Covered California's marketing includes extensive "in-language" marketing — targeting consumers who speak Spanish, Mandarin, Cantonese, Korean, Vietnamese and other Asian languages. This has resulted in a demographic enrollment that matches the eligible population. Marketing also targets African-Americans through a range of media and outreach strategies and the LGBTQ community in newspapers and magazines that provide a platform for long-form messaging while targeting specific lifestyles, location and culture through radio, out-of-home and digital ads.
- **Online Enrollment**: Covered California invests significantly in an online enrollment portal that makes it easy for consumers to enroll and compare plans in order to find the best value. Approximately 40 percent of consumers self-enroll through the online enrollment application, rather than enrolling through an agent or other form of person-to-person assistance. Separate from the marketing budget, Covered California plans to spend $36 million to increase the ease and effectiveness of its online enrollment system during the upcoming fiscal year, plus $8.3 million on IT infrastructure to drive efficiencies throughout the organization to provide better customer service.
- **Telling the Story of Covered California Enrollees**: All over California, people are getting access to the care they deserve through Covered California. In their own words, they are sharing why health insurance is so important to them in videos that appear on CoveredCA.com and social media channels.
- **Helping and Encouraging Those Who Start Shopping**: Covered California's sales funnel consists of prospects who are in all stages of the consumer journey. The funnel consists of "Awareness," "Consideration," and "Purchase Intent."
- **Retention Support**: Covered California conducts robust ongoing communications with those who enroll, and uses its call centers, direct mail, email and other customer service efforts to keep its members informed, while boosting retention efforts. These efforts seek to build relationships with customers, resulting in brand loyalty and increased customer satisfaction.
- **Research**: Research helps Covered California better understand what resonates with consumers, and allows Covered California to remain nimble and quickly change as situations warrant. Research, such as user testing, consumer experience surveying and focus groups, allow Covered California to better understand its customers and identify effective messaging.
- **Organization and Staffing**: Covered California has invested in having a skilled and experienced staff who know how marketing works. The staff knows how to effectively manage the competitive bidding process in order to find, secure and engage top-class vendors. They also conduct in-depth evaluations, both

[101] As discussed previously, for the purposes of this report, Covered California Service Center costs are not included in the marketing and outreach budget.

internally and externally, to better understand consumers' needs and remain nimble in determining what works. Covered California plans to increase the staffing of Marketing, Outreach and Sales from 157 positions to 168 in fiscal year 2017–18, with more than $16 million allocated to support their salaries and benefits.

The efforts of Covered California, however, are not all that has contributed to the creation of a stable individual market in California. The exchange operates in a state where private insurers have also invested in marketing and invested significant resources to support agent commissions. Covered California's planned outreach spend of approximately $111 million is complemented by another $299 million[102] in spending by private insurance plans to promote enrollment in health insurance in the individual market — bringing the total annual spend to more than $400 million.

California's circumstances are unique, but also directly relevant to other states and the Federally-facilitated Marketplace. As one of the most populous and diverse states in the country, California is truly a microcosm of our nation, with numerous large media markets surrounded by hundreds of miles of rural landscape. California's success through targeted investments in marketing and outreach provides a benchmark that may be helpful to inform strategic planning by the federal government and other states that are also working to foster stable and competitive individual markets.

[102] This figure comprises $123 million in on-exchange agent commissions, $145 million in off-exchange agent commissions, and $31 million in direct media advertising.

Paid Media

Using a multi-channel strategy to reach California's diverse communities, nearly every Californian will be exposed to one of Covered California's TV, radio, print, billboard or digital advertisements on average 90 times during the 2017 plan year. Consumers are encouraged to sign up during open enrollment through strategic media placements that drive traffic to CoveredCA.com and keep Covered California top of mind as Californians are making health insurance decisions during open enrollment and throughout the year.

The goal is to acquire 700,000 new members and retain current members for the 2017 plan year, using the "It's Life Care" theme. Covered California wants its consumers to understand the value of health insurance for everyday life, improve understanding of what Covered California offers consumers, and increase consumer understanding of health insurance.

Covered California is targeting insured and uninsured Californians of multiple ethnicities who are subsidy eligible (federal poverty level 138 percent to 400 percent), as well as non-subsidy-eligible Californians, ages 26-54 with a household income between $50,000 and $130,000.

Many consumers face barriers to purchasing insurance, such as:

- The consequences of not having health insurance are not immediate or impactful enough.
- It is not clear to them why Covered California is the right place to purchase health insurance.
- People do not have the knowledge they need to make decisions with confidence.

In Table 8 and Figure 21: Covered California Media Spend by Channel for 2017 and following sections, Covered California provides benchmark information by showing: (1) the total spend by Covered California by media channel; (2) the percent that spend represents as a percentage of on-exchange premium[103]; (3) the percent the segment represents for Covered California's marketing and outreach budget[104]; (4) total impressions, if applicable[105]; and (5) where available, aggregate spending of the 11 health plans in Covered California.[106] After presenting these figures for 2017, each section includes the projected spend for the upcoming 2018 plan year.

[103] The percent of spend to premium is calculated by dividing the total spend by $6.9 billion (the total premium collected by Covered California in 2017).

[104] The percent of spend to marketing and outreach is calculated by dividing the total spend by $99 million (the total marketing and outreach budget for Covered California in 2017).

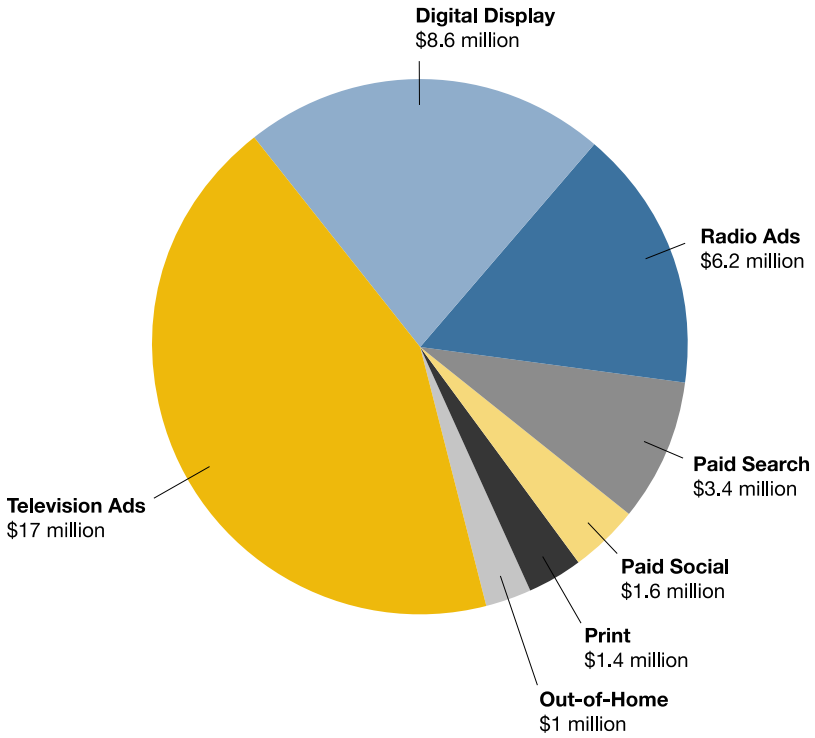
[105] Impressions are a measure of the number of times a consumer in California viewed a Covered California ad.

[106] Compared to Covered California spending.

TABLE 8
Covered California Media Spend by Channel for 2017

Channel	Covered California Spend	Percent of Spend to On-Exchange Premium	Percent of Spend to Covered California Marketing and Outreach Budget	Total Impressions	Health Plan Spend by Channel
Television	$17,050,000	0.25%	17.3%	413,887,303	$2.8 million
Radio	$6,234,090	0.09%	6.3%	256,407,270	$4.4 million
Digital Display	$8,586,910	0.12%	8.7%	1,255,842,869	$6.4 million
Social	$1,573,000	0.02%	1.6%	195,204,781	$106,000
Search	$3,367,000	0.05%	3.4%	279,950,394	$8.6 million
Print	$1,364,000	0.02%	1.4%	49,540,228	$480,000
Out-of-Home	$1,023,000	0.01%	1.0%	343,887,136	$5.2 million
Total	**$39 million**	**0.57%**	**39.8%**	**2.8 billion**	**$28 million**

FIGURE 21
Covered California Media Spend by Channel for 2017



Covered California is committed to continuing robust paid-media marketing efforts in the future with a total marketing and outreach budget for 2018 of $111.5 million, of which $45 million is allocated for paid media.

TABLE 9
Covered California's Planned Paid Media Spend by Channel for 2018

Media Channel	Budget	Percent of Spend to Covered California Marketing and Outreach Budget
Television	$18,102,773	0.23%
Radio	$8,273,348	0.11%
Digital Display	$9,736,168	0.12%
Social	$1,942,893	0.02%
Search	$2,329,000	0.03%
Print	$3,100,493	0.04%
Out-of-Home	$1,515,325	0.02%
Total	**$45,000,000**	**0.58%**

As mentioned previously, by using a multi-channel strategy to reach California's diverse communities, nearly every Californian will be exposed to one of Covered California's TV, radio, print, billboard or digital advertisements on average 90 times in 2017. In the following pages we describe the efforts in each of the following paid-media channels.

Television

Covered California uses television advertising to drive overall brand awareness and keep Covered California top of mind. Certain advertisements carry a specific call to action to drive engagement.

"Welcome to Answers"
English/Spanish

"Happy"
English, Mandarin, Cantonese, Korean, Vietnamese

Other TV Advertising Examples
Scene (English) https://youtu.be/5tIy2cbwO0A
Scene (Spanish) https://youtu.be/2Mty13Gloao

Radio

Covered California incorporates traditional radio ads, traffic sponsorships, streaming and DJ endorsements to drive incremental reach by complementing the TV schedule and providing continuity in a cost-efficient way. It also keeps Covered California top of mind and creates a local connection with its target audience by aligning with local DJs and stations.

Digital Display

Digital ads drive users to CoveredCA.com to encourage engagement and to generate more qualified leads.

Social Media
These efforts are designed to increase awareness and enthusiasm for open enrollment and renewal through informed, targeted social engagement. The social media efforts include:

- Providing reliable, actionable information to support current members and prospective customers.
- Promoting content with brand-controlled messages that inspire consumers to engage with and share that content.
- Cross-promoting media campaign content including imagery, video and messaging.
- Actively monitoring all social channels and providing social customer support, primarily on Facebook and Twitter.
- Encouraging members to shop due to rate changes.

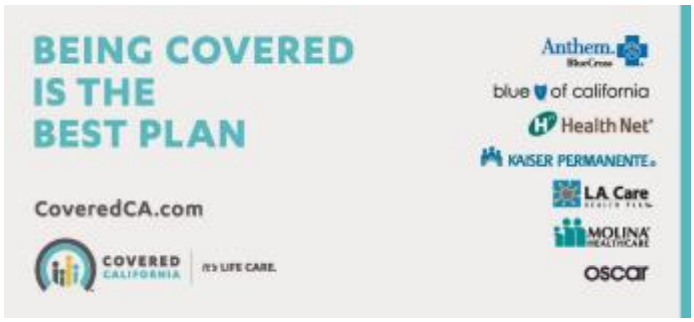
Search Engine Marketing
Paid search funnels traffic from all other paid media to CoveredCA.com, encouraging engagement and intercepting consumers seeking information about open enrollment and Covered California through search engines.

Print

Covered California purchases advertisements in newspapers and magazines to extend reach and increases the frequency of message against niche target segments. Covered California provides a platform for long-form messaging and creates a local connection with our target by partnering with local community publications.

Out-of-Home

Covered California purchases billboards, posters and transit shelter ads to extend overall campaign reach, drive awareness and keep the Covered California brand top of mind.



Collateral Materials
Collateral materials are a tool to support the Covered California sales teams to help educate consumers about health insurance and Covered California.

Covered California invests millions of dollars to promote the benefit of insurance on printed materials that are distributed to consumers and enrollment partners. In 2017, Covered California spent $5.7 million on these materials, which accounted for 0.09 percent of the premium collected by Covered California and 5.8 percent of Covered California's marketing and outreach budget.

TABLE 10
Covered California's Collateral Spend in 2017

Total Collateral Spend in 2017	**$5.7 million**
Percent of Spend to Premium	0.09%
Percent of Spend to Marketing and Outreach Budget	5.8%

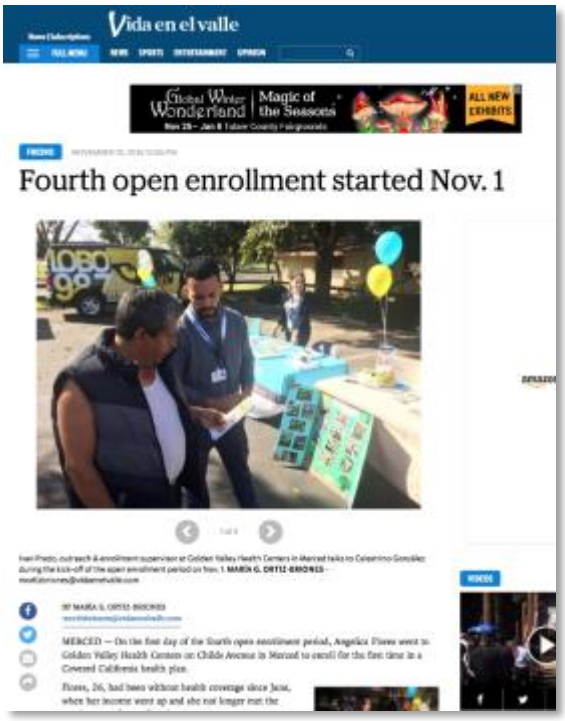
Earned Media

Covered California invests heavily in earned media to encourage enrollment during open and special enrollment. Earned media is publicity gained through promotional efforts other than paid media advertising, usually “earned” through the establishment and development of ongoing positive working relationships with members of the media. At Covered California, this is done in the form of interviews with media outlets, print-ready articles for newspapers, tweets, phone banks, community outreach efforts and press briefings.

In 2017, earned media efforts amounted to $4.5 million. This spend was to support a staff of 15 Covered California media professionals and a contract with the global public relations firm, Ogilvy. These efforts have won numerous awards including the prestigious PR Week “Best in Public Sector” in 2017.

In the fourth open-enrollment period alone, Covered California conducted more than 200 interviews with newspapers, radio, television and online news sources, generating nearly 90 million impressions with an ad value of nearly $2.4 million.

In previous open-enrollment periods, Covered California has highlighted the “basics” of health insurance and literally shined spotlights on places where consumers can enroll. Covered California’s bus visited hospitals throughout California at media events to highlight the cases and types of care provided to those who gained health insurance through Covered California. Examples of Earned Media Coverage:



Covered California’s investment of $4.5 million in earned media results in significant coverage across the country and the state and helps support overall outreach efforts.

TABLE 11
Covered California’s Earned Media Spend in 2017

Total Earned Media Spend in 2017	**$4.5 million**
Percent of Spend to Premium	0.07%
Percent of Spend to Marketing and Outreach Budget	4.6%
Total Impressions	90 million

In-Person Enrollment

Covered California supports a variety of sales channels to provide free, confidential in-person enrollment assistance. These channels include Certified Insurance Agents, community enrollers and Covered California's Service Center.

Certified Insurance Agents
Certified Insurance Agents work one on one with consumers to help them complete the Covered California application and select and enroll in a health insurance plan. Certified Insurance Agents provide impartial information about a consumer's plan choices, and they can offer advice about which plan may best meet a consumer's needs.

Certified Insurance Agents support two markets:

- Individual market: Offers on-exchange individual plans to individual consumers.
- Covered California for Small Business: Offers on-exchange small business plans to small business consumers.

There are currently 15,174 Certified Insurance Agents across the state, who are experienced in selling health insurance. Because of their experience, agents currently have a higher consumer enrollment effectuation rate when compared to the other sales service channels (this also includes self-enrollers and the Service Center representatives). Agents account for 47 percent of current Covered California enrollment.

Agents are not compensated by Covered California; they are compensated by health plans directly. Since Covered California's inception, agents across the state have received hundreds of millions of dollars in compensation. In 2016, agents are estimated to have received $229 million in compensation in the individual market ($117 million from plans in Covered California and $112 million outside of Covered California).

Covered California's investment of $9 million reflects only Covered California's direct expense to support agents and agent-based sales. It does not include agent commissions paid by the health plans. In 2017, Covered California estimates that health plans paid $110 million in agent commissions and $129 million off-exchange.

TABLE 12
Health Care Market Spend for Agents in 2017

Total Agent Support Spend in 2017	**$9 million**
Percent of Spend to Premium	0.13%
Percent of Spend to Marketing and Outreach Budget	9.1%

Community Enrollers
Covered California works closely with a variety of community enrollers to assist consumers to sign up for coverage. Except for the Navigator grant program, community enrollers are not compensated. Below are the types of community enrollers:

- **Navigator Grant Program:** Grant-based partners providing outreach, education and pre- and post-enrollment services to individual consumers.
- **Certified Application Counselor Program:** A network of certified counselors providing enrollment service to individual consumers. There are currently 2,145 Certified Application Counselors.
- **Plan-Based Enrollment Program:** Carrier-specific certified enrollers. There are currently 1,033 Plan-Based Enrollers.
- **Community Outreach Network:** A network of organizations distributing Covered California marketing materials. There are currently more than 300 Community Outreach Network partners.
- **Medi-Cal Managed Care Program:** Enrollers specifically assigned to help with Medi-Cal qualified enrollees. There are currently 26 Medi-Cal Managed Care Plan-Based Enrollers.

Community enrollers have an established and trusted presence in the communities they serve and speak 17 different languages. Three percent of current Covered California consumers were enrolled by community enrollers.

The most important set of community enrollers is composed of groups funded in part by the Navigator grant program, which awarded grants to organizations with a goal of enrolling new entrants into the marketplace efficiently; not to exceed $200 per acquisition.

Navigators are compensated through competitive grants. In FY 2016–2017, Navigator grants totaled $7.1 million, and were distributed to 46 Navigator enrollment entities. Currently, there are 1,354 Navigator Certified Enrollment Counselors who have assisted 124,570 consumers from Sept. 1, 2016, to April 30, 2017.

TABLE 13
Community Enroller Spend in 2017

Total Community Enroller Spend in 2017	**$8.2 million**
Percent of Spend to Premium	0.12%
Percent of Spend to Marketing and Outreach Budget	8.3%

Covered California Service Center

The Service Center provides comprehensive pre- and post-enrollment education and support to Covered California consumers by responding to consumer inquiries, enrolling them in coverage and promptly resolving challenges.

The Service Center FY 2017–2018 budget is $86,843,965, and is not a part of the marketing and outreach budget. However, Service Center representatives serve a critical function in assisting consumers to enroll. In 2017, the Service Center enrolled 9 percent of all enrollment.

The Service Center offers a critical function in handling 2,778,616 calls.

Covered California's Service Center budget of $89.9 million is 1.3 percent of spend to premium, which is not reflected in the marketing and outreach total spend.

TABLE 14
Service Center Spend in 2017

Total Service Center Spend in 2017	**$89.9 million**
Percent of Spend to Premium	1.3%

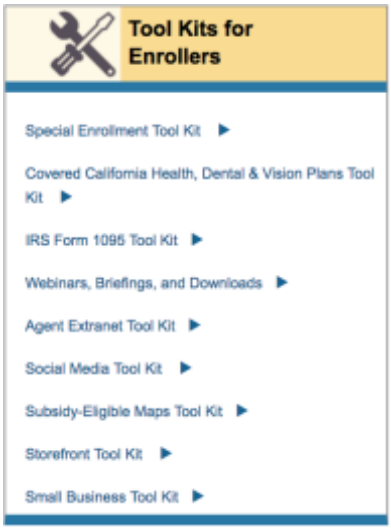
Supporting in-Person Enrollment and Enrollment Partners

Covered California endeavors to support all of our enrollment partners with tools they can use to enroll consumers.

- **Business Analytics:** Sales partners can use regional heat maps to identify the locations of subsidy-eligible consumers.

- **In-Person Administrative System (IPAS):** The system of record for community enrollers in the Navigator grant program and Certified Application Counselors, Plan-Based Enrollers and Medi-Cal Managed Care. Developed to help community enrollers manage the administration and monitoring of their reports, productivity reports, and counselor roster management.
- **Agent and Community Enroller CalHEERS Portals:** The system of record for our certified agents and certified community enrollment partners. Developed to offer direct access and administration of their consumer enrollment portal.
- **Agent Extranet:** Additional resource created to offer certified agents a secured portal with tailored book of business databases, intended to support retention and enrollment activities.
- **Training Webinars:** Additional web-based training resource intended to be used on a regular basis with a quick turnaround time for our enrollment channels to disseminate urgent information and program and system updates.

- **E-News and Alerts:** E-based resource intended to be used on a regular basis with a quick turnaround time for our enrollment channels to disseminate urgent information and program and system updates.



- **Tool Kits:** Issue-specific bundle of centralized documents, forms, FAQs and additional resources for quick access. Intended to help enrollment channels access one entry point into comprehensive information for specific issue or campaign. This is a web-based resource.
- **Sales Channel Meetings:** Hosted kickoff meetings statewide to incorporate sales partner trainings and regional meetings in high density areas where certified enrollers reside and work for enrollment strategy planning. In total, facilitated 98 agent and community partner meetings.

- **Field Operations Support:** The field operations team and the account services team are liaisons between Covered California headquarters and certified agents and community leaders, as well as liaisons between Covered California headquarters and the community enrollers program.

- **Find Local Help:** Covered California's website includes a page that allows consumers to find a certified enroller or other entities that can assist them to complete their enrollment. The page includes storefronts (explained in the next bullet), offices for certified enrollment agents and other enrollers and enrollment events.

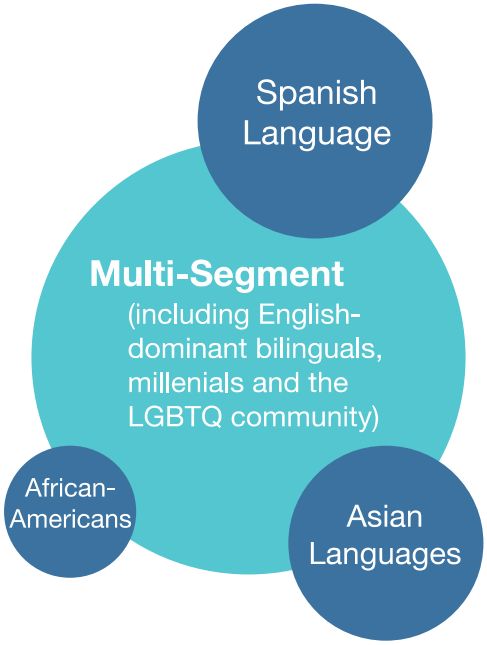
- **Storefronts:** Storefronts are brick and mortar offices operated by Covered California certified enrollment partners to assist consumers in applying for coverage. Currently there are 776 storefronts throughout California (75 percent of storefronts are owned by agents, 18 percent offer assistance in Spanish and another 18 percent offer assistance in other languages — Chinese, Vietnamese, Korean, etc.)

- **Enrollment Events Portal:** Covered California offers consumers a web-based locator tool to find events in their community. In 2016, there were 4,998 enrollment events throughout California.
- **Help on Demand:** An Uber-like experience to connect consumers to expert local enrollment assistance available at CoveredCA.com. This tool provides direct support from a certified enrollment agent/counselor. More than 750 Certified Insurance Agents with a proven track record are selected to be part of the Help on Demand network. Help on Demand supports 17 different languages.

Targeted Outreach

Covered California's media and marketing campaign is organized around cultural segments that specifically complement the extensive community outreach campaigns happening in all parts of the state. The campaign segments are: general market (multi-segment), Latino, Asian-Pacific Islander, African American and LGBTQ (see Figure 22: Covered California Multi-Segment Target Audiences).

FIGURE 22
Covered California Multi-Segment Target Audiences.



Multi-Segment Outreach
Reaching diverse communities is a key to Covered California. Its multi-segment marketing plan assumes:

- TV still king, but digital and mobile consumption on the rise.
- Adults ages 25 to 54 spend between three to four hours a day watching TV. Time-shifted viewing is up by nearly 15 percent while average time spent on Live TV has decreased by only three minutes.
- Adults spend more than 13 hours per week listening to radio. Ninety percent of people stated they listen to traditional radio while 53 percent said they listen to digital radio. Digital music consumption is on the rise.
- In 2010, the General Market spent just 24 minutes a day consuming non-voice media on their phones. In 2013, the rate catapulted to two hours and 22 minutes of mobile consumption (more than five times higher).
- Subsidy eligible and non-subsidy eligible ages 25-54 spend between 17-20 hours per week on the internet.

Multi-segment placements were made in television, radio, digital, social and search. Examples of Covered California placements include:

Latino Outreach

Latinos make up 40 percent of California's population and represent 38 percent of the subsidy-eligible population. In the 2017 open-enrollment period, Latinos represented 35 percent of subsidy-eligible enrollments. There are two distinctive groups in the Latino community: those who prefer to consume media in Spanish, and those who prefer to consume media in English. Covered California has been working with culturally competent staff and contractors who understand how to reach this community, including the advertising agency Casanova/McCann.

To better understand how to appropriately reach the Latino community, Covered California applies research findings to ensure its messages are appropriate for this community. Our research shows that:

- Latinos are less familiar with Covered California than other groups are.
- They are more likely to have looked into coverage but have not attempted to enroll.
- Though insurance was not a priority for them, it is a priority for their children to have health insurance.

Less acculturated Spanish-dominant Latinos have similar characteristics but show some important differences:

- Less likely to have had health insurance in the past.
- More likely to have tried to enroll in Covered California but did not complete enrollment.
- Issues with terminology and overwhelming confusion were a more significant hurdle.
- They are less concerned about having issues with their health and more confident in their ability to obtain health care elsewhere, such as in Mexico and at corner clinics.

Applying these findings, Covered California developed a paid media rationale to reach this group.

- There is dual consumption with higher engagement in-language.
- California Latino adults ages 25-54 spend 20+ hours per week watching TV.
- Over 90 percent of Latino adults 25-54 are reached weekly by radio. It is an efficient high frequency medium to help generate top-of-mind awareness among the Latino target.
- Latinos spend more time online — 3.5 hours per day on a home computer compared to 3.3 hours per day for non-Latinos.
- Sixty-nine percent pay more attention to ads created specifically for Latinos or ads created for the general population that include Latinos.

Spanish-language placements were made in television, radio, print, digital, out-of-home, social and search. Examples of Covered California placement in Latino-specific outlets include:

Spanish-Language Media Outreach
The Latino market is California's largest subsidy-eligible population, making it one of the most important. There is a three-pronged approach to reaching this community:

- Promote Covered California's mission through well-crafted messages for TV, print, online and radio.
- Partner with Spanish media to conduct phone banks and regional media tours.
- Sponsor health care roundtables with experts and clients who can share their experiences.

Asian-Pacific Islander Outreach
The Asian-Pacific Islander community (API) makes up 15 percent of the California population and represents 21 percent of the subsidy-eligible population and also the percentage enrolled in Covered California.

The API community is incredibly diverse, requiring specific outreach methods. Reaching the API community requires efforts in multiple languages.

Covered California has been working with culturally competent staff and contractors who understand how to reach this community, including Imprenta Communications and interTrend Communications.

To better understand how to appropriately reach the API community, Covered California applies research findings to ensure messages that are appropriate to this community. Research shows the following:

- Covered California as a government-funded program was seen as positive in these communities, whereas other segments do not see this as a selling point.
- “Name-brand insurance companies” resonated well.
- The API segment’s strategy to avoid medical attention was to maintain a healthy lifestyle.
- Most insured API community respondents obtained their health insurance coverage through insurance agents who also provide them with home, auto or life insurance. They rely heavily on agents to do the legwork and make suggestions for them.

Applying these findings, Covered California developed a paid media rationale to reach this group.

- There is an affinity to in-language content, in both traditional and digital.
- Nearly 50 percent of the API community are dual-language TV viewers.
- While the API community are tech savvy, many still use traditional media such as TV, radio, and print to get culturally relevant entertainment and information.
- The API community is leading the digital revolution and 40 percent spend more time viewing streamed content than live video content (compared to 33 percent of the total population).
- Newspapers and magazines are widely read by the API community. Sixty-eight percent of Chinese and 66 percent of Koreans read their news through hard copy print.

Asian-language placements were made in television, radio, print and digital. Examples of Covered California placement in API-specific outlets include:

African-American Outreach
The African-American community makes up 6 percent of the California population and represents 5 percent of the subsidy-eligible population. In the 2017 open-enrollment period, African-Americans represented 4 percent of subsidy-eligible enrollments.

African-American outreach must take the following into consideration:

- When asked why they have not signed up with Covered California, many reported thinking they were not eligible.
- African Americans are also the most likely to rationalize that it is cheaper to pay the tax penalty than the cost of coverage.
- In the African-American community, building trust in government and Covered California is essential.

To better understand how to appropriately reach the African-American community, Covered California applies research findings to ensure messages that are appropriate to this community. Their research shows the following:

- Lean into culture — there is heavy consumption across channels.
- Ninety percent of African-Americans believe that Black media is more relevant to them.
- African-Americans watch TV more than any other group at more than 200 hours per month or 37 percent more than any other group.
- Radio is the leading medium reaching African-Americans ages 25 to 54 at 94 percent.
- Eighty percent of African-Americans are internet users.

African-American placements were made in television, radio, print, digital and out-of-home. Examples of Covered California placement in African-American-specific outlets include:

LGBTQ Outreach
The LGBTQ community is an important segment to reach. Covered California's research shows:

- The message with the strongest resonance is that Covered California has knowledgeable experts who are part of the LGBTQ community who can help you choose and enroll in a health plan that best fits your needs.
- The Affordable Care Act coverage of many transition services (e.g. hormone treatments and transition surgeries) was respected by this group.
- It is important to use imagery and messages that are clear and unambiguously directed at the community in LGBTQ media. The use of LGBTQ imagery in mainstream media "thrills" them.
- The LGBTQ respondents felt that if they maintained a healthy lifestyle, they could avoid the need for medical attention.

Applying these findings, Covered California developed a paid media rationale to reach this group.

- Digital remains the core source of targeted content.
- The highest consumption among the LGBTQ community remains targeted content sites and blogs; 67 percent of gay men and 58 percent of lesbians.
- More than one-third of LGBTQ Web users said they have increased their visits to these sites in the past year.
- Forty-one percent of gay men had read LGBTQ email newsletters during the past week, and 50 percent had read regional LGBTQ publications.

LGBTQ placements were made in print and digital. Examples of Covered California placement in LGBTQ-specific outlets include:

QUEERTY
LGBTQ NATION
GayCities
Bay Area Reporter
FRONTIERS
the pride
THE FIGHT
BAY TIMES
GAY SAN DIEGO
LGBT weekly

Online Enrollment

Covered California has invested significantly into developing an online application that serves consumers' needs. Forty percent of consumers self-enroll through the online application.

In the last year, Covered California spent more than $65.2 million on information technology. The information technology budget is not a part of the marketing and outreach budget, but signing up is a critical function in enrolling consumers.

TABLE 15
Information Technology Spend in 2017

Total Information Technology Spend in 2017	**$65.2 million**
Percent of Spend to Premium	0.94%

Covered California's website, CoveredCA.com, was developed to serve as the first point of entry for Californians searching for information about Covered California and on how to enroll. The website includes a wealth of information to educate consumers on how to choose the best plan. The website is updated often to refine the consumer experience based on user testing.

As part of online enrollment, Covered California created a shopping tool that makes it easy for consumers to shop for and compare the best plan that fits their needs. The shopping tool allows consumers to review their plan options side by side.

Telling the Story of Covered California Enrollees

Covered California also works to tell the story of Californians who have benefited from a Covered California plan. All over California, people are getting access to the care they deserve through Covered California. In their own words, our members are sharing why health insurance is so important to them. Find them at: www.CoveredCA.com/real-stories.

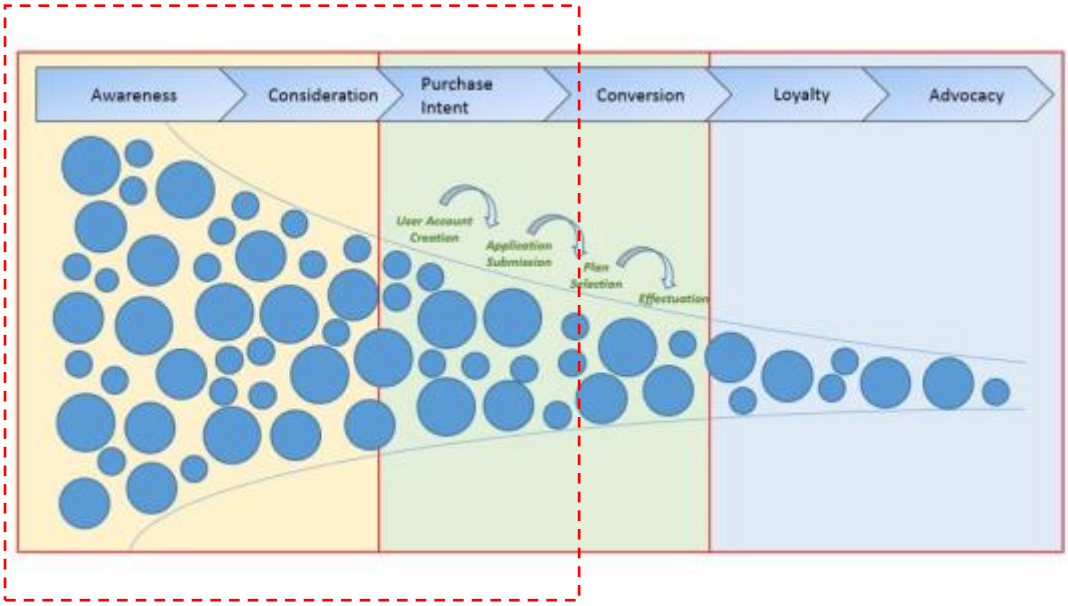
Helping and Encouraging Those Who Start Shopping

Covered California attempts to reach consumers in different stages of the shopping experience, or funnel, to make sure they are getting the information they need. Covered California's sales funnel consists of "prospects" who are in all stages of the consumer journey (see Figure 23: The Interested Consumer Sales Funnel Overview). The high funnel in particular consist of:

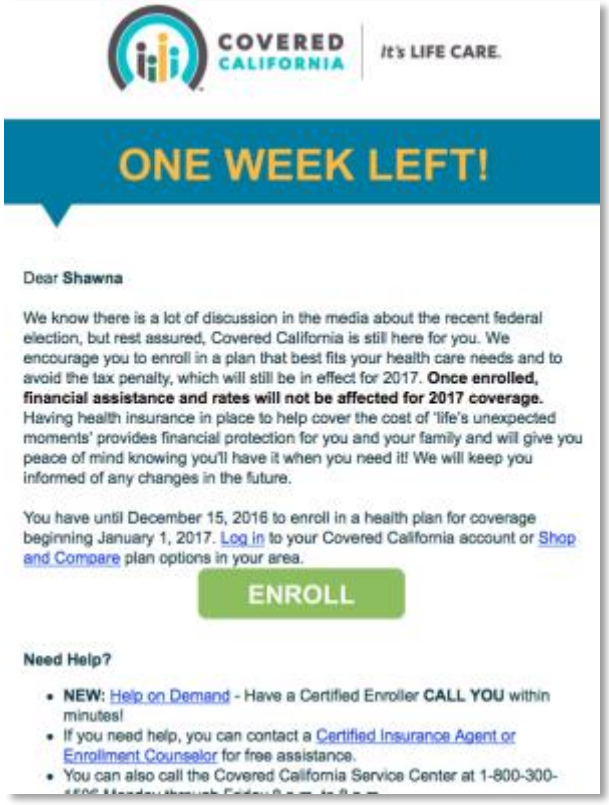
- **Awareness:** The prospect is aware that Covered California exists and has a general understanding of its services and products.
- **Consideration:** The prospect has a pretty clear understanding of what Covered California offers, and are considering themselves as potential consumers.
- **Purchase Intent:** The prospect has started the application process online and is on track to eventually select a plan. It is here where prospects straddle the line between the high funnel and low funnel.

FIGURE 23

The Interested Consumer Sales Funnel Overview



Funnel Communication examples:



COVERED CALIFORNIA | It's LIFE CARE.

ONE WEEK LEFT!

Dear **Shawna**

We know there is a lot of discussion in the media about the recent federal election, but rest assured, Covered California is still here for you. We encourage you to enroll in a plan that best fits your health care needs and to avoid the tax penalty, which will still be in effect for 2017. **Once enrolled, financial assistance and rates will not be affected for 2017 coverage.** Having health insurance in place to help cover the cost of 'life's unexpected moments' provides financial protection for you and your family and will give you peace of mind knowing you'll have it when you need it! We will keep you informed of any changes in the future.

You have until December 15, 2016 to enroll in a health plan for coverage beginning January 1, 2017. Log in to your Covered California account or Shop and Compare plan options in your area.

ENROLL

Need Help?

- **NEW:** Help on Demand - Have a Certified Enroller **CALL YOU** within minutes!
- If you need help, you can contact a Certified Insurance Agent or Enrollment Counselor for free assistance.
- You can also call the Covered California Service Center at 1-800-300-

COVERED CALIFORNIA | It's LIFE CARE.

Real Stories
of Covered California

Life is unpredictable, it can throw something your way when you least expect it. Have you ever thought "it won't happen to me" or "I am healthy, so I don't need health insurance?"

We never know what's going to happen day to day, and having a health plan in place to help cover the cost of the unexpected is a big reason people choose to have health insurance. This financial protection for you and your family will give you peace of mind knowing you'll have it when you need it!

These Covered California members' lives were changed when they received coverage and were brave enough to share their experiences with us. Watch the videos below and see what the unexpected could be like!

Sarah Kinsumba
Los Angeles, CA

A month after signing up for Covered California, Sarah had a sudden medical crisis.

Retention Support

Covered California endeavors to maximize the retention and renewal of 1.3 million Covered California members, keep members insured and promote informed access and utilization of benefits. It aims to nurture leads with messages targeted to where they are in the enrollment process to help conversion through multiple touches.

COVERED CALIFORNIA | It's LIFE CARE.

Helpful Tips
From Covered California

Have you taken advantage of the benefits offered to you with your new coverage? There are many **FREE** preventive services available to help keep you healthy!

FREE preventive care covers:

- Annual check-ups and wellness visits
- Common vaccinations
- Cholesterol and blood pressure screenings
- Skin and lung cancer screenings for high risk adults
- ...and more! See the full list HERE, under the Free Preventive Care section.

Tips on getting started:

Select a Doctor - Click HERE to access your health plan website in order to choose a Doctor. Be sure to call your plan to make sure the Doctor you choose is in your network.

Make your first preventive check up appointment - **make sure you let the Doctor's office know that this is your FREE preventive checkup to avoid being charged.**

Be open with your Doctor about your health history. Share information such as allergies, medications and past procedures that will help your Doctor provide the best possible care.

Carry your insurance card with you at all times.

COVERED CALIFORNIA | It's LIFE CARE.

Helpful Tips
From Covered California

Having difficulties resetting your password, uploading documents or reporting changes? You're in luck, we have some helpful shortcuts and videos to make things easier to understand.

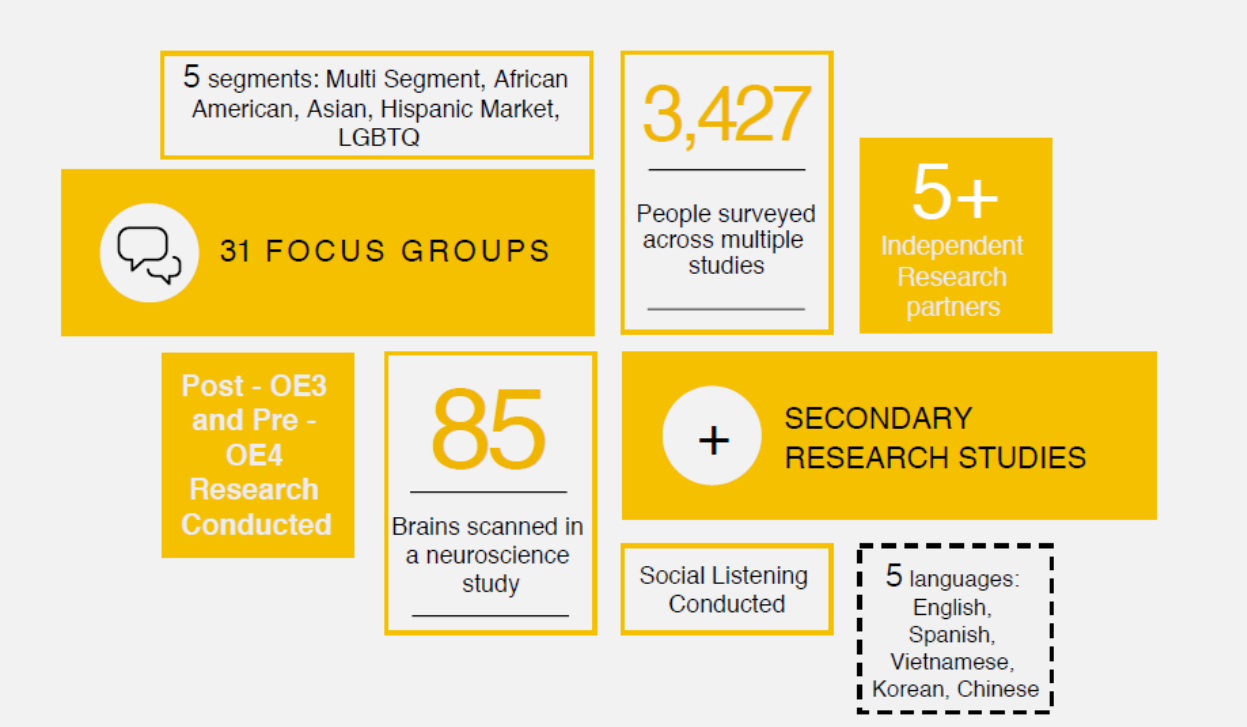
Link: How do I reset my password?

MANAGE YOUR ACCOUNT
HOW DO I RESET MY PASSWORD?

Link: How do I upload documents?

MANAGE YOUR ACCOUNT
HOW DO I UPLOAD DOCUMENTS TO MY ACCOUNT?

Ongoing Research to Inform Marketing and Outreach Strategies



To help inform the fourth open-enrollment periods' creative efforts and planning, Covered California conducted qualitative and quantitative research with uninsured Californians in the multi-segment, African-American, Latino, API and LGBTQ communities.

Across all segments, the research found:

- **The new brand campaign, "It's life care,"** which emotionally conveys the value of coverage, tested very well.
- **The remaining uninsured are harder to convince** and they have found ways to cope.
- **Awareness of Covered California** is good, but there is still confusion about what Covered California is and what it offers. Audiences want specifics.
- **Affordability** is, by far, offered as the No.1 barrier.
- Consumers feel overwhelmed. **Health insurance is complicated,** and they face difficulties with the shopping and enrollment process.

The following are the top-performing message topics across segments and channels:

- Preventive care with specific examples.
- Availability of dental coverage.
- Health insurance at a lower cost.
- Choice of plans, including names of health insurance companies.
- Free expert help.

Research also identified key barriers and motivators for consumers. These barriers and motivators allow Covered California to best message to its consumers.

TABLE 16
Barriers and Motivators for Covered California Consumers[107]

Key Barriers	Motivators
Cost and Competing Priorities	Lower Cost
Lack of Basic and Specific Information	Preventive Care and Dental Coverage
Lack of Urgency/Need	More/Better/Consistent Coverage
Complicated Process	Peace of Mind
	Simplicity and Convenience When Enrolling

Covered California conducts and commissions a wide range of research and analysis to inform its marketing, outreach and enrollment efforts, including focus group testing, quantitative surveys, user testing and expert academic research. The following is a sample of some of the research conducted both to inform marketing, outreach and enrollment efforts as well as bring the best products to the marketplace:

- "An Integrated Quantitative and Qualitative Study on Post-Election Attitudes Toward Enrolling in and Renewing Health Insurance Coverage" (January 2017). Conducted by Covered California, this research analyzed sentiment among Covered California enrollees. (http://www.coveredca.com/news/pdfs/CC_Current_Sentiment_Topline_012417_FINAL.pdf).
- "Consumer Survey," conducted by Covered California in October 2015. This survey found that 85 percent of consumers who move on from Covered California coverage remain insured, with 44 percent acquiring employer-based coverage, 16 percent going to Medi-Cal, 13 percent getting private health coverage, 11 percent getting another form of coverage and 15 percent becoming uninsured (http://hbex.coveredca.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf).

[107] These key barriers and motivators were gleaned from focus groups conducted by Covered California in May 2016.

- "Consumer Tracking Survey," conducted by the independent research organization NORC at the University of Chicago in October 2015. This survey showed that a third of eligible consumers still did not understand they could get help to buy health insurance (http://hbex.CoveredCA.com/data-research/library/2015CA-Affordable-Care-Act%20Consumer-Tracking-Survey.pdf).
- "Sorting out the Health Risk in California's State-Based Marketplace" (Jan. 2015). The study was conducted by a team of researchers from the University of California, San Francisco; the Department of Health Care Services and actuaries from Covered California. The study appeared in the journal *Health Services Research.* An analysis of state data on health care usage by Covered California enrollees found that many were healthier and presented less risk to insurance companies than expected, helping drive down the cost of health premiums offered through the exchange in 2015 (http://escholarship.org/uc/item/3b490590).
- 2014's "Lessons Learned" is a comprehensive overview of practices that worked and course corrections following Covered California's first open-enrollment period (http://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf).

HEALTHCARE BY DESIGN:

Consumer-Centric Benefits for California's Individual Market

JULY 2017

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

ACKNOWLEDGEMENTS

This paper benefited from the input of many people. First, deep thanks to Marian Mulkey, independent consultant at Mulkey Consulting, who served as primary author. Her partnership in researching and organizing the material was invaluable. Thanks, too, to Allie Mangiaracino and Doug McKeever at Covered California for scanning the finished product and validating some facts about the Exchange's benefit design specifics. At Consumers Union, Angela Elizabeth Perry contributed her excellent proofreading skills, and Carol Rivas Pollard cheerfully guided the paper through the final production.

Of course, the underlying work described in the paper was the result of a team of consumer advocacy organizations, including Consumers Union, which doggedly worked over a period of years with Covered California staff to create, and continually improve, the benefits offered in the individual market in California. The organizations are listed in this paper, but special recognition is owed to the individual colleagues from those organizations who worked most intensively on benefit design: Beth Capell for Health Access California, Cary Sanders for the California Pan-Ethnic Health Network (CPEHN), and Jen Flory for Western Center on Law and Poverty.

This paper, and Consumers Union's work on implementing health reform in California, is supported by The California Endowment. We are most grateful to the foundation for its support and partnership in working to improve the health and well-being of Californians, particularly the most vulnerable.

Elizabeth M. Imholz, Consumers Union, Editor

FOREWARD

A decade ago, before the enactment of the Affordable Care Act, California artist Susan Braig faced huge medical bills despite having coverage sold to her as health insurance. When she was diagnosed with breast cancer, she found, to her surprise, that her policy only covered hospital care—not the lumpectomy, chemotherapy, mammograms, or other care she so desperately needed. Ms. Braig ended up with tens of thousands of dollars in medical bills. And, in the pre-Affordable Care Act world without protections for those with pre-existing conditions, she had no ability to buy any other coverage.

Ms. Braig shared her story with Health Access California and Consumers Union in support of our fight for California legislation to standardize benefits, create tiers to facilitate plan comparisons, and set a floor on benefits—similar to what later became the essential health benefits and other standards required under the Affordable Care Act. While these state efforts did not succeed, Ms. Braig went on to become a tenacious advocate for these policies in the ACA to prevent others from facing her same fate.

Once the ACA became the law of the land in 2010, California was primed to implement and improve the law quickly since policymakers, consumer advocates, and other health care stakeholders in California had already been through several debates on state health reform. From these prior deliberations, policymakers and the health policy community already had envisioned an exchange for the individual insurance market to offer health plans, actively negotiate with health insurers on cost and quality, and require standardized benefit designs. The state had experience using its bargaining power in purchasing health benefits for state employees through CALPERS, for children through its S-CHIP program, and in its Medicaid program.

Implementing the ACA, California set strong market rules and gave its Health Benefits Exchange, now called Covered California, selective contracting authority, including the ability to require standardized benefit designs for coverage it sold as well as for coverage sold off-exchange. Now these consumer-centric benefit designs dominate the individual market in the state.

This comprehensive paper shows how this authority can be used to improve the market and the experience for healthcare consumers. Our vision as consumer advocates was that Covered California would function like a human resources department for those in the individual market— bargaining with insurers and helping create understandable products that could be compared using apples-to-apples comparisons, spurring greater price competition, and providing patients greater peace of mind. The goal was to prevent unpleasant surprises for consumers like Susan Braig. Covered California, a state agency subject to the open meetings law, now takes crucial benefit design issues out of a private corporate boardroom and into a public stakeholder forum where consumer advocates can have a say. We hope the experience of California can help policymakers and advocates in other states improve the market and experience for all consumers seeking health coverage.

Beth Capell and Anthony Wright, Health Access California

INTRODUCTION

Shopping for health insurance is a high stakes, stressful undertaking for consumers.[1] The market-based health insurance system in the United States has long encouraged a proliferation of products with cost-sharing levels and covered services that vary enormously. The resulting complexity makes it difficult for consumers to understand their options and make choices in their best financial interest. Thus, in short, consumers—particularly those who rely on the individual market—dread shopping for health insurance.

California, the first state in the nation to create its own Exchange, has taken many steps to mitigate that dread. In the 2010 statute creating the Exchange,[2] Covered California, state legislators made a key decision. They gave Covered California the option to create standardized products[3] that would ease consumers' ability to compare plans and make wise choices. Covered California seized that opportunity from the outset, offering only products with consumer-friendly benefit designs and standardized cost-sharing—that is, what consumers pay in addition to monthly premiums, including deductibles, copayments, and coinsurance. The state law creating the Exchange also required carriers in Covered California that sell individual market products outside the Exchange to offer "mirror products" with the same benefits, networks, and premiums as in the Exchange. Thus, all California consumers seeking individual plans can directly compare them, both inside and outside Covered California, via standardized cost-sharing.[4]

These policy decisions, enshrining consumer-centered standardized cost-sharing in the individual market, have led to better outcomes—in terms of coverage, cost, consumer comprehensibility, and market stability—than many other states have experienced. The close collaboration of several strong consumer advocacy organizations (see sidebar) contributed crucially to California's progress and momentum. This paper describes Covered California's iterative cost-sharing design process and choices; consumer advocates' involvement in that journey; and the positive impact on consumer and market outcomes. Finally, it offers implications for other states and for federal decision-makers.

ELEVATING CONSUMER CONCERNS: A TEAM EFFORT

Many factors influenced California's ACA implementation, but central to the adoption of benefit standardization and other consumer-friendly benefit features was sustained attention from a core group of consumer advocacy organizations. Four organizations regularly participated in Covered California work groups and its Plan Management and Delivery System Reform Advisory Committee, drilling down on the details of benefit design: Consumers Union, Health Access California, California Pan-Ethnic Health Network, and Western Center on Law and Poverty. Each of these organizations brought a unique perspective and skillset to the effort, with a shared mission to advocate for consumer interests, a special emphasis on vulnerable populations, and a commitment to successful implementation of health reform in California. Their long history of collaboration offered a formidable coalition of voices on behalf of California healthcare consumers.

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1 Lynn Quincy, *What's Behind the Door: Consumers' Difficulty Selecting Health Plans,* Consumers Union (Jan. 2012), available at https://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf.

2 While the California Exchange sells both individual market and small business products, this paper focuses solely on the individual market designs, process and outcomes.

3 California Government Code 100504(c)(1).

4 California Health & Safety Code 1366.6(c); Insurance Code 10112.3(c). Outside of Covered California, non-standardized products are permitted, but very few are offered.

5 For more information about each organization, visit consumersunion.org, health-access.org, cpehn.org, and wclp.org.

The Foundation: Keeping Consumer Needs at the Forefront

California's decisions about how to successfully implement and build upon the Affordable Care Act (ACA) rest on a firm foundation: prioritizing consumer needs.

Making Choices Manageable

In shopping for health coverage, consumers want to be able to quickly and confidently choose a plan to fit their needs. The adage is that consumers like lots of choice. The theory is that more options help consumers by increasing the likelihood that they will find an option that meets their specific needs. However, particularly for complicated products and high-stakes decisions such as choosing a health insurance plan, a broad body of evidence suggests otherwise. In many contexts—from selecting a 401(k) fund to a Medicare drug plan—too many options discourage action, or lead to sub-optimal choices.[6] While consumers generally do value having more than one option, being presented with too many choices can lead to less satisfaction, more anxiety, greater disengagement, and poorer decision-making.[7]

Consumers struggle mightily to understand health insurance jargon. Cost-sharing concepts—coinsurance, copayments and deductibles, including how such features interact within a given product—are especially confusing to consumers.[8] While consumers have a strong desire to understand what they are getting for their premium dollar, they also find it difficult to synthesize the various health plan provisions to arrive at a comparative sense of plans' overall value.[9] Each cost-sharing feature in isolation is difficult enough to comprehend, but combining concepts and understanding their interaction is an insurmountable challenge. For example, the deductible must be satisfied first, but are there exceptions? Do copays apply to the deductible? Numeracy skills may limit consumers' ability to estimate the financial impact of different cost-sharing features even if they understand, in theory, what terms mean.[10] These factors argued for Covered California circumscribing both the number of products available and for standardizing cost-sharing within those product choices.

Beyond narrowing the number of plan choices to a manageable universe, the Exchange needed to consider how else its benefit designs could meet consumers' financial and health needs. Affordability concerns were paramount—obviously in premiums, but also as to other out-of-pocket costs. When cost-sharing curtails use, consumers are as likely to cut necessary as unnecessary services. Reduced health care use due to cost-sharing is greatest for patients who are poor, particularly those with chronic health conditions.[11] Increased cost-sharing for people with chronic conditions can lead to increased expenditures

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6 Lynn Quincy and Julie Silas, *The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making,* Consumers Union (Nov. 2012), available at http://consumersunion.org/pdf/Too_Much_Choice_Nov_2012.pdf.

7 Ellen Peters et al., More Is Not Always Better: Intuitions About Effective Public Policy Can Lead to Unintended Consequences, Social Issues Policy Review (Jan. 2013), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3758756/#.

8 Mira Norton et al., Assessing Americans' Familiarity with Health Insurance Terms and Concepts, Kaiser Family Foundation (Nov. 2014), available at http://www.kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/.

9 Early Consumer Testing of Actuarial Value Concepts, Kleiman Communication Group and Consumers Union (Sept. 2011), p. 26, available at http://consumersunion.org/wp-content/uploads/2013/04/prescriptionforchange.org_testing_actuarial_value_concepts1.pdf; George Loewenstein et al., Consumers' Misunderstanding of Health Insurance, *Journal of Health Economics* (Feb. 2013), pp. 850-862, available at https://sites.hks.harvard.edu/fs/bmadria/Documents/Madrian%20Papers/Consumers%20Misunderstanding%20of%20Health%20Insurance.pdf

10 Sharon Long et al., Low Levels of Self-Reported Literacy and Numeracy Create Barriers to Obtaining and Using Health Insurance Coverage, Urban Institute Health Policy Center (Oct. 2014), available at http://hrms.urban.org/briefs/Low-Levels-of-Self-Reported-Literacy-and-Numeracy.html.

11 Melinda Beeuwkes Buntin et al., "Healthcare Spending and Preventive Care in High-Deductible and Consumer-Directed Health Plans," RAND (Feb. 2011), available at http://www.rand.org/pubs/external_publications/EP20110048.html. See also, Robert H. Brooke et al, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," RAND (Dec. 2006), available at https://www.rand.org/pubs/research_briefs/RB9174.html.

ACTUARIAL VALUE: DEFINITION AND APPLICATION

Actuarial Value (AV)[13] is a summary measure that estimates the generosity of coverage provided under a particular health plan, taking into account covered benefits and cost-sharing arrangements. AV measures the percentage of medical expenses paid by a health plan for a standard population (for example, the population enrolled in the individual market). For the group of people enrolled in a Silver (70% AV) plan, plan payments would average 70% of total medical expenses and enrollee payments would average 30%. But each individual enrolled in that silver plan might pay a very different proportion, depending on what health care services s/he actually used.

Under the ACA, the federal Center for Medicare and Medicaid Services updates its Actuarial Value Calculator annually.[14] AV is tightly defined and can be a tough taskmaster. Covered California continually learns from consumer needs, concerns and preferences and gauges product trends. Each year, Covered California considers market factors and adjusts cost-sharing to stay within the calculator's and the statutory bounds.

on hospitalizations.[12] Thus, product design needed to aim for cost-sharing arrangements that would incentivize access to appropriate health-sustaining services.

Making the Consumer, Not the Health Plan, "The Decider"

Prior to the ACA, insurers generally developed individual market products based on risk avoidance, creating products to attract customers with fewer healthcare needs and lower costs. The ACA, however, upended that paradigm, establishing a framework for putting consumers in the driver's seat by encouraging health plans to compete not on risk selection, but on more consumer-centric ends such as price, quality, provider networks, and customer service—in short, on value. The ACA thus:

- Required coverage of ten categories of "essential health benefits (EHBs)";
- Prohibited annual dollar limits and lifetime limits for EHBs;
- Required that carriers pay a minimum percentage of premium dollars toward actual medical care (also known as medical-loss ratios);
- Established a standardized display of each policy's coverage, the "Summary of Benefits and Coverage"; and
- Required that products be grouped into "metal tiers" that meet broad standards for cost-sharing generosity for an average population, as measured by actuarial value (AV): Bronze (60%); Silver (70%); Gold (80%); Platinum (90%).

Together, these requirements were aimed at averting "adverse selection"—when a disproportionate share of high-risk and high-utilizing individuals purchase within a pool. If Exchanges experienced adverse selection, their costs would rise at an unsustainable pace and, at the extreme, make it impossible to offer affordable products, leading to the market collapsing.

These ACA parameters, however, went only so far. They neither required that products be simplified nor limited the number of products that health

12 Sarah Goodell and Katherine Swartz, "Cost-sharing: Effects on spending and outcomes," Robert Wood Johnson Foundation Synthesis Project (Dec. 2010), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103.

13 Actuarial Value Under the Affordable Care Act, American Academy of Actuaries (July 2011), available at https://www.actuary.org/pdf/health/Actuarial_Value_Issue_Brief_072211.pdf.

14 Final 2017 Actuarial Value Calculator Methodology, Center for Medicare and Medicaid Services (Jan. 2016), available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf.

insurance carriers could offer. Instead, the ACA maintained a good deal of state flexibility and preserved the central role of state regulators in approving health insurance products. In its authorizing legislation, California added requirements to exceed these federal floors,[15] including a requirement that the Exchange selectively contract with carriers, rather than "take all comers."[16] In addition, carriers participating in the Exchange must offer a product at every metal level, whereas federal law simply requires plans to offer at least two tiers on an Exchange.[17] Finally, carriers that participate in the Exchange, if they also sell off-Exchange, must offer all their Covered California products as "mirror products" off-Exchange, whereas federal law requires participating plans to simply offer two "mirror plans" off-Exchange.[18]

Notwithstanding these extensive requirements within the ACA and in California's implementing legislation that were intended to level the playing field and minimize adverse selection, Covered California and consumer stakeholders sought further protections since old habits—including health plan tendencies to use benefit designs to attract or deter consumers based on risk—die hard. The National Association of Insurance Commissioners observed that, "the more choices a market provides, the greater the opportunity for adverse selection, either directly or indirectly."[19] Consumer advocacy groups, as well as some other stakeholders, noted that challenges with complexity, affordability, and risk selection could persist despite mitigating features of federal and state law if Covered California permitted a variety of product designs. They urged Covered California to exercise an important option provided by the authorizing state statute: for the Exchange to standardize its cost-sharing designs.[20]

As detailed below, Covered California from the outset determined to follow that course. It thus prioritized consumer needs by ensuring an easier way to compare plans, encouraging informed choices, and offering consumers incentives to get the right care.

Guiding Principles

The threshold decision for Covered California to exercise the option to require standardized benefit designs was adopted in August 2012 and was not controversial. Several principles guided that decision and the steps that followed it. Chief among them was having a fully transparent policymaking process with public hearings from the outset. As staff who worked on the authorizing legislation noted, "...we tried to put in the most solid foundation that we possibly could, with transparency and openness that one expects of government."[21] That foundational precept of Covered California's establishment as an independent state entity—subject to open meeting requirements—carried through to its administrative processes, including on benefit design. Through public Board meetings, notices, and Plan Management and Delivery System Reform Advisory Committee meetings, starting in the first year and continually thereafter, the decisions about the cost-sharing designs—a technical but critical topic—have been fully vetted, probed, and decided in full public view. The public

15 See Kelch Policy Group, Benefit and Coverage Rules Under the ACA: California vs. Federal Provisions, California Health Care Foundation (March 2014), available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20A/PDF%20ACAbenefitRules.pdf.

16 CA Government Code 100503(c)

17 CA Government Code 100503(e)

18 CA Government Code 100503(f)

19 Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act, National Association of Insurance Commissioners (2011), p. 5, available at http://www.naic.org/store/free/ASE-OP.pdf.

20 CA Government Code 100504(c)(1). See also 100503(i) directing the Exchange to set cost-sharing for qualified health plans, though not requiring it be standardized amongst them.

21 *See,* California's Insurance Exchange: Experts Tackle the Big Questions, California Health Care Foundation (Dec. 2010), available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CAInsuranceExchangeExpertsTackleBigQuestions.pdf (quoting Sumi Sousa).

process supported robust debate and sound decisions grounded in principles of consumer choice, investments in health, and competition amongst carriers based on value.

Support informed consumer choice

When Covered California first articulated its core values, "consumer-focus" was at the top of the list. Both Covered California staff and consumer advocates prioritized a benefit structure that assured consumers could compare and choose options to reflect their financial interests and preferences.

Advocates encouraged Covered California to allow for apples-to-apples comparisons among products, keeping the designs as transparent, intuitive, relevant, and stable as possible. They urged standardized cost-sharing designs[22] that were:

- **Transparent:** Present key cost-sharing features as plainly as possible, so that consumers do not encounter big surprises when they access services. Use co-pays rather than coinsurance wherever possible since consumers overwhelmingly prefer the certainty of fixed dollar cost-sharing. Avoid cost-sharing features that are subject to exceptions or special circumstances.
- **Intuitive:** Assure that benefits and premiums are arrayed in logical "stair steps." Do not let cost-sharing vary in opposition to what actuarial value differentials suggest: copays should increase and premiums decrease as metal level decreases from platinum to bronze. Consumers should not have to make sense of counter-intuitive features.
- **Relevant:** Offer consumers something of value across a range of circumstances and metal levels, so that all consumers—including those of very limited means and those in excellent health—can see reasons to enroll.
- **Appropriate:** Consider how consumers' out-of-pocket costs relate to their available financial resources (for example, compare potential out-of-pocket costs to monthly salary). Provide clear signals to encourage consumers who qualify for cost-sharing subsidies[23] to enroll in Silver plans and obtain those cost-sharing subsidies.
- **Stable:** Make sound foundational design decisions in early years and keep year-to-year changes incremental. With a relatively stable benefit structure, consumers' efforts to understand and compare coverage options would be rewarded over time as features became increasingly familiar. In contrast, frequent or dramatic changes in products or features would confuse consumers and undermine their ability to choose wisely.

22 Letter to Peter Lee and Andrea Rosen of Covered California, Consumers Union, Health Access, Western Center on Law & Poverty (Oct. 2012), available at http://consumersunion.org/california-health/2012_10_Jt-comments-standard-benefit-design_JS.pdf.

23 Enrollees earning between 100% and 250% of the federal poverty guideline (FPL) are eligible for additional cost-sharing assistance if they enroll in Silver plans. That cost-sharing assistance elevates the actuarial value from Silver's basic 70% AV, to 73% AV for those 200-250% FPL; 87% AV for those 151-200% FPL; and 94% AV for consumers between 100 and 150% FPL.

Encourage getting the right care, at the right time

One purpose of health insurance is to provide protection from financial catastrophe; another, which Covered California chose to emphasize, is to provide access to care that supports good health outcomes. The ACA requires private health insurance plans to cover certain preventive services without any cost-sharing.[24] Income-eligible consumers may qualify for cost-sharing subsidies under the ACA—but only if they choose a Silver plan offering in an ACA Exchange. So that consumers would be less likely to delay basic care due to cost concerns, California consumer advocates urged decision-makers to:

- Make payments for primary care and generic drugs manageable for consumers, prioritizing lowering copayments as much as possible.
- Make payments for primary care and related services predictable. Consumers may avoid diagnostic tests that involve coinsurance if they have no idea how much they will owe. Delayed diagnosis may lead to adverse health outcomes and higher total costs down the road.
- Exempt primary care services from application of the deductible. While deductibles keep premiums lower and help actuarial values stay in line with ACA requirements, they discourage consumers from obtaining timely basic care.[25] Advocates encouraged Covered California to think creatively about when and how to administer deductibles—and how to describe them.

Encourage appropriate competition among plans

In an ideal world, consumers would select among health plans that represent "the optimal combination of choice, value, quality and service."[26] Value is a complex concept and means different things to different people; at the same time, the structure of products and benefits can make it simpler or harder for consumers to consider tradeoffs and assess value. If every product differs along many unique dimensions, consumers will find it difficult if not impossible to estimate their total cost (premiums plus out-of-pocket costs). In contrast, products with identical cost-sharing categories are easier for consumers to compare and thus exercise their market power, rewarding plans that excel in quality, efficiency and service. To assure consumers would be able to make informed choices, consumer advocates encouraged Covered California to:

- Standardize benefit designs so that consumers could compare options on an "apples-to-apples" basis. Presented with standardized benefits, consumers could focus instead on areas of relevant variation, most notably premium, provider network, and quality.
- Impose quality requirements via plan contract negotiations, assuring that any plan offered through Covered California met threshold quality standards.
- Prioritize timely provision of information to the public about provider networks, participating hospitals, and plan quality including customer service.

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24 Preventive Services Covered by Private Health Plans under the Affordable Care Act, Kaiser Family Foundation (Aug. 2015), available at http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/.

25 Zarec Brot-Goldberg et al., What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics, Harvard Kennedy School Faculty Research Working Paper (Oct. 2015), available at https://research.hks.harvard.edu/publications/getFile.aspx?Id=1265.

26 See, AB 1602 (Perez), available at http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html (Covered California enacting legislation).

Decisions Reflected Consumer Interests

Consumer advocates actively participated in the Exchange's Plan Management and Delivery System Reform Advisory Committee, specific benefit design work groups that sprung from the Advisory Committee, and Board meetings, thus making substantial contributions to many of Covered California's plan decisions. Many stakeholders came into ACA implementation assuming that the existing product constructs would form the basis for Covered California products. Given the challenges consumers faced in understanding and choosing health plans, however—as well as new goals for improving health outcomes and care coordination—consumer advocates urged Covered California to take a fresh look at products and benefit design. The following examples illustrate how steady attention to what was and wasn't working well for consumers helped upend some of the conventional wisdom, making Covered California's products and benefits more and more consumer-friendly over time.

Coinsurance vs Copayments

Prior to the ACA, the majority of enrollees in California's individual health insurance market were covered through PPOs for which coinsurance was a common cost-sharing arrangement.[27] Continued reliance on familiar designs seemed natural; envisioning a shift to greater reliance on copayments was not a given.

From the outset, however, consumer advocates questioned continued extensive reliance on coinsurance, explaining that coinsurance created great confusion and insecurity for consumers. Research on consumer numeracy skills confirms what common sense tells us: that people overwhelmingly prefer fixed dollar share-of-cost amounts to coinsurance percentages.[28] And they do so for several reasons. Ascertaining which coinsurance portion the plan pays and which the customer is responsible for can be confusing to consumers. Coinsurance final costs are unknowable since consumers don't know either initial costs or allowed amounts. Even if underlying costs were known, evidence suggests that many consumers have difficulty comparing fixed dollar payments to percentages.[29] In contrast, actual dollar amounts are concrete and do not require the numeracy skills and assumptions required for percentage calculations.

Advocates' first ask was to eliminate coinsurance cost-sharing altogether. Modeling by Covered California actuaries showed the challenge of eliminating coinsurance altogether within the constraints of the actuarial levels, while keeping premiums manageable. However, on deeper exploration, Covered California staff did find

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27 Katherine B. Wilson, California's Individual and Small Group Markets on the Eve of Reform, California Health Care Foundation, (April 2011), available at http://www.chcf.org/publications/2011/04/ca-individual-small-group-eve-reform.

28 *See,* Early Consumer Testing of Actuarial Value Concepts, Kleiman Communication Group and Consumers Union (Sept. 2011), p. 12, available at http://consumersunion.org/wp-content/uploads/2013/04/prescriptionforchange.org_testing_actuarial_value_concepts1.pdf (In focus groups and intensive interviews testing consumer understanding of insurance concepts, when presented with side-by-side comparisons of dollar amounts and percentages (e.g. Platinum: $40 vs. Gold: 20%), participants noted an overwhelming preference for actual dollar amounts which are considered concrete, plus it was clearer to participants that copays were their responsibility. Percentages, such as coinsurance, were harder to decipher because the final cost depends on the initial total cost, which is unknown.).

29 Lynn Quincy, *What's Behind the Door: Consumers' Difficulty Selecting Health Plans,* Consumers Union (Jan. 2012), available at https://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf.

opportunities to reduce the use of coinsurance significantly. The most critically important example was regarding Silver plans—which nearly 60% of Covered California enrollees choose. Advocates illustrated through detailed charts based on the proposed designs the very minimal differences between cost-sharing features in the 2014 and 2015 Silver plans labeled "Copay Plan" versus those labeled "Coinsurance Plan"—each of which were based primarily on copayments. They argued that the confusion created by this distinction-without-much-difference was detrimental to consumer understanding. In response, after extensive input from all stakeholders which yielded agreement, the Exchange merged the two into a single Silver design for 2016 that relied primarily on copay cost-sharing.

Over time, through ongoing review of plan designs and consumer product choices, as well as the updates to the actuarial value calculator required by the federal government, Covered California designs have shifted where possible from use of coinsurance in other metal levels as well. For example, in the Bronze plan, whereas laboratory tests had been subject to a 30% coinsurance in 2015, in 2016 a $40 copay applied.

Deductibles

Deductibles—the upfront amount for which a consumer is responsible before insurer payments kick in—have a powerful effect in keeping premiums down and meeting actuarial value requirements, yet can be a barrier to necessary care.[30] They can also be a sharp financial pain point for consumers, and one that adds complexity as consumers often struggle to understand to what services and when deductibles apply.

Consumer advocates worked with Covered California to explore whether deductibles were necessary and, if so, how they might best be applied to keep coverage affordable and avoid surprises for consumers when they seek, or consider seeking, care. From the beginning, Platinum and Gold plans included no deductibles. However, to meet Silver and Bronze actuarial value requirements and keep premiums affordable, it was necessary to impose deductibles in those tiers. Given this reality, advocates sought to avoid consumer confusion and limit the extent to which deductibles discouraged consumers from using needed care. A particular concern was that consumers, especially low-income consumers, be able to weigh a known out-of-pocket cost against medical need. Consumers should not be confused or unduly discouraged by cost-sharing, nor surprised by higher-than-expected bills after getting care.

While California HMO products typically waived the deductible for office visits even prior to Covered California's establishment, removing office visits from the deductible was not initially proposed for all Covered California products. Following exploration and actuarial modeling, these services were removed from the deductible in Silver plans starting in 2014. In Bronze plans—which have a very high deductible—three visits (plus the free preventive visit annually) provided were not subject to the deductible.[31] Consumers who chose these least generous and lowest premium plans thus gained flexibility and immediate value because most outpatient services (primary care or specialist office visits) were subject only to a simple copay.

Over time, to make benefits as understandable and affordable as possible, the span of services to which the deductible applied evolved. Consumer groups advocated, for example, to remove emergency room (ER) services from the deductible so as not to hit consumers with outsize bills, beyond their copay, when they had not met their deductible. The aim was to neither surprise enrollees with unexpectedly large bills, nor to discourage those who truly need emergency

30 Zarec Brot-Goldberg et al., What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics, Harvard Kennedy School Faculty Research Working Paper (Oct. 2015), available at https://research.hks.harvard.edu/publications/getFile.aspx?Id=1265.

31 In addition, in the 2014 and 2015 plan year, in Bronze (as well as Silver) plans, prenatal care and preconception visits had no cost-sharing.

treatment from seeking it. Thus, for 2017 individual market plans Covered California removed ER facility and ER physician fees from the deductible in Silver products.

Today, almost all outpatient services for Covered California individual market products receive "first-dollar coverage"—that is, coverage excluded from deductibles. Rather than having the deductible apply to relatively common professional services—and thus requiring the consumer to bear all the cost if the deductible has not been otherwise met—the deductible applies primarily to high-cost, infrequent services such as care in hospitals, skilled nursing facilities, and other inpatient services. In addition, to assist consumers in comparing products on a head-to-head basis, deductibles apply to facility-related charges for copay products as well as coinsurance products.

A final issue related to deductibles is whether, if deductibles are necessary for a given product, having a separate deductible for medical care and one for prescription drugs is in consumers' interest. During the work group process on benefit design, advocates were initially skeptical, concerned that having two deductibles would add complexity and generate confusion about what services and products were subject to which deductible. However, actuarial calculator modeling demonstrated that a relatively low prescription drug deductible—say $100—could help keep premiums down and get a consumer to first dollar coverage for drugs more quickly than requiring them to satisfy the much larger medical deductible in full. Once consumer groups reached the (initially counter-intuitive) conclusion that two separate deductibles could be consumer-friendly, they advocated for clear labeling, displays, and messaging to clarify how deductibles would work.

Prescription drug benefit design

About half of all Americans regularly take a prescription drug, and more than one in ten takes five or more.[32] For many years, prescription drug costs have accounted for a growing share of health care spending and of insurance premiums. Over the past decade or more, prescription drug benefits have grown very complex. For example, many products have separate prescription drug out-of-pocket limits and deductibles; most sort drugs into several tiers (generic, preferred, non-preferred, specialty) that are subject to different copays or coinsurance levels. To forecast needs and estimate costs under such complex schemes poses significant cognitive challenges for consumers.

Recognizing the importance of prescription drug coverage as both consumer benefit and cost driver, the structure of prescription drug benefits was subject to ongoing review by Covered California and its Plan Management Advisory Group, on which consumer advocates served. By early 2015, consumer cost burden associated with specialty drugs was attracting heightened concern. Covered California convened an intensive group process over several months that included several consumer advocates, health plan representatives, and representatives of California's Department of Managed Health Care and Department of Insurance. As a result of extensive study, educational sessions with pharmaceutical experts, and workgroup recommendations, the Board approved 2016 standard benefits designs that imposed caps on consumer out-of-pocket costs for specialty drugs.[33] A maximum charge of $250 for Platinum, Gold, Silver and Silver 73 plans; $150 for Silver 87 and Silver 94 plans; and $500 for Bronze plans applied for a 30-day supply. In contrast to earlier benefit designs with open-ended coinsurance for specialty drugs, these changes made consumer out-of-pocket prescription drug costs more predictable. It also spread the maximum out-of-pocket amount over the course of a year, in an effort to allow consumers some month-to-month relief.

32 National Center for Health Statistics Fast Stats, Center for Disease Control and Prevention, available at https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm.

33 *See,* James DeBenedetti, Benefit Design Updates and Consumer Clarity, Covered California Plan Management Advisory Group (May 2015), available at http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Plan%20Management%20Advisory%20Group_Slide%20Deck_%20May_14_2015.pdf.

CONSIDERED BUT DEFERRED: ALTERNATIVE VALUE-BASED INSURANCE DESIGN

Since its early days, Covered California has demonstrated a deep commitment to delivery system reform, innovation, and value. In that vein, Covered California considered incorporating value-based insurance design (VBID) in some of its products. The goal of VBID is to structure consumer cost-sharing so that enrollees are guided toward services known to improve health outcomes and away from services of limited or uncertain value.[34] For example, waiving cost-sharing for diabetes monitoring or treatment may make sense if cost-sharing is a barrier to maintaining normal blood glucose levels and leads to serious health complications.

Advocates acknowledged that consumer cost-sharing can impede access to care and affect health outcomes. Diabetes management is a particular concern to millions of Americans and disproportionately affects communities of color. So the Plan Management and Delivery System Reform Advisory Committee decided to explore whether a VBID for diabetes was feasible. Advocates urged that VBID proposals be considered from the viewpoint of consumers. Cost-sharing arrangements that vary by health condition can be difficult for consumers to understand. Allowing different plans to test multiple VBID variations could undermine the simple comparison shopping made possible by standardized benefits.[35]

During 2015, Covered California staff led a thorough exploration of a potential VBID focused on diabetes for potential implementation in the 2017 plan year.[36] However, lacking solid evidence of value, advocates determined—as did Covered California—that at this stage consistency was more important than offering unproven innovation with possible unintended consequences. Potential benefits were outweighed by two concerns: additional confusion and complexity for consumers and health care providers; and increased premiums for those not targeted by the effort.

34 Lance Lang et al., Moving the Needle on Primary Care: Covered California's Strategy to Lower Costs and Improve Quality," Health Affairs blog (June 2017), available at http://healthaffairs.org/blog/2017/06/14/moving-the-needle-on-primary-care-covered-californias-strategy-to-lower-costs-and-improve-quality/.

35 Letter to Peter Lee and Andrea Rosen of Covered California, Value-Based Insurance Design Options, Consumers Union and Health Access (Sept. 2012) (on file with author); Consumer Criteria for Value-Based Insurance Designs, Consumers Union (Jan. 2013), available at https://consumersunion.org/wp-content/uploads/2013/01/Consumer_Critera_1_13.pdf.

36 Lance Lang et al., Memo to 2017 Benefits & Networks Subcommittee: Consideration Issues for Implementing Value-Based Insurance Design (VBID) for Diabetes (Dec. 2015) (on file with author).

On a parallel path, Health Access California, drawing from learnings from the work group process at Covered California, sponsored legislation, AB 339, to cap outpatient prescription drug costs across the entire commercial insurance market in California. AB 339 was signed into law by Governor Brown and took effect in January 2017.

Focusing on Consumers Yields Win-Win Outcomes

Gauged along many dimensions—and in comparison to many other states—California has proven how the Affordable Care Act can truly work for consumers.[37] California adopted the ACA's optional Medicaid expansion, declined to allow continuation of plans that do not comply with ACA requirements, and pursued many other policies that fostered the ACA's successful implementation. As a result, California's uninsured rate has dropped by nearly half[38] and Covered California has attracted robust participation by plans and a healthy mix of consumers. California's consumer orientation has been a critical contributor to that success. Further details on the positive impacts of that orientation are set forth below.

Premiums and out-of-pocket costs

Covered California's weighted average premium increase was 4.2% in 2015, 4.0% in 2016, and 13.2% in 2017. According to experts,[39] the 2017 increase included a one-time bump due to the end of the temporary federal risk mitigation programs (reinsurance and risk corridors)[40] intended to cushion the expenses of high-cost patients. While any premium increase is a burden on consumers, taken together these rates of increase compare very favorably to the median annual increase in California's individual market prior to ACA implementation: 9.8% from 2011 to 2014.[41] California's premiums also compared favorably to those in other states.[42] Premiums reflect many factors: competition among plans and providers, use of health care services, labor costs. But there is a case to be made that Covered California's benefit structure has encouraged plan competition and exercised a check on premiums.

Standardizing benefits, in addition to making shopping easier for consumers, also streamlined evaluation of health plan bids by Covered California staff.[43] When all plans offer comparable benefits, it makes reviewing complex rate filings simpler and provides greater opportunity to clarify what drives premium differences.

Significantly, California consumers also fared well in terms of out-of-pocket costs, compared to consumers in states that did not standardize cost-sharing nor engage in active purchasing. According to a Covered California analysis, consumers enrolled in similarly priced products in Denver and Miami, for example, had higher deductibles and more exposure to cost-sharing than those in Los Angeles with Covered California products.[44]

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37 Jonathan Cohn, Trump Says Obamacare Is 'Imploding.' That's News To California, Huffington Post (June 2017), available at http://www.huffingtonpost.com/entry/covered-california-obamacare_us_5936cf84e4b013c4816b639f.

38 Paul Fronstin, California's Uninsured: As Coverage Grows, Millions Go Without, California Health Care Foundation (Dec. 2016), available at http://www.chcf.org/publications/2016/12/californias-uninsured.

39 Drivers of 2017 Health Insurance Premium Changes, American Academy of Actuaries (June 2016), available at http://www.actuary.org/content/drivers-2017-health-insurance-premium-changes-0.

40 Cynthia Cox et al., "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors, Kaiser Family Foundation (Aug. 2016), available at http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

41 Katherine Wilson, Premium Rates in California's Individual Market, 2011–2014, California Health Care Foundation (July 2014), available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20P/PDF%20PremiumRatesIndivMarket.pdf.

42 Cynthia Cox et al., 2017 Premium Changes and Insurer Participation in the ACA's Health Insurer Marketplaces, Kaiser Family Foundation (Oct. 2016), available at http://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/.

43 Open Enrollment 2013-14: Lessons Learned, Covered California (Oct. 2014), p. 21, available at https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf.

Enrollment

In 2016, Covered California had enrolled 48% of its estimated potential Marketplace population, more than the 40% share enrolled in the federally-facilitated Exchange and a greater share than in most other state-based Exchanges.[45] California's robust individual market enrollment under the ACA may be due in part to California's previous high rate of uninsurance and an unregulated pre-ACA individual market, but also can be attributed to strong outreach efforts by the Exchange. Also, by making it easier to compare and understand products, benefit standardization may have helped California attract enrollees.

Moreover, enrollees in Covered California plans seem to be choosing the right plans for their health needs. An analysis of medical risk profiles for enrollees in Covered CA for 2016 and 2017 showed that mean "risk scores" are higher for plans with higher actuarial value.[46] In other words, those consumers expected to use more care are selecting a plan in a metal tier that provides more comprehensive coverage, in line with their financial interests. While further research is needed,[47] it may well be that standardized benefit designs, combined with Covered California's well designed web-based search tools, have helped consumers find plans that fit their health status.

Consumer satisfaction within Covered California has been strong. From 2015 to 2016, 88% of renewing consumers maintained their carriers and benefit levels, suggesting that they were satisfied with the combination of price, access, quality, and service they were receiving.[48] The ability to compare standardized options likely increased consumer confidence in their choices and contributed to enrollment stability.

Effective Process Grounded in Transparency

Covered California has a deep commitment to mission. Its early articulation of core values, developed with input from stakeholders, served to rally diverse stakeholders.[49] Decisions and implementation actions taken by the Covered California Board, its executive leadership, and its staff were guided by a steady commitment to consumers. In addition to achieving outcomes that served consumers well, that commitment helped solidify consensus among stakeholders and supported an efficient process for airing and resolving differences when they did arise.

Extending upon its identity as an open government entity, Covered California has built a culture that elicits and attempts to respond to stakeholder concerns. Consumer advocates regularly voice their questions, concerns, and suggestions at Covered California Board meetings. In early 2013, Covered California established a Plan Management and Delivery System Reform Advisory Group, which continues to meet regularly, to inform initial Covered California benefit design decisions. Participants include health plans, health care providers, independent health experts, and several consumer advocates. Throughout health plan design deliberations, Covered California staff provided analysis, modeled different cost-sharing options, and demystified actuarial tools to help

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44 Delivering on the Promise of the Affordable Care Act, Covered California (July 2015), p. 15, available at http://nashp.org/wp-content/uploads/2015/07/7-17-15-CoveredCA-Delivering-on-the-Promise-of-the-ACA.pdf.

45 Marketplace Enrollment as a Share of the Potential Marketplace Population, Kaiser Family Foundation (March 2016), available at http://www.kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22desc%22%7D.

46 Covered California Continues to Attract Sufficient Enrollment and a Good Risk Mix Necessary for Marketplace Sustainability, Covered California (May 2017), available at http://hbex.coveredca.com/data-research/library/CoveredCA_Sufficient_Enrollment_Good_Risk_Mix.pdf.

47 *See also,* Vicki Fung et al., Nearly One-Third of Enrollees in California's Individual Market Missed Opportunities to Receive Financial Assistance, Health Affairs (Jan. 2017), available at http://content.healthaffairs.org/content/36/1/21.abstract (The jury is out with respect to consumers optimizing access to premium subsidies and cost-sharing reduction.).

48 New Data Show How Covered California Spurs Competition Among Health Insurance Companies, Covered California (Feb. 2016), available at http://news.coveredca.com/2016/02/new-data-show-how-covered-california.html.

49 *See,* About Us: California's Health Benefit Exchange, Covered California, available at http://hbex.coveredca.com/about/ (Covered California describes its values in the following domains: Consumer-Focused; Affordability; Catalyst; Integrity; Partnership; Results).

advocates and other stakeholders grapple with tradeoffs and understand actuarial implications or various cost-sharing adaptations.

From the start, a commitment to consumers' experience and their ability to understand options led Covered California to consider both short- term choices and long- term implications. Balancing the desire to innovate with a desire for stability, Covered California defined a structure for standardized benefits in its first year, but then revisited each year—tweaking where needed, but avoiding sweeping changes that would have been disruptive for consumers, as well as health plans.

As a result, Covered California's implementation path on cost-sharing was smooth, yet also allowed for continuous improvement. There were no dramatic retrenchments or reconsiderations in benefit policy or product design. Covered California's clear vision and stable priorities—anchored in consumer needs—supported long-term planning by health plans and health care providers. All parties were able to invest resources in steady improvement rather than revisiting major past decisions or operating under uncertainty.

Implications

California established a well-functioning health benefit Exchange and consumer-friendly, standardized cost-sharing products under the ACA. California's consumer-centric approach paid dividends for those enrolled through Covered California. More broadly, it improved choices and supported comparison shopping for all Californians who rely on the individual market. California's experience offers insights for coverage policy and implementation decisions in other states and at the federal level.

Many consumer challenges—and ways to address them—are universal:

- Consumers wrestle with tradeoffs between affordability and access to care. Tools and presentations that illustrate tradeoffs help consumers make wise and durable choices. Standardizing benefit designs removes one source of variability and uncertainty.
- Having too many choices impairs decision-making and may prevent consumers from acting at all. Simplified benefit designs streamline decisions and improve consumer confidence. Offering a limited number of products makes it easier for consumers to choose.
- Consumers want to minimize time spent shopping, yet avoid buyer's remorse. Streamlined structures to compare options and clear messaging encourage enrollment and increase satisfaction.

In implementing the ACA in California, prioritizing consumer concerns has paid off both directly and indirectly. Within Covered California, enrollment levels, health of the risk pool, premiums, consumer participation and satisfaction compare favorably to those features in California non-Exchange markets and in other state Exchanges. Within the broader California market, innovative standardized cost-sharing benefit designs and expanded consumer protections have begun to take hold—some through legislation, as in the case of caps on out-of-pocket costs for specialty drugs; some through other policy decisions, as in the requirement for standardized products, offered both inside and

outside Covered California so that consumers can compare all options.

California's experience can inform deliberations at the federal level and within other states. One sign that the federal government has learned from California's approach came when the Center for Medicare and Medicaid Services adopted standardized cost-sharing as one option within the federal Exchange.[50] Consumers Union vigorously encouraged this step and offered concrete suggestions drawn from the California experience about how to maximize its usefulness for consumers.[51] Those suggestions remain relevant as long as Exchanges play a role in presenting individual market products to consumers. In 2016, Avalere analyzed the federal proposal, including its proposed reliance on first-dollar coverage for outpatient services, and noted the potential appeal to healthier consumers of benefit designs such as Covered California's.[52]

At the state level, advocates and policymakers may want to consider opting for consumer-friendly standardized cost-sharing designs. In addition to easing the burden on consumers in comparing plans and fostering access to valuable services, such as primary care, this approach may also have the benefit of reducing regulatory burden for the states. Some states are already on that path, also allowing carriers to offer non-standardized plans in addition to requiring standardized plans. Researchers have suggested that offering both presents a difficult balancing act to ensuring consumer understanding, however, making improved web-based consumer choice tools especially important.[53]

Consumers' need for coverage that is understandable and reliable—devoid of hidden exclusions and other unwelcome surprises—is undeniable. As advocates and leaders within the public and private sectors work to protect and assure health coverage—either under the ACA or within a new policy context—they would do well to emulate California's strong commitment to transparency and to consider adopting standardized, consumer-friendly benefits that encourage primary and high-value care.[54]

50 HHS Notice of Benefit and Payment Parameters for 2017, Federal Register (March 2016), available at https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf.

51 Consumers Union, Comments to HHS Secretary Burwell Re: CMS-9937-P: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017 (December 21, 2015).

52 Caroline F. Pearson and Elizabeth Carpenter, Proposed Exchange Standardized Benefit Designs Expand First-Dollar Coverage for Services and Drugs, Avalere (Jan. 2016), available at http://avalere.com/expertise/life-sciences/insights/proposed-exchange-standardized-benefit-designs-expand-first-dollar-coverage.

53 Sabrina Corlette et al., Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefits Designs, Robert Wood Johnson Foundation and Urban Institute (July 2016), available at http://www.urban.org/sites/default/files/publication/82611/2000862-Missed-Opportunities-State-Based-Marketplaces-Fail-to-Meet-Stated-Policy-Goals-of-Standarized-Benefit-Designs.pdf.

54 Elliott S. Fisher and Peter V. Lee, Toward Lower Costs and Better Care—Averting a Collision between Consumer- and Provider-Focused Reforms, New England Journal of Medicine (March 2016), available at http://www.nejm.org/doi/full/10.1056/NEJMp1514921.

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Congressional Budget Office

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The Effects of Terminating Payments for Cost-Sharing Reductions

Summary

The Affordable Care Act (ACA) requires insurers to offer plans with reduced deductibles, copayments, and other means of cost sharing to some of the people who purchase plans through the marketplaces established by that legislation. The size of those reductions depends on those people's income. In turn, insurers receive federal payments arranged by the Secretary of Health and Human Services to cover the costs they incur because of that requirement.

At the request of the House Democratic Leader and the House Democratic Whip, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have estimated the effects of terminating those payments for cost-sharing reductions (CSRs). In particular, the agencies analyzed what would happen under this policy: By the end of this month, it is known that CSR payments will continue through December 2017 but not thereafter.

Effects on Market Stability and Premiums

CBO and JCT expect that insurers in some states would withdraw from or not enter the nongroup market because of substantial uncertainty about the effects of the policy on average health care costs for people purchasing plans. In the agencies' estimation, under the policy, about 5 percent of people live in areas that would have no insurers in the nongroup market in 2018. By 2020, though, insurers would have observed the operation of markets in many areas under the policy and CBO and JCT expect that more insurers would participate, so people in almost all areas would be able to buy nongroup insurance (as is projected to be the case throughout the next decade under CBO's baseline projection).[1]

Because they would still be required to bear the costs of CSRs even without payments from the government, participating insurers would raise premiums of "silver" plans to cover the costs. In order to qualify for CSRs, most enrollees must purchase a silver plan through the nongroup insurance marketplace in their area, generally have income between 100 percent and 250 percent of the federal poverty level (FPL), receive premium tax credits toward the silver plan, and not be eligible for other types of coverage, such as employment-based coverage or Medicaid. According to CBO and JCT's projections, for single policyholders, gross premiums (that is, before premium tax credits are accounted for) for silver plans offered through the marketplaces would, on average, rise by about 20 percent in 2018 relative to the amount in CBO's March 2016 baseline and rise slightly more in later years. Such premiums for other plans would rise a few percent during the next two years, on average, above the increases already projected in the baseline in response to uncertainty among states and insurers about how to respond under the policy. In later years, the agencies anticipate, premiums for other plans would not generally rise above baseline projections because CSRs are not available for those plans.

When premiums for silver plans increased under the policy, tax credit amounts per person for purchasing insurance in the nongroup market would increase because the credits are directly linked to those premiums. According to CBO and JCT's projections, many people eligible for the credits with income between 100 percent and 200 percent of the FPL—who, under the baseline, receive most of the cost-sharing reductions paid—would use their increased tax credits to purchase the same silver plans with low cost sharing that they would purchase

1. Under the policy analyzed, because of the timing, insurers would know about the termination of the CSR payments before having to finalize premiums for next year. But if the timing was different, if CSR payments were stopped after premiums were finalized or were already being charged, CBO and JCT expect that additional insurers would exit the marketplaces in 2018 to reduce their financial losses.

under the baseline, and they would pay net premiums (with the tax credits factored in) that were similar to what they would pay if the CSR payments were continued. Alternatively, they could buy insurance that covered less of their health care expenses, and in many of those cases, the tax credits would cover the premiums entirely. Because CBO and JCT anticipate that most insurance commissioners would eventually permit insurers to substantially increase the gross premiums for silver plans in the marketplaces and not to do so for other plans, almost all people at other income levels would then buy other plans. (Under the baseline, some of those people would buy silver plans, and some would buy other plans.)

Effects on the Federal Budget and Health Insurance Coverage

Implementing the policy would increase the federal deficit, on net, by $194 billion from 2017 through 2026, CBO and JCT estimate. Total federal subsidies for health insurance in the nongroup market—in particular, the sum of the premium tax credits and the CSR payments—would increase for two reasons: The average amount of subsidy per person would be greater, and more people would receive subsidies in most years.

Because the tax credits would increase when premiums for silver plans rose, the agencies estimate that the average subsidy per person receiving premium tax credits to purchase nongroup health insurance would increase. Increases in those tax credits for people with income between 100 percent and 200 percent of the FPL would roughly offset the reductions in CSR payments. However, increases in premium tax credits for those with income between 200 percent and 400 percent of the FPL would substantially exceed the small reductions in CSR payments for this group.

By CBO and JCT's estimates, the number of people receiving subsidies for nongroup health insurance would increase under the policy in most years. In particular, because tax credits would increase and gross premiums for plans other than silver plans in the marketplaces would not change substantially, many people with income between 200 percent and 400 percent of the FPL would, compared with outcomes under the baseline, be able to pay lower net premiums for insurance that pays for the same share (or an even greater share) of covered benefits. As a result, more people would purchase plans in the marketplaces than would have otherwise and fewer people would purchase employment-based health insurance—reducing the number of uninsured people, on net, in most years. (Under the policy, demand for employment-based insurance among some employees would be weaker because insurance in the marketplaces would be more attractive, and the agencies expect fewer employers would offer health insurance to their workers in most years.)

During the next two years, the increase in subsidies stemming from those two reasons would be partially offset by lower spending in areas where no insurers participated in the marketplaces in response to the policy, CBO and JCT estimate. In those years, the number of uninsured people would be slightly higher or about the same as under the baseline.

Overall Effects

As a result of the increase in total subsidies under the policy, CBO and JCT project these outcomes, compared with what would occur if the CSR payments were continued:

- The fraction of people living in areas with no insurers offering nongroup plans would be greater during the next two years and about the same starting in 2020;
- Gross premiums for silver plans offered through the marketplaces would be 20 percent higher in 2018 and 25 percent higher by 2020—boosting the amount of premium tax credits according to the statutory formula;
- Most people would pay net premiums (after accounting for premium tax credits) for nongroup insurance throughout the next decade that were similar to or less than what they would pay otherwise—although the share of people facing slight increases would be higher during the next two years;
- Federal deficits would increase by $6 billion in 2018, $21 billion in 2020, and $26 billion in 2026; and
- The number of people uninsured would be slightly higher in 2018 but slightly lower starting in 2020.

Those effects are uncertain and would depend on how the policy was implemented.

For this analysis, the agencies have measured the budgetary effects relative to CBO's March 2016 baseline to

produce estimates most comparable to those published earlier this year for legislation related to the budget reconciliation process for 2017. In an analysis using a preliminary version of updated projections of spending to subsidize health insurance purchased through the marketplaces that will be published soon, CBO and JCT find most of the results to be similar to those discussed here.[2] The main exception is this: Premiums under the policy would rise by a smaller amount in 2018—as the updated projections incorporate some increase in premiums next year as a result of current uncertainty about future CSR payments. Specifically, the agencies now expect that some insurers will assume that CSR payments will not be made in full during 2018 (as some insurers have indicated in preliminary filings), will incorporate the associated costs into their premiums for that year, and will, if CSR payments continue to be made, make adjustments in 2019 to account for them. Those expectations will be reflected in the updated projections but were not included in the March 2016 baseline.

How Key Elements of the Current System Work

In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the average percentage of the total cost of covered medical expenses paid by the insurer (that is, the actuarial value of the plan) differs. The share of medical expenses that is not paid by the insurer is paid by enrollees in the form of deductibles and other cost sharing.

Silver plans differ from other plans because they must provide CSRs to eligible enrollees: The actuarial value depends on the policyholder's income as a percentage of the FPL.[3] Insurers are required to offer such plans to participate in the marketplaces. For people at most income levels, the actuarial value for a silver plan is 70 percent; the average deductible for a single policyholder, for medical and drug expenses combined, is about $3,600 in 2017. People with income between 100 percent and 250 percent of the FPL, however, are generally eligible for silver plans with higher actuarial values (and with lower deductibles), as follows:

- For people with income between 100 percent and 150 percent of the FPL, 94 percent (with an average deductible of about $300);
- For people with income between 150 percent and 200 percent of the FPL, 87 percent (with an average deductible of about $800); and
- For people with income between 200 percent and 250 percent of the FPL, 73 percent (with an average deductible of about $2,900).

Insurance companies can cover those higher shares of health care costs at current premium rates because they receive CSR payments from the federal government based on the number of enrollees they have in each eligibility category. To pay such shares of the cost of benefits in the absence of CSR payments, insurers would raise premiums.

The premium tax credits also reduce the amount that certain low-income people pay for health care in the nongroup market. The eligibility for such tax credits and the method for calculating the credit amounts in the nongroup market would be unchanged under the policy. The size of the premium tax credits depends on household income and on the premiums for a benchmark plan—the second-lowest-cost silver plan—in an enrollee's geographic area. An enrollee eligible for the tax credits pays a certain maximum percentage of his or her income toward the premiums for that benchmark plan, and the credits cover the amount by which the premiums for the benchmark plan exceed that percentage of income.

When the premiums for the benchmark plan go up, the amount of the tax credits goes up, and the amount of the premiums paid by an enrollee who is eligible for the credits is generally unchanged. Hence, an enrollee eligible for the premium tax credits is insulated from variations in premiums in different geographic locations and is also largely insulated from increases in the premiums for the benchmark plan. If a person chooses a plan with premiums higher than those for the benchmark plan, then he or she pays the difference as an additional amount toward the premiums, providing some incentive to choose lower-priced insurance. Similarly, if the person

2. Those updated estimates will be used to adjust the current set of baseline projections of such spending, which were published in June 2017. See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801.

3. In addition, certain Native Americans are eligible for plans with no deductibles or other cost sharing; the eligibility rules for those plans differ.

chooses a plan with premiums lower than the benchmark plan's, then he or she pays a lower cost.

In addition, the federal requirement that health insurers maintain a minimum medical loss ratio, which is equivalent to capping the share of premiums that may go toward insurers' administrative costs and profits, would be unchanged under the policy analyzed here. That requirement, combined with the competitive pressure to attract enrollees to lower-priced insurance in markets with more than one insurer, would eventually constrain increases in premiums for silver plans—even though the sums paid by subsidized enrollees in the marketplaces would largely be determined by their income, and the increases would primarily be borne by the federal government in the form of larger premium tax credits.

Effects on Market Stability

Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people living in areas with participating insurers and on the likelihood of premiums' not rising in an unsustainable spiral. The market for insurance purchased individually with premiums not based on one's health status would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable.

Although premiums have been rising, subsidized enrollees purchasing health insurance coverage in the nongroup market are insulated from increases in premiums when they purchase a plan with premiums at or below those for the benchmark plan because the net premiums they pay are based on a percentage of their income. The subsidies to purchase coverage, combined with the requirement that most people obtain health insurance coverage (also known as the individual mandate), are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas as the ACA is currently being implemented. Under the baseline, fewer than one-half of one percent of people live in areas of the country that are projected to have no participation by insurers in the nongroup market. Several factors may affect insurers' decisions to not participate—including lack of profitability and substantial uncertainty about enforcement of the individual mandate and about future payments for CSRs.

CBO and JCT anticipate that, under this policy, the nongroup insurance market would also continue to be stable in most areas of the country. Subsidies to purchase insurance combined with the individual mandate would maintain sufficient demand for insurance by people with low health care expenditures. Substantial uncertainty about how consumers might respond to the significant increases in premiums following the termination of CSR payments would lead some insurers to withdraw from or not enter the nongroup market in some states, but the agencies anticipate that the situation would be temporary. Under the policy, CBO and JCT estimate, about 5 percent of people live in areas of the country in which insurers would not participate in the nongroup market in 2018, but insurers would participate in nearly all areas by 2020. (If the timing of the policy was different, its effects in 2018 would be different.)

Effects on Gross Premiums Charged by Insurers

Under this policy, average premiums for the second-lowest-cost silver plan offered through the marketplaces for single policyholders would be about 20 percent higher in 2018 than the premiums projected in CBO's March 2016 baseline, mainly because gross premiums alone, rather than premiums in combination with CSR payments, would have to cover the insurer's share of enrollees' health care costs. In 2020 and subsequent years, by CBO and JCT's estimates, the premiums for such benchmark plans would be about 25 percent higher than under the baseline.

Those increases would occur, CBO and JCT expect, because most state insurance commissioners would eventually allow insurers to compensate for the termination of CSR payments by raising premiums substantially for silver plans offered through the marketplaces. The agencies anticipate that insurers would propose to raise premiums for those plans because they are the plans required to bear—through cost-sharing reductions—the costs of having actuarial values of 87 percent or 94 percent for people with income between 100 percent and 200 percent of the FPL who enroll. Many insurance commissioners would favor that increase, CBO and JCT expect, because it would result in larger increases in premium tax credits for people in their states and, thus, lower net premiums paid by enrollees than alternatives that insurers might propose. Very few people at other income levels (facing the same gross premiums but for coverage with an actuarial value of 73 percent or lower)

would then enroll in silver plans in the marketplaces under the policy. Instead, they would purchase other plans, the agencies project.

The gross premiums for bronze plans with actuarial values around 60 percent and gold plans with actuarial values around 80 percent would change much less as a result of the policy, CBO and JCT anticipate, although some increases would occur during the next two years because of insurers' uncertainty about the policy's effects. The agencies expect that most state insurance commissioners would not allow insurers to significantly raise premiums for bronze and gold plans under the policy, especially after a year or two of experience, as those plans are not accompanied with cost-sharing reductions. Allowing premium increases for bronze and gold plans because of increases in costs for silver plans would distort prices in the market, because the increases would not correspond to changes in costs for those plans and would result in lower premium tax credits than if the increases were concentrated among silver plans.

However, for some bronze plans in the marketplaces, CBO and JCT project that gross premiums would modestly increase: those with an actuarial value that insurers would increase (within the allowable range) in an attempt to attract people who would have bought silver plans under the baseline but would not under the policy because of the large premium increases for them.

For gold plans in the marketplaces, the agencies project that gross premiums would be modestly lower under the policy because those plans would attract a larger share of healthier people who, under the baseline, would have bought silver plans. Under the baseline, gold plans tend to attract less healthy people who expect to have high health care expenditures, whereas silver plans attract healthier people as well.[4]

Effects on Net Premiums Paid by Enrollees

CBO and JCT anticipate that many people with income between 100 percent and 200 percent of the FPL purchasing insurance through the marketplaces would enroll in a silver plan with net premiums, after accounting for premium tax credits, that were similar under this policy and under the baseline. Some people in that income range would purchase bronze or gold plans for which the tax credits would cover the premiums entirely; however, in doing so, they would not be eligible for CSRs.

In general, CBO and JCT expect that most purchasers in the nongroup market with income between 200 percent and 400 percent of the FPL could pay net premiums equal to or less than those under the baseline for insurance with an actuarial value the same as (or even greater than) under the baseline. The main reason that purchasers could pay less or obtain a higher actuarial value is that the higher premiums for silver plans would boost the premium tax credit amounts.[5]

For purchasers in the nongroup market with income above 400 percent of the FPL, net and gross premiums would be the same because they are not eligible for premium tax credits. Under the policy, they could pay about the same premiums for bronze or silver plans (by purchasing outside the marketplaces) as under the baseline and lower premiums for gold plans (because of the health of enrollees in the plans), CBO and JCT project.

Effects for People With Income Between 100 Percent and 200 Percent of the FPL

To assess the potential effects of the policy change, CBO and JCT constructed a set of examples to illustrate average amounts for gross premiums, premium tax credits, and net premiums (after accounting for the tax credits) in 2026. The agencies project, for instance, that people with income at 125 percent of the FPL, regardless of age, would pay a net premium of $500 in 2026 to purchase a silver plan—the plan with the highest actuarial value for them—under the policy and $450 under the baseline (see Table 1, at the end of this document).[6] People

4. Federal risk-adjustment payments—which are made under the baseline and would be under the policy as well—aim to compensate insurers whose plans cover less healthy people, but the payments can address the risk only imperfectly. As a result, CBO and JCT anticipate that the greater share of healthy enrollees in gold plans under the policy would contribute to the modest reduction in premiums for those plans even though risk-adjustment payments would be made.

5. For related projections in California's market, see Wesley Yin and Richard Domurat, *Evaluating the Potential Consequences of Terminating Direct Federal Cost-Sharing Reduction (CSR) Funding* (commissioned by Covered California, January 26, 2017), http://tinyurl.com/yb86m89v.

6. Those estimates of net premiums are determined by CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026, which differs under the policy and under the baseline. That projection takes into account the difference in the probability, as estimated under the policy and

with income at 175 percent of the FPL, the agencies estimate, would pay a net premium of $1,850 under the policy and $1,700 under the baseline for a silver plan. Although gross premiums would be higher because of the termination of CSR payments under the policy, net premiums would be determined as a percentage of people's income, and larger premium tax credits would make up most of the difference.

Under the policy, because of the larger premium tax credits (reflecting the higher costs of silver plans), some people in this income range would pay no net premiums for a plan with a higher actuarial value than one they could have purchased with no net premiums under the baseline. For example, under the policy, a 64-year-old with income at 125 percent of the FPL could purchase a gold plan and pay no net premiums but, under the baseline, could obtain only a bronze plan with no net premiums.

Effects for People With Income Between 200 Percent and 400 Percent of the FPL

Under the policy, CBO and JCT anticipate, people with income between 200 percent and 400 percent of the FPL would continue to have access to the same silver plans that they are projected to purchase under the baseline—with net premiums being similar in 2026. For those people, silver plans would have an actuarial value between bronze and gold plans. In the marketplaces, the gross premiums for silver plans would be higher than under the baseline, but premium tax credits for many people in that income range would be larger (see Table 2, at the end of this document). Outside the marketplaces, where such tax credits could not be used, CBO and JCT expect that silver plans would be offered with gross premiums about the same as those charged under the baseline because insurers would design slightly different products for sale there and could therefore price them differently than the plans sold in the marketplaces. Plans outside the marketplaces could be attractive to younger people whose premiums were not a large enough percentage of their income to qualify them for tax credits.

in CBO's March 2016 baseline, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be greater under the policy than it is under the baseline.

However, CBO and JCT project that, under the policy, people with income between 200 percent and 400 percent of the FPL who are eligible for premium tax credits would mostly use those larger amounts to purchase bronze or gold plans rather than silver plans—eventually boosting enrollment in the marketplaces. Bronze plans would have a lower actuarial value and lower premiums than silver or gold plans, offering potential enrollees a trade-off. But gold plans would have a higher actuarial value than silver plans available to people in this income range and, for many of those people, lower net premiums—such that very few of them would choose a silver plan.

For instance, in the agencies' set of illustrative examples for 2026 under the policy, a 40-year-old with income at 225 percent of the FPL could pay a net premium of $1,150 for a bronze plan or $3,050 for a gold plan. (A silver plan would be available with a net premium of $3,350—more than the cost for a gold plan with a higher actuarial value.) Under the baseline, that person could pay $2,050 for a bronze plan, $3,050 for a silver plan, or $4,900 for a gold plan. Thus, under the policy, that person would have lower net premiums for a plan of equal or higher actuarial value.

Gold plans would attract a larger share of enrollees under the policy—mostly people with income between 200 percent and 400 percent of the FPL who would have purchased a silver plan under the baseline. In addition to the larger premium tax credits under the policy, lower gross premiums would eventually contribute to higher enrollment. Under the policy, gross premiums for gold plans would eventually be lower than those for silver plans because, the agencies expect, silver plans would almost exclusively insure people with income between 100 percent and 200 percent of the FPL and (with CSRs) provide actuarial values of 87 percent or 94 percent—significantly higher than the actuarial value of around 80 percent for gold plans. Gross premiums for gold plans under the policy would be modestly lower than under the baseline because, in CBO and JCT's estimation, enrollees would be healthier and therefore have lower health care expenditures.

Enrollees' ages would make a bigger difference in their net premiums for those at the higher end of this income range. A 21-year-old with income at 375 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan ($4,300) or a silver plan ($5,100)

under the policy (by purchasing outside the marketplace) as under the baseline, and $350 less for a gold plan.[7] A 64-year-old with that income would see more attractive options. Such a person could pay a net premium of $6,800 for a gold plan under the policy, compared with $6,750 for a silver plan under the baseline. For a bronze plan, that person could pay $2,300 under the policy, compared with $4,350 under the baseline. Older people's much larger premium tax credits under the policy explain the difference.

Effects for People With Income Above 400 Percent of the FPL

For people with income above 400 percent of the FPL, silver plans offered through the marketplaces would be less attractive than other plans. Because those people are not eligible for premium tax credits, however, the increase in their purchases of gold plans would be proportionately smaller than the increase for people with income between 200 percent and 400 percent of the FPL—and the increase in their purchases of plans outside the marketplaces, proportionately larger. In the agencies' set of illustrative examples, a 40-year-old with income at 450 percent of the FPL, for instance, could pay the same net premium in 2026 for a bronze plan or a silver plan under the policy (by purchasing outside the marketplace) as under the baseline, and $450 less for a gold plan.

Effects on the Federal Budget

CBO and JCT estimate that, on net, adopting this policy would increase the federal deficit by a total of $194 billion over the 2017–2026 period. That change would result from a $201 billion increase in outlays and a $7 billion increase in revenues (see Table 3, at the end of this document).

The total increase in the deficit that would result under the policy includes the following amounts:

- Costs of $247 billion from net increases in marketplace subsidies (an increase of $365 billion for premium tax credits offset by a reduction in CSR payments of $118 billion) stemming from increases in the average subsidy per person for people receiving the ACA's tax credits for premium assistance to purchase nongroup health insurance and in the number of people receiving those subsidies in most years and

- A net increase of $7 billion in federal outlays for Medicaid because of higher enrollment resulting from a reduction in the number of employers offering health insurance to their workers in most years.

Those increases in the deficit would be partially offset by:

- Savings of $47 billion, mostly associated with shifts in the mix of taxable and nontaxable compensation—resulting in more taxable income—from a net decrease in most years in the number of people estimated to enroll in employment-based health insurance coverage, and

- A net increase of $11 billion in revenues resulting from an increase in most years in the number of employers subject to penalties for not offering health insurance.

Effects on Health Insurance Coverage

According to CBO and JCT's estimates, the number of people uninsured under this policy would be about 1 million higher than under the baseline in 2018 but about 1 million lower in each year starting in 2020 (see Table 4, at the end of this document). In 2018, under the policy, the largest effect on coverage would derive from the drop in the number of insurers participating in the nongroup market.

By 2020, the effect on coverage would stem primarily from the increases in premium tax credits, which would make purchasing nongroup insurance more attractive for some people. As a result, a larger number of people would purchase insurance through the marketplaces, and a smaller number of people would purchase employment-based health insurance.

7. CBO and JCT expect that, under the policy, gross premiums for bronze and silver plans offered outside the marketplaces would be about the same as under the baseline and lower than those for plans offered through the marketplaces in most areas. For bronze plans, the agencies anticipate, some insurers would raise the actuarial value of plans offered through the marketplaces to 65 percent (the maximum currently allowed) to try to attract enrollees who might have purchased silver plans if the premiums were lower. Bronze plans offered outside the marketplaces with an actuarial value of 60 percent would have lower premiums. For silver plans, premiums would be lower for ones offered outside the marketplaces because plans offered through the marketplaces would have premiums covering the costs of people eligible for higher actuarial values (of 87 percent and 94 percent).

Uncertainty Surrounding the Estimates

CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes. Such estimates are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by this policy are all difficult to predict.

Under this policy, the responses by states and insurers in the short term are particularly uncertain. For example, under the policy, total federal subsidies would be smaller and the number of uninsured people would be larger if more people lived in areas with no insurers in the marketplaces than the agencies project, and vice versa. Also, the increases in premium tax credits could be larger than CBO and JCT project if states allowed very large increases in premiums in 2018 to ensure that they had at least one insurer in an area. But the increases in tax credits could be smaller than projected if more people than the agencies expect lived in states requiring insurers to spread premium increases in 2018 across bronze, silver, and gold plans in the marketplaces as well as outside them, rather than focusing the increases on silver plans in the marketplaces.

Additional Issues Depending on How the Policy Was Implemented

CBO and JCT analyzed the effects of eliminating the Administration's authority to make CSR payments. For their analysis, the agencies assumed that hypothetical legislation with that end would be enacted by August 31, 2017, and that CSR payments would not be made after December 31, 2017. If the Administration, either of its own volition or in response to a court order, announced by August 31, 2017, that it would not make CSR payments after December 31, 2017, the agencies expect that the results would be similar to those discussed here. If the policy was implemented differently, various additional issues would arise.

Timing

If the announcement date and the effective date for the policy differed from what CBO and JCT used in this analysis, then the effects of the policy would differ. For example, if CSR payments were terminated after insurers had finalized or had begun charging premiums not incorporating such a change, insurers would suffer significant financial losses. To reduce those losses, some insurers would exit the marketplaces in the middle of the year. Some of those marketplaces would have no insurers remaining—reducing federal costs but increasing the number of people who were uninsured. Also, subsequent lawsuits might result in outlays by the federal government. If the effective date for terminating CSR payments was the beginning of 2019 instead of 2018, the effects in 2018 would be much smaller.

Certainty

Implementation of the policy through legislation, as opposed to executive or judicial action, would provide greater certainty about how the ACA would be carried out in the short term. Executive or judicial action could very well be challenged in lawsuits that would take some time to resolve—potentially extending the number of years insurers might not participate in the marketplaces.

CBO's Baseline

In CBO and JCT's initial cost estimate for the ACA and in subsequent baseline projections, the agencies have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action)—a conclusion reached because the cost-sharing subsidies were viewed as a form of entitlement authority. The statute that specifies construction of the baseline requires that CBO assume full funding of entitlement authority.[8]

In 2014, the government began making payments for cost-sharing subsidies, and the House of Representatives subsequently brought a lawsuit challenging the department's authority to make such payments. On May 12, 2016, the District Court for the District of Columbia held that the government did not have the authority to make payments for cost-sharing subsidies but allowed it to continue making payments pending appeal. On February 22, 2017, at the request of the House of Representatives and the Administration, the U.S. Court of Appeals for the District of Columbia Circuit agreed to hold the appeal in abeyance while the Congress and the Administration seek a resolution, presumably through legislation. On August 1, 2017, that court allowed 17 states and the District of Columbia to intervene in the case, so future actions in the case will now involve those parties in addition to the House of Representatives and the Administration.

8. See section 257(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985; 2 U.S.C. §907(b)(1).

CBO has not made any changes to its baseline projections in response to that court case because the case is on appeal and the Administration has continued to make the payments for cost-sharing subsidies. CBO typically updates its baseline budget projections at specific times each year to reflect legislative action, economic changes, and other developments. During the course of a year, however, events occur (usually, the enactment of legislation, actions by the courts, or decisions by executive branch agencies) that are different from those anticipated in developing the baseline projections. If new information indicates that an action or event that would affect CBO's baseline has happened or definitely will happen, CBO incorporates that information in its next regular update of its baseline. In addition, CBO immediately takes that information into account in assessing what will happen under current law when it analyzes the effects of legislation being considered by the Congress, even if the agency has not published new baseline projections.

If the Administration stopped making CSR payments because of executive or judicial action, CBO's typical procedures for updating its baseline would not necessarily apply because of the conflict between that action and the statutory requirements for constructing the baseline. Specifically, because the CSR payments are considered an entitlement, projections incorporating that action would differ from ones reflecting the statutory requirement that CBO assume full funding of entitlement authority. Hence, CBO would consult with the Budget Committees to decide whether and how to reflect the action in the agency's baseline and cost estimates. If the policy was implemented through legislation, no such conflict would arise, and its effects would be reflected in the baseline and cost estimates immediately.

Methodology

This policy's effects would depend in part on how individuals responded to changes in the prices, after subsidies, they had to pay for nongroup insurance and on their underlying desire for such insurance. Effects would also stem from how businesses responded to changes in those prices for nongroup insurance and in the attractiveness of other aspects of nongroup alternatives to employment-based insurance.

To capture those complex interactions, CBO uses a microsimulation model to estimate how rates of coverage and sources of insurance would change as a result of alterations in eligibility and subsidies for—and thus the net cost of—various insurance options. Based on survey data, that model incorporates a wide range of information about a representative sample of individuals and families, including their income, employment, health status, and health insurance coverage. The model also incorporates information from the research literature about the responsiveness of individuals and employers to price changes and the responsiveness of individuals to changes in eligibility for public coverage. CBO regularly updates the model so that it incorporates information from the most recent administrative data on insurance coverage and premiums. CBO and JCT use that model—in combination with models to project tax revenues, models of spending and actions by states, projections of trends in early retirees' health insurance coverage, and other available information—to inform their estimates of the numbers of people with certain types of coverage and the associated federal budgetary costs.[9]

This document was requested by the House Democratic Leader and the House Democratic Whip. Kate Fritzsche, Jeffrey Kling, Sarah Masi, Eamon Molloy, and Allison Percy prepared it with guidance from Jessica Banthin and Holly Harvey and with contributions from Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, and the staff of the Joint Committee on Taxation. Chad Chirico, Theresa Gullo, Mark Hadley, Alexandra Minicozzi, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

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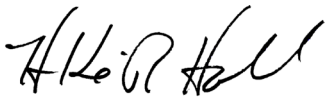

Keith Hall
Director
August 2017

9. For additional information, see Congressional Budget Office, "Methods for Analyzing Health Insurance Coverage" (accessed August 14, 2017), www.cbo.gov/topics/health-care/methods-analyzing-health-insurance-coverage.

Table 1. Illustrative Examples, for Single Individuals With Income Under 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Gold Plan				Silver Plan			
	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]
Single Individual With Annual Income of $18,900 (125 percent of FPL) and Not Eligible for Medicaid[d]												
Under the Baseline												
21 years old	4,300	4,300	0		*6,550*	*4,650*	*1,900*		5,100	4,650	450	
40 years old	5,500	5,500	0	60	*8,350*	*6,050*	*2,300*	80	6,500	6,050	450	94
64 years old	12,900	12,900	0		*19,650*	*14,850*	*4,800*		15,300	14,850	450	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,700	0		6,200	5,900	300		6,400	5,900	500	
40 years old	6,000	6,000	0	65	7,900	7,700	200	80	8,200	7,700	500	94
64 years old	*14,100*	*14,100*	*0*		18,600	18,600	0		19,200	18,700	500	
Single Individual With Annual Income of $26,500 (175 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	3,400	900		*6,550*	*3,400*	*3,150*		5,100	3,400	1,700	
40 years old	5,500	4,800	700	60	*8,350*	*4,800*	*3,550*	80	6,500	4,800	1,700	87
64 years old	12,900	12,900	0		*19,650*	*13,600*	*6,050*		15,300	13,600	1,700	
Under the Policy, in the Marketplaces												
21 years old	4,700	4,550	150		6,200	4,550	1,650		6,400	4,550	1,850	
40 years old	6,000	6,000	0	65	7,900	6,350	1,550	80	8,200	6,350	1,850	87
64 years old	14,100	14,100	0		18,600	17,350	1,250		19,200	17,350	1,850	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under the baseline and under a policy in which CSR payments to insurers are eliminated. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. Premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage grows over time. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The subsidy amounts in this example would range from $1,600 for a 21-year-old with income at 125 percent of the FPL to $4,750 for a 64-year-old at the same income level and from $1,100 for a 21-year-old with income at 175 percent of the FPL to $3,350 for a 64-year-old at the same income level. Under current law, CSRs generally have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $18,900 will equal 125 percent of the FPL and an income of $26,500 will equal 175 percent of the FPL.

Table 2. Illustrative Examples, for Single Individuals With Income Over 200 Percent of the FPL, of Subsidies for Nongroup Health Insurance in 2026 Under CBO's Baseline and Under a Policy Eliminating CSR Payments

Dollars

	Bronze Plan				Silver Plan				Gold Plan			
	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan After Cost-Sharing Subsidies (Percent)[c]	Premium[a]	- Premium Tax Credit[b]	= Net Premium Paid	Actuarial Value of Plan (Percent)[c]
Single Individual With Annual Income of $34,100 (225 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	2,050	2,250		5,100	2,050	3,050		6,550	2,050	4,500	
40 years old	5,500	3,450	2,050	60	6,500	3,450	3,050	73	8,350	3,450	4,900	80
64 years old	12,900	12,250	650		15,300	12,250	3,050		19,650	12,250	7,400	
Under the Policy, In the Marketplaces												
21 years old	4,700	3,050	1,650		*6,400*	*3,050*	*3,350*		6,200	3,050	3,150	
40 years old	6,000	4,850	1,150	65	*8,200*	*4,850*	*3,350*	73	7,900	4,850	3,050	80
64 years old	14,100	14,100	0		*19,200*	*15,850*	*3,350*		18,600	15,850	2,750	
Under the Policy, Outside the Marketplaces												
21 years old	*4,300*	*0*	*4,300*		*5,100*	*0*	*5,100*		*6,200*	*0*	*6,200*	
40 years old	*5,500*	*0*	*5,500*	60	*6,500*	*0*	*6,500*	73	*7,900*	*0*	*7,900*	80
64 years old	*12,900*	*0*	*12,900*		*15,300*	*0*	*15,300*		*18,600*	*0*	*18,600*	
Single Individual With Annual Income of $56,800 (375 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	8,550	4,350		15,300	8,550	6,750		19,650	8,550	11,100	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		*6,400*	*0*	*6,400*		6,200	0	6,200	
40 years old	6,000	800	5,200	65	*8,200*	*800*	*7,400*	70	7,900	800	7,100	80
64 years old	14,100	11,800	2,300		*19,200*	*11,800*	*7,400*		18,600	11,800	6,800	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	*5,500*	*0*	*5,500*	60	6,500	0	6,500	70	*7,900*	*0*	*7,900*	80
64 years old	*12,900*	*0*	*12,900*		*15,300*	*0*	*15,300*		*18,600*	*0*	*18,600*	
Single Individual With Annual Income of $68,200 (450 percent of FPL)[d]												
Under the Baseline												
21 years old	4,300	0	4,300		5,100	0	5,100		6,550	0	6,550	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	8,350	0	8,350	80
64 years old	12,900	0	12,900		15,300	0	15,300		19,650	0	19,650	
Under the Policy, In the Marketplaces												
21 years old	4,700	0	4,700		*6,400*	*0*	*6,400*		6,200	0	6,200	
40 years old	6,000	0	6,000	65	*8,200*	*0*	*8,200*	70	7,900	0	7,900	80
64 years old	14,100	0	14,100		*19,200*	*0*	*19,200*		18,600	0	18,600	
Under the Policy, Outside the Marketplaces												
21 years old	4,300	0	4,300		5,100	0	5,100		6,200	0	6,200	
40 years old	5,500	0	5,500	60	6,500	0	6,500	70	7,900	0	7,900	80
64 years old	12,900	0	12,900		15,300	0	15,300		18,600	0	18,600	

Continued

Table 2 continued.

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

All dollar figures have been rounded to the nearest $50. Amounts in light italic type show premiums for plans that very few people would buy because either more comprehensive coverage would be available at the same or a lower cost or equivalent coverage would be available at a lower cost.

CSR = cost-sharing reduction; FPL = federal poverty level.

a. For this illustration, CBO projected the average national premiums for a 21-year-old in the nongroup health insurance market in 2026 both under the baseline and under a policy in which CSR payments to insurers are eliminated. On the basis of those amounts, CBO calculated premiums for a 40-year-old and a 64-year-old, assuming that the person lives in a state that uses the federal default age-rating methodology, under which 64-year-olds can be charged premiums that are three times as much as those for 21-year-olds. CBO projects that, under both the baseline and the policy, most states will use the default 3-to-1 age-rating curve.

b. Premium tax credits are calculated as the difference between the reference premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage grows over time. The reference premium under current law is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which the person resides. CBO's projection of the maximum percentage of income for calculating premium tax credits in 2026 takes into account the difference in the probability, as estimated in CBO's March 2016 baseline and under the policy eliminating CSR payments, that the specified percentages of income would be increased. Such an increase would apply if total federal subsidies through the marketplaces (including subsidies for both premiums and cost sharing) exceeded 0.504 percent of gross domestic product in the preceding year. CBO projects that the probability of reaching that percentage would be higher under the policy than it is under the baseline.

c. The actuarial value of a plan is the percentage of costs for covered services that the plan pays on average. The federal government's CSR payments to insurers reduce the cost-sharing amounts (out-of-pocket payments required under insurance policies) for covered people whose income is generally between 100 percent and 250 percent of the FPL. The subsidy amounts in this example would range from $150 for a 21-year-old with income at 225 percent of the FPL to $450 for a 64-year-old at the same income level. Under current law, CSRs generally have the effect of increasing the actuarial value of the plan from 70 percent for a typical silver plan to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent. For people whose income is greater than 250 percent of the FPL, a silver plan would have a standard 70 percent actuarial value.

If CSR payments were eliminated, insurers would still have to provide plans with reduced cost-sharing to qualified individuals at the specified income levels. CBO projects that state insurance commissioners would most likely direct insurers to incorporate the amounts into the premiums only for silver plans because doing so would best take advantage of increases in premium tax credits. CBO anticipates that in most states, bronze plans available in the marketplaces would have an actuarial value of 65 percent, and gold plans, 80 percent. Silver plans would have an actuarial value of 70 percent for those not eligible for CSRs and 73 percent, 87 percent, or 94 percent for those eligible. Outside the marketplaces, plans would be available at actuarial values of 60 percent, 70 percent, and 80 percent, CBO anticipates.

The premiums for plans reflect not only the difference in the percentage of costs paid but also the effects of induced demand, as people in plans with a higher actuarial value tend to consume more health services, and risk selection, as people with higher expected health care costs are more likely to buy plans with higher actuarial values. A risk-adjustment program under the Affordable Care Act mitigates but does not fully eliminate the effect of risk selection.

Because plans and premiums available in and outside the marketplaces would differ more under the policy than they do under current law, individuals would have a greater incentive to compare options in both markets.

d. Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. CBO projects that in 2026, a modified adjusted gross income of $34,100 would equal 225 percent of the FPL, an income of $56,800 will equal 375 percent of the FPL, and an income of $68,200 will equal 450 percent of the FPL.

Table 3. Estimate of the Net Budgetary Effects of Terminating Payments for Cost-Sharing Reductions

Billions of Dollars, by Fiscal Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017-2026
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	6	13	22	28	32	35	36	37	37	247
Medicaid	0	-1	-1	*	1	1	1	2	2	2	7
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	*	*	-1	-1	-2	-2	-2	-3	-11
Change in Penalty Payments by Uninsured People	0	0	*	*	*	*	*	*	*	*	*
Medicare[d]	0	0	*	*	*	*	*	*	*	*	-2
Other Effects on Revenues and Outlays[e]	0	1	1	-1	-4	-7	-8	-9	-10	-10	-47
Total Effect on the Deficit	**0**	**6**	**14**	**21**	**24**	**25**	**26**	**26**	**26**	**26**	**194**
Memorandum:											
Total Changes in Direct Spending	0	4	9	17	23	26	30	31	31	31	201
Total Changes in Revenues[f]	0	-3	-5	-4	-1	2	3	5	5	5	7
Details of Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues											
Premium tax credits											
Effects on outlays	0	13	22	29	35	38	41	43	44	44	309
Effects on revenues	0	2	4	5	6	7	8	8	8	8	56
Subtotal	0	15	25	35	41	45	49	51	52	52	365
Cost-sharing outlays	0	-8	-12	-13	-13	-13	-14	-14	-15	-16	-118
Outlays for the Basic Health Program	0	*	*	*	*	*	*	*	*	*	*
Collections for risk adjustment	0	0	-1	-1	-1	-1	-1	-1	-1	-1	-6
Payments for risk adjustment	0	0	1	1	1	1	1	1	1	1	6
Total	0	6	13	22	28	32	35	36	37	37	247

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. Budget authority would be equal to the outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. Related spending and revenues includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 4. Effects of Terminating Payments for Cost-Sharing Reductions on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Total Population Under Age 65	273	274	275	276	276	277	278	279	279	280
Uninsured Under Current Law	26	26	27	27	27	27	27	28	28	28
Change in Coverage Under the Policy										
Medicaid[a]	0	*	*	*	*	*	*	*	*	*
Nongroup coverage, including marketplaces	0	-1	*	2	3	3	4	4	3	3
Employment-based coverage	0	1	*	-1	-2	-3	-3	-3	-3	-3
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	1	*	-1	-1	-1	-1	-1	-1	-1
Uninsured Under the Policy	26	27	27	27	26	27	27	27	27	27
Percentage of the Population Under Age 65 With Insurance Under the Policy										
Including all U.S. residents	90	90	90	90	90	90	90	90	90	90
Excluding unauthorized immigrants	93	92	93	93	93	93	93	93	93	93

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Estimates are based on CBO's March 2016 baseline, adjusted for subsequent legislation. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under the age of 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and 500,000.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity

FINAL REPORT

SEPTEMBER 14, 2017

NATIONAL QUALITY FORUM

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CONTENTS

EXECUTIVE SUMMARY

Despite overall improvements in public health and medicine, disparities in health and healthcare persist. In 2015, the Centers for Disease Control and Prevention reported significant health and healthcare disparities in leading causes of death. For example, African Americans are more likely to die prematurely from heart disease; the prevalence of heart disease is higher for individuals with lower incomes and lower educational attainment; and individuals with disabilities face disproportionately higher levels of health care need and cost. In addition, the *2016 National Healthcare Quality and Disparities* report highlighted significant disparities in healthcare quality. Racial and ethnic minorities, individuals with disabilities, individuals who have low incomes, and individuals with other social risk factors are more likely to receive lower quality care. Eliminating these disparities has become the priority of the U.S. Department of Health and Human Services (HHS) and many other stakeholder groups.

Performance measurement is an essential yet underused tool for advancing health equity. Measurement allows the monitoring health disparities and assessment of the level to which interventions known to reduce disparities should be employed. Performance measures can also allow stakeholders to assess the impact of interventions known to reduce disparities. Moreover, measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality.

Measurement increasingly serves as a driver for healthcare payment. The growing adoption of global payment systems, alternative payment models (e.g., accountable care organizations [ACOs]), and value-based purchasing offers expanded opportunities for the healthcare system to better address disparities and incentivize the achievement of equity. However, a systematic approach requires use of both measurement and associated policy levers for eliminating disparities and promoting health equity. Stakeholders need a guiding roadmap to help them coordinate and systematically implement strategies for reducing disparities through measurement. Because many quality measures used in alternative payment models, particularly outcome measures, show disparities that may or may not reflect disparities in underlying processes of care, it is essential that these models are not implemented in such a way that safety net providers are unfairly penalized.

The National Quality Forum (NQF) convened a multistakeholder Committee, with funding from the U.S. Department of Health and Human Services (HHS), to provide recommendations on how performance measurement and its associated policy levers can be used to reduce disparities in health and healthcare. The Disparities Standing Committee developed its recommendations by focusing on selected conditions as case studies: cardiovascular disease, cancer, diabetes and chronic kidney disease, infant mortality/low birthweight, and mental illness. Disparities within these conditions were reviewed based on the social risk factors outlined in the 2016 National Academy of Medicine (NAM) report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Three interim reports document each phase of the project:

- report 1: a review of the evidence that describes disparities in health and healthcare outcomes;
- report 2: a review of interventions that have been effective in reducing disparities;

- report 3: an environmental scan of performance measures and assessment of gaps in measures that can be used to assess the extent to which stakeholders are deploying effective interventions to reduce disparities.

This final report presents a roadmap for reducing health and healthcare disparities through performance measurement and associated policy levers. The roadmap primarily focuses on ways in which the U.S. healthcare system (i.e., providers and payers) can use more traditional pathways to eliminate disparities; however, it also identifies areas where collaboration and community partnerships can be used to expand the healthcare system's role to better address disparities. The roadmap lays out four actions, "Four I's for Health Equity," that healthcare stakeholders can employ to reduce disparities:

- **Identify** and prioritize reducing health disparities
- **Implement** evidence-based interventions to reduce disparities
- **Invest** in the development and use of health equity performance measures
- **Incentivize** the reduction of health disparities and achievement of health equity

In the first action, the Committee recommends that measure implementers prioritize the use of measures that are sensitive to disparities in health and healthcare. The Committee noted that stakeholders such as policymakers, payers, and purchasers should leverage existing performance measures, quality improvement, and value-based purchasing programs by implementing disparities-sensitive measures and stratifying them by subgroups to identify disparities. The second action calls for stakeholders to implement evidence-based interventions to reduce disparities at every level of the healthcare system (i.e., government, community, organization, and individual levels). The third action calls for the development and use of health equity performance measures that can be used to assess the use of interventions known to reduce disparities. The Committee developed five domains of measurement that should be used together to advance health equity: collaboration and partnerships, culture of equity, structures for equity, equitable access to care, and equitable high-quality care. The final and fourth action involves incentivizing the reduction of disparities. The use of measurement for reporting and accountability can powerfully promote health equity. However, stakeholders across the U.S. healthcare system must be motivated to act on the results of health equity measures and drive towards improved performance while ensuring that providers have the resources necessary to care for those who are most vulnerable. Although performance measurement is only a tool for advancing health equity, it can have a significant impact on reducing disparities.

To guide implementation of the roadmap, the Committee developed 10 recommendations:

1. Collect social risk factor data.
2. Use and prioritize stratified health equity outcome measures.
3. Prioritize measures in the domains of Equitable Access and Equitable High-Quality Care for accountability purposes.
4. Invest in preventive and primary care for patients with social risk factors.
5. Redesign payment models to support health equity.
6. Link health equity measures to accreditation programs.
7. Support closing disparities by providing additional payments to providers who care for patients with social risk factors.
8. Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.
9. Fund care delivery and payment reform demonstration projects to reduce disparities.
10. Assess economic impact of disparities from multiple perspectives.

The roadmap defines a path for systematically reducing disparities in health and healthcare. The Four I's for Health Equity represent four strategies for healthcare stakeholders to reduce disparities and advance health equity. NQF is committed to collaborating with stakeholders within healthcare and beyond to achieve health equity.

BACKGROUND

The World Health Organization's (WHO) constitution states that the attainment of the highest possible standard of health is a fundamental right of every human being, regardless of race or socioeconomic status. The WHO recognizes the importance of healthcare in achieving health, noting that "the extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health." While there have been significant improvements in medicine and our collective understanding of the impact of social determinants of health on health outcomes, the current reality falls short of this ideal. Many individuals residing throughout the United States continue to face disparities in both health and healthcare. Health equity can only be achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1]

The HHS Office of Minority Health describes a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (based on an individual's gender, age, race, and/or ethnic group, etc.). The Centers for Disease Control and Prevention (CDC) report, *Health Disparities and Inequalities Report-United States, 2013,* found racial and ethnic disparities in mortality due to heart disease and stroke, socioeconomic disparities in the prevalence of diabetes, disparities in suicide rates based on gender, and many others.[2] Healthcare disparities are related to "differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions" (i.e., differences based on discrimination and stereotyping).[3] The *2016 National Healthcare Quality and Disparities Report* found disparities in healthcare related to race, ethnicity, and socioeconomic status (SES) that persist across all National Quality Strategy (NQS) priorities.[4] Poor households received worse care than people in high-income households for about 60 percent of quality measures. African Americans, Hispanics, and American Indians and Alaska Natives received worse care than whites for about 40 percent of quality measures, and Asians and Pacific Islanders received worse care for about 30 percent of the measures.[5]

The reduction of disparities and promotion of health equity have been a goal for the U.S. healthcare system for decades. For instance, the 1983 *President's Commission for the Study of Ethical Problems in Medicine, Biomedicine, and Behavioral Science Research* declared that equitable access to care requires that all citizens have the ability to secure an adequate level of care, as access is a critical driver of health disparities.[6] In the 2001 report, *Crossing the Quality Chasm,* the National Academy of Medicine (NAM) (formally the Institute of Medicine) established equity as an essential aspect of healthcare quality, noting that equitable care does not vary in quality because of social characteristics such as gender, ethnicity, geographic location, and socioeconomic status (SES).[7] Other seminal reports like *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* demonstrated that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for factors such as insurance, SES, comorbidities, and stage of presentation.[8]

Addressing health and healthcare disparities is a priority for both public- and private-sector stakeholders. For instance, the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities and National Partnership for Action to End Health Disparities*, *The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with*

Disabilities, *Healthy People 2020*, the *2013 HHS Language Access Plan*, the *Centers for Medicare and Medicare Services (CMS) Equity Plan for Improving Quality in Medicare*, and provisions in the Affordable Care Act (ACA) have all prioritized the reduction of health and healthcare disparities. The Institute for Healthcare Improvement (IHI) has highlighted the "forgotten" quality aim of health equity, and the Robert Wood Johnson Foundation (RWJF) has donated significant resources towards research and initiatives to improve health equity. In addition, The California Endowment, Aetna Foundation, and the Kresge Foundation have all invested in work to reduce disparities and promote health equity. These are only a few example of commitments that have led to development of guidance and many interventions to reduce disparities, but the implementation of these intervention efforts are rarely systematic and have yet to achieve desired advances in health equity.

Performance measurement can illuminate the healthcare system's progress towards achieving health equity (variation and poor performance) and incentivize both improvement and innovation through accountability. Performance measurement is the regular collection of data to assess whether the correct processes are being performed, structures are in place, and desired results are being achieved.[9] In the same way, performance measures can assess the extent to which stakeholders are employing effective interventions to reduce disparities. Therefore, measures are a critical tool in the effort to promote health equity.

Several organizations have developed guidance on the use of measurement for reducing disparities. For example, the Robert Wood Johnson Foundation (RWJF) has published several reports with recommendations for data collection and performance measurement strategies to reduce disparities. These recommendations include creating a nationwide health information infrastructure to facilitate health disparities research[10] and stratifying quality measures by social risk factors to uncover and respond to disparities.[11] The Commonwealth Fund has also published guidance on data collection to support the detection of disparities and strategies for closing gaps.[12] In addition, the 2016 NAM report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors,* (released in response to provisions in the IMPACT Act and the first of five reports) defines SES and other social risk factors that could be accounted for in Medicare payment and quality programs.[13] The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) also released guidance in 2016 for accounting for social risk in value-based purchasing programs with recommendations to stratify measures by patient demographic characteristics, adjust performance measure scores, directly adjust payment, and restructure payment incentives.

Performance measurement in healthcare, while critical to monitoring and reducing disparities, is one of many tools needed to eliminate health disparities. Public policy also shapes the environment to promote healthy lifestyles, expand access to care through insurance coverage, eliminate environmental hazards, determine the racial and ethnic distribution of housing, optimize the equitable distribution of food, transportation, vital services, and utilities, and promote many other efforts to advance health equity. The causes of disparities represent complex interactions among institutional, historical, and sociopolitical factors that can only be fully addressed through a variety of mechanisms. Eliminating disparities in health and healthcare will require reengineering the systems that drive disparities and employing interventions that mitigate the impact of social risk on the health of individuals.

PROJECT OVERVIEW

The National Quality Forum (NQF), with funding from the Department of Health and Human Services (HHS), convened a multistakeholder Committee (Appendix F), comprising experts in disparities, social risk factors, and healthcare quality improvement, clinical, and measurement expertise to develop a roadmap that demonstrates how performance measurement and its associated policy levers can be used to eliminate disparities. The Disparities Standing Committee focused on the leading causes of morbidity and mortality (i.e., cardiovascular disease, cancer, diabetes, chronic kidney disease, infant mortality, low birthweight, and mental illness) to serve as use cases for the identification of disparities and performance measures that can be used to monitor and reduce disparities. However, the Committee's recommendations apply to all conditions where health and healthcare disparities exist.

Each phase of the Committee's work is documented in a series of three interim reports, which are posted to the NQF disparities project webpage. The three interim reports support the primary objectives of the project, which were to:

- review the evidence that describes disparities in health and healthcare outcomes;
- review the evidence of interventions that have been effective in reducing disparities;
- perform an environmental scan of performance measures and assess gaps in measures that can be used to assess the extent to which stakeholders are deploying effective interventions to reduce disparities; and
- provide recommendations to reduce disparities through performance measurement and associated policies.

The Committee used the findings in the three interim reports to create a roadmap for reducing disparities through measurement (roadmap development process included in Appendix C). This final report presents the Committee's recommendations.

THE ROADMAP

The growing adoption of global payment systems, alternative payment models (e.g., accountable care organizations [ACOs]), and value-based contracts, has expanded opportunities for the US healthcare system to better address disparities (including through community partnerships). Performance measurement offers an opportunity to assess, support, and incentivize the reduction of disparities. For these reasons, a roadmap is needed to guide stakeholders in coordinating and systematically implementing strategies for reducing disparities through measurement. In developing the roadmap, the Committee recognized that many conceptual models/frameworks/roadmaps have been developed to demonstrate why disparities exist and how they can be reduced. NQF has also engaged in extensive work to better understand the role quality measurement can play in reducing disparities. The Committee built on this work by developing a roadmap with the unique goal of demonstrating how performance measurement can be used to promote health equity and eliminate disparities. The roadmap sets an aspirational goal of eliminating disparities in health and healthcare by describing actions to achieve this goal.

The roadmap builds on the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. It integrates existing conceptual models and guidance to form a comprehensive set of strategies for sparking performance measure development and incentivizing the use of measures for reducing disparities. Namely, it draws on the NAM report, *Accounting for Social Risk Factors in Medicare: Identifying Social Risk Factors,* which highlights key social risk factors that include socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context. It also incorporates concepts from the five A's of access to care defined by Penchansky and Thomas: affordability, availability, accessibility, accommodation, and acceptability.[14] The roadmap primarily focuses on ways the U.S. healthcare system (i.e. providers and payers) can use more traditional pathways to eliminate disparities; however, it also identifies areas where collaboration and community partnerships can be used to expand the healthcare system's role to better address disparities.

The roadmap provides guidance for addressing a wide spectrum of disparities based on age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and other social risk factors. It emphasizes the importance of cultural competence, community engagement, and cross-sector partnerships to reduce disparities. In particular, the roadmap includes measurement beyond clinical settings, structures, and processes of care. For example, it includes the assessment of collaboration between healthcare and other sectors (e.g., schools, social services, transportation, housing, etc.) to reduce the impact of social risk factors. Figure 1 illustrates the roadmap's four actions, "Four I's for Health Equity" (i.e., identify, implement, invest, and incentivize)., stakeholders should employ to promote health equity and reduce disparities.

FIGURE 1. A ROADMAP FOR PROMOTING HEALTH EQUITY AND REDUCING DISPARITIES

Although the primary audience for the roadmap is public- and private-sector payers, achieving health equity will require a meaningful commitment and efforts from all stakeholders in the U.S. healthcare system. Consequently, the actions presented in the roadmap allow multiple stakeholders to identify how they can begin to play a part in reducing disparities and promoting health equity. For example, hospitals and/or health plans can identify and prioritize reducing disparities by stratifying performance measures that can detect and monitor known disparities and distinguish which they can address in the near, medium, and long-term. Clinicians can implement evidence-based interventions by connecting patients to community-based services or culturally tailored programs shown to mitigate the drivers of disparities. Healthcare organizations and researchers can test new interventions to add to the current evidence base. Measure developers can work with patients to translate concepts of equity into performance measures that can directly assess health equity. Policy-makers and payers can incentivize the reduction of disparities and the promotion of health equity by building health equity measures into new and existing healthcare payment models. These are only a few of the many ways the roadmap can be implemented and only some of the stakeholders that can act on its recommendations.

Identify and Prioritize Reducing Health Disparities

The use of measurement to identify disparities can help to ensure that all individuals receive quality healthcare regardless of their social risk factors. Measurement can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality. While national disparities are well documented, individual health and healthcare organizations usually do not systematically assess disparities within the populations they serve. Moreover,

the volume of existing measures can make prioritization a challenge, but measures that can help to monitor and reduce disparities should be prioritized. The Disparities Standing Committee built on NQF's 2011 commissioned white paper, developed by researchers at Harvard Medical School and Massachusetts General Hospital, which focused on implications of measurement for health and healthcare disparities.

The white paper provides guidance on criteria for selecting measures that can be used for identifying disparities based on race, ethnicity, and language proficiency. However, many of the recommendations apply to disparities based on all social risk factors. The white paper explains how disparities-sensitive measures can be used to identify and prioritize the reduction of disparities. Disparities-sensitive measures detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups. The ability of hospitals, health plans, and other healthcare organizations to identify disparities depends on their capacity to collect information on an individual's sociodemographic characteristics. Once these data are collected, healthcare organizations should routinely stratify performance measures to monitor disparities. The authors of the white paper reviewed guiding principles established by an NQF Steering Committee in 2008, included in the report *National Voluntary Consensus Standards for Ambulatory Care-Measuring Healthcare Disparities*, and provided recommendations for refining the criteria.[15]

The Disparities Committee considered these recommendations and revised the criteria to include four key areas of consideration:

1. **Prevalence**—How prevalent is the condition among populations with social risk factors? What is the impact of the condition on the health of populations with social risk factors?
2. **Size of the disparity**—How large is the gap in quality, access, and/or health outcome between the group with social risk factors and the group with the highest quality ratings for the measure?
3. **Strength of the evidence**—How strong is the evidence linking improvement in performance on the measure to improved outcomes in the population with social risk factors?
4. **Ease and feasibility of improvement (actionable)**—Is the measure actionable (e.g. by providers/clinicians/health plans, etc.) among the population with social risk factors?

The authors of the white paper noted that prevalence is important for disparities sensitivity because disparities that are relatively more widespread in populations with social risk factors (e.g. end-stage renal disease, diabetes, and congestive heart failure) may allow for the detection of disparities that have not yet been identified. Further, understanding the quality gap is often even more important if there is evidence that demonstrates differences in quality, access, or health outcomes. If a gap is found, there must be an assessment of whether changes in performance, assessed by the measure, actually leads to improved outcomes in the population with social risk factors. Lastly, some measures assess structures, processes, and outcomes that are more actionable by providers, health plans, communities and other stakeholders. Stakeholders should consider whether there is an entity or group of entities that can take action to improve performance as assessed by the measure. Examples of disparities sensitive measures are included in Table 1 and a more extensive list is included in Appendix D.

TABLE 1. EXAMPLES OF DISPARITIES-SENSITIVE MEASURES

Selected Condition	Measure Title	Measure Steward
Cardiovascular disease	Controlling high blood pressure (diagnosis of hypertension and blood pressure adequately controlled during the measurement period)	CMS/NCQA
Diabetes	Hemoglobin A1c Poor Control (A1c > 9.0% during the measurement period)	NCQA
Cancer	Colorectal cancer screening (appropriate screening for colorectal cancer)	NCQA
Mental health	Initiation and engagement of alcohol and other drug dependence treatment (new episode of alcohol or other drug dependence and received treatment)	NCQA/WC
Low birth weight (PQI9)	Low birth weight (assess the number of low birth weight infants per 100 births)	AHRQ

The Committee acknowledged some of the challenges to identifying disparities-sensitive measures. First, data on social risk factors can be limited, making it hard to explore performance by social group. The Committee also noted the need to ensure patient privacy and that small numbers can make it difficult to stratify while preserving privacy and confidentiality. While small numbers should not be publicly reported, small population sizes should not be used as a justification for not collecting or stratifying data in the first place. When there are concerns that may prevent the reporting of data, oversampling and multiyear pooling techniques should be considered. Stratification should not be used to create an impression that different levels of quality of care are acceptable.

Implement Evidence-Based Interventions to Reduce Disparities

The second action of the roadmap involves the identification of interventions that reduce disparities in health and healthcare. The reduction of disparities will require multilevel, systemic, and sustained interventions. To illustrate the different levels that contribute to the reduction of disparities, the Committee modified the Social-Ecological Model (SEM) to apply to health systems. The SEM illustrates the interactions among various personal and environmental factors that influence health. The Committee extended the SEM to reflect the findings of Chin et al. and others who demonstrated the need for interventions by government, communities, organizations, and providers (with improved patient/individual outcomes as the ultimate target of interventions).[16] By leveraging multiple stakeholders throughout the system, these interventions can lead to improved outcomes for people with social risk factors, helping to demonstrate measurable progress towards achieving health equity.

The Committee built on the work of Cooper et al. that outlined drivers and mediators of disparities. Cooper et al. recognized the impact of individual, financial, structural, social-political, cultural, community, and healthcare system factors on disparities. However, the Cooper et al. framework focuses primarily on disparities based on race and ethnicity. Therefore, the Committee expanded the scope by identifying additional drivers that apply to other social risk factors and including interventions that the healthcare system could use to amplify the effects of the mediators of disparities. The Committee directed a review of the literature to identify effective interventions to reduce disparities based on the modified Cooper et al. framework. The interventions were categorized by the accountable entity as illustrated in the modified SEM in Figure 3.

FIGURE 2. MODIFIED SOCIAL-ECOLOGICAL MODEL

The literature review captured many interventions that have succeeded in reducing disparities in the selected conditions and highlighted gaps in research. The primary findings follow:

- The majority of research focuses on overall improvement of outcomes in populations that are socially at risk (in absolute terms), rather than improving outcomes relative to a socially privileged reference group (e.g., white vs. African American).
- A paucity of health equity-focused implementation science studies is a barrier to the uptake of evidence-based interventions into routine healthcare, clinical, organizational, or policy contexts.
- Existing interventions largely focus on patient education, lifestyle modification, and culturally tailored programs. Far fewer interventions address how to improve health systems for populations with social risk factors.[17]
- Most Interventions target disparities based on race and ethnicity. Few interventions address disparities based on disability status, income, social relationships, health literacy, and residential and community context.
- Many interventions could potentially reduce disparities among multiple conditions (e.g., disparities in the incidence, prevalence, and burden of disease in diabetes and cardiovascular conditions), but are usually implemented and evaluated for addressing disparities in one condition. In addition, many interventions could also address disparities related to more than one social risk factor.

The findings demonstrate the need for further investment in research and demonstration projects to better understand the mediators of disparities, especially in healthcare services. No one intervention can eliminate disparities. There is, however, enough evidence to begin developing, implementing, and adapting programs and policies to reduce disparities and advance health equity. For instance, the RWJF *Finding Answers: Solving Disparities Through Payment and Delivery* Systems *Reform* includes six steps to achieve equity with practical resources for healthcare organizations, a systematic review of articles of disparities interventions, and a searchable database of disparities interventions.[18] The NAM has also published community-based solutions to promote health equity, which provided short- and long-term strategies and solutions that communities may consider to expand opportunities to advance health equity.[19] There are also many other resources for stakeholders seeking to reduce disparities in particular health outcomes. For example, the Patient Centered Outcomes Research Institute (PCORI) published a landscape review of options to reduce disparities in cardiovascular disease.[20] In addition, in 2016 the Institute for Healthcare Improvement published a white paper with five key components for healthcare organizations to improve health equity in the communities they serve.[21]

Addressing disparities in health and healthcare will require interventions that reengineer the systems that lead to and/or perpetuate disparities

as well as interventions that target individuals who are at risk. These interventions must be tailored to specific populations, community, and organizational contexts, and address root causes of disparities.[22,23] When these interventions are employed, outcomes must be routinely assessed. Hence, performance measures are needed to monitor the extent to which stakeholders are using interventions known to be effective.

Invest in the Development and Use of Health Equity Performance Measures

The third action of the roadmap involves the selection of health equity performance measures. Health equity measures are quality performance measures that can drive reductions in disparities by incentivizing providers to use interventions known to improve disparities or test new interventions to reduce them, investigate their own practice and community, and try new processes to improve equity. Advancing equity will mean improving both access to and quality of care. The Committee recognized a need for both stratified performance measures that directly measure whether results are equitable between different groups, and other disparity measures that can help guide efforts to improve systems of care such as whether structures are in place that have been demonstrated to reduce disparities. [delete -both disparities-sensitive measures and measures that directly assess equity through the use of interventions known to reduce disparities. To guide the selection and development of health equity measures, the Committee identified domains of health equity measurement. The Committee recognized that achieving equity is a process and requires resources and that stakeholders are at varying stages in that process. The Committee also recognized that no single solution can achieve health equity. Stakeholders must customize interventions to the needs of the populations they serve. The domains of measurement, identified by the Committee, are intended to represent the core processes, structures, and outcomes that must be assessed to achieve equity.

Domains of Health Equity Performance Measurement

The domains of health equity performance measurement represent a prioritized set of goals that must be attained for the healthcare system to achieve equity. They should be considered as a group through which relevant stakeholders can assess how well they are achieving goals outlined within each domain. To develop these domains, the Committee built on current evidence. The Committee adopted a cross-cutting approach (i.e., a method that applies to multiple conditions and social risk factors) rather than a condition-specific or social risk approach. The Committee also recognized that the use of effective interventions is one facet in the achievement of equity. Many structures are needed to support health equity and assess if outcomes are equitable for all. Many of the goals presented in the domains of measurement are rooted in evidence-based interventions known to reduce disparities, and others are based on the Committee's consensus judgment. These goals include several measurable concepts, outlined in the domains below. To achieve equity, the U.S. healthcare system must:

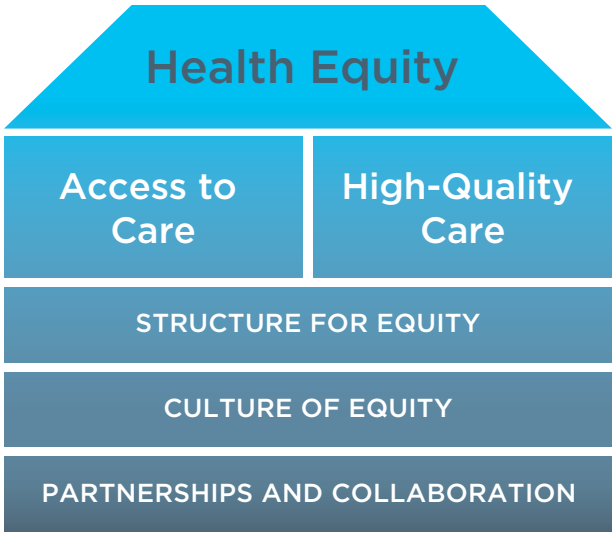
- **Collaborate and partner with** other sectors that influence the health of individuals (e.g., neighborhoods, transportation, housing, education, etc.). Collaboration is necessary to address social determinants of health that are not amenable to what doctors, hospitals, and other healthcare providers alone are trained and licensed to do.
- Adopt and implement a **culture of equity**. A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, the creation of environments where all individuals, particularly those from diverse and/or stigmatized backgrounds, feel safe in addressing difficult topics, e.g., racism, and advocating for public and private policies that advance equity.
- Create **structures** that support a culture of equity. These structures include policies and procedures that institutionalize values that

promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability about the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, and evaluate their impact.

- Ensure **equitable access to healthcare.** Equitable access means that individuals with social risk factors are able to easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors.
- Ensure **high-quality care** that continuously reduces disparities within the system. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately, eliminating disparities through effective interventions.

The Committee recognized the potential challenges to developing performance measures for the domains of *Collaboration and Partnerships*, *Culture of Equity*, and *Structures for Equity*. The Committee recognized a need to minimize the burden of measurement and to ensure that public-reporting and value-based purchasing programs emphasize outcomes that are most valuable for public reporting and supporting consumer decision making. Some domains in the roadmap are more suitable for accountability and others, for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. While measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability. However, the Committee strongly endorsed reporting progress towards meeting the goals outlined in each domain to ensure transparency. Public reporting, transparency, and accountability are important tools for advancing health equity. Each accountable entity will have various capacities to implement the goals outlined in the *Structure for Equity*, *Culture for Equity*, and *Collaboration and Partnerships* domains and should be allowed the flexibility to customize its approach to meeting these goals based on its unique needs.

FIGURE 3A. DOMAINS OF HEALTH EQUITY MEASUREMENT



Subdomains of Health Equity Performance Measurement

The Committee also identified subdomains to describe the types of concepts and actions to measure within each domain (Figure 4b). These subdomains demonstrate more specific ways to advance the goals of each overarching domain. Many of the concepts reflect traditional means of performance measurement with a health equity lens. Existing performance measures can be modified or adapted to monitor the use of interventions for populations that have social risk factors. Other concepts represent a growing knowledge of the impact of social determinants of health on disparities. Many of these concepts will require the identification of new data sources, data collection tools, and/or the development of new performance measures.

FIGURE 3B. SUBDOMAINS OF HEALTH EQUITY PERFORMANCE MEASUREMENT

Collaboration and Partnerships

SUBDOMAINS	EXAMPLES
Collaboration across health and nonhealth sectors	• Care addresses social determinants of health • Supporting social services needs between clinical visits • Support for high quality child care • Support for early, high-quality education systems within disadvantaged communities through partnerships, research, and advocacy • Support for effective community-based interventions (family nurse partnership, early child intervention) • Leveraging the training and employment role of healthcare organizations (i.e., education, job training, jobs, and career pathways for underserved groups) • Distribution of naloxone to early responders and families of persons with opioid dependence
Community and health system linkages	• Linking medical care with community services to connect patients to resources more effectively • Supporting adequately and equitably resourced public health systems and services • Use of community mapping to link clients to community-based social services • Community engagement and long-term partnerships and investments • Improved integration of medical, behavioral, oral, and other health services • Care coordination between jails/prisons and community care providers • Use of community health workers, navigators, and *promotoras* to address social determinants of health among patients in the health care system.
Build and sustain social capital and social inclusion	• Measure assessing number of completed referrals to family-based programs to encourage family communication, bonding, lifestyle improvements • Measure assessing number of completed referrals to school programs to encourage parent, teacher, student involvement • Measure assessing number of completed referrals to community-based programs in socially disadvantaged communities (e.g., gang rehabilitation, church-based health programs) • Involvement in neighborhood improvement programs (e.g., parks, social space, sidewalk improvements) • Involvement in neighborhood safety, personal safety programs • Community-based self management groups for people with chronic conditions • Involvement in financial literacy, retirement, homeownership programs • Outreach to marginalized communities (e.g., immigrants, undocumented, LGBTQ), communities living in fear of discrimination, deportation
Promotion of public and private policies that advance equity	• Supporting industry standards of care that include and highlight equity and actionable approaches delivering high-value care and services • Supporting and implementing payment systems (at the state, community, institutional, and provider levels) that explicitly prioritize and incentivize identification and reduction of disparities and achievement of equity • Supporting public programs that provide health insurance coverage to the uninsured (e.g., Medicaid, Children's Health Insurance Program, Medicare) and improving healthcare affordability for low-income persons

Culture of Equity

SUBDOMAINS	EXAMPLES
Equity is high priority	• Governance (e.g., membership, policies, mission, vision, etc.) • Leadership • Avoidance of segregated care by status, income, or insurance, e.g. special suites for donors, private office care for those with commercial insurance, and 'clinics' for uninsured patients and those with Medicaid.
Safe and accessible environments for individuals from diverse backgrounds	• Physical safety (especially for disabled, sexual and gender minorities, individuals experiencing trauma and/or domestic violence, etc.) • Emotional safety where people feel safe in speaking up regarding difficult hot topics (e.g., racism, microaggressions, abusive power, stigma, etc.) • Cultural safety (e.g., attire, hair, language, nationality, religion etc.)
Cultural competency	• Workforce diversity at all levels (i.e., among staff and leadership) • Training/continuing education of all providers and staff • Awareness of cumulative structural disadvantage, bias, and stigma and commitment to mitigation – Structural racism and other disadvantages – Intersectionality of multiple structural disadvantages (e.g., limited English proficiency and disability) – Adverse childhood experiences/trauma-informed care • Cumulative allostatic load
Advocacy for public and private policies that advance equity	• Supporting industry standards of care that include and highlight equity and actionable approaches to advancing equity and value, i.e., less costly healthcare • Supporting and implementing payment systems that incentivize identification and reduction of disparities and achievement of equity • Supporting existing public insurance programs that provide health insurance coverage to the uninsured (e.g., Medicaid, Children's Health Insurance Program) and improving healthcare affordability for low-income persons

Structure for Equity

SUBDOMAINS	EXAMPLES
Capacity and resources to promote equity	• Workforce has the knowledge, attitudes, skills, and resources to advance equity • Dedicated budget allocations to promote equity • Information technology (IT) and data analytics capabilities
Collection of data to monitor the outcomes of individuals with social risk factors	• Systematic identification of patients' social risk factors (e.g., implementing "Capturing Social and Behavioral Domains in Electronic Health Records" and/or use of "the Accountable Health Communities Screening Tool") • Systematic reporting and improvement in performance data stratified by social risk factors • Learning systems; doing quality improvement with an equity lens
Population health management	• Integrated information systems and strategies to track key health outcomes and health disparities in communities (e.g., IOM/NAM metrics for health and healthcare progress)
Systematic community needs assessments	• Identifying collective capabilities of communities to enhance assets that promote health and health equity • Public reporting on hospital community health needs assessment including actionable metrics for progress • Targeting interventions toward community-prioritized needs
Policies and procedures that advance equity	• Optimal health literacy as an organizational/system commitment • Comprehensive language assistance and communications services for individuals with limited English proficiency and individuals with disabilities • Comprehensive language assistance and communications services for individuals with limited English proficiency and individuals with disabilities • The health care system takes steps to ensure that all patients have the opportunity (or not) to interact with students and medical trainees. Avoiding policies that create a hidden curriculum in which poor patients are systematically assigned to students and trainees.
Transparency, public reporting, and accountability for efforts to advance equity	• Public reporting of quality performance at increasingly granular levels (e.g., health plan that reports on quality performance of its providers) • Reporting on progress related to other steps the organization has taken (e.g., other domains cited above) • Formalized processes to get comment from the public and other stakeholders in planning and in revising

Equitable Access to Care

SUBDOMAINS	EXAMPLES
Availability	• Assessment of access to quality care in a geographic service area • Availability and access to specialty care including needed treatment, e.g. mental health or drug treatment. • Network adequacy, inclusion of essential community providers • Timely (same day appointments, time to next appointment, timely appointments with specialists, etc.) • "After-hours" access
Accessibility	• Physical accessibility for individuals with disabilities • Geographic (no transportation barriers or transportation support) • Language accessibility including effective communication about the availability of interpreter services including American Sign Language
Affordability	• Fewer delays and less care including visits, tests, prescriptions, and specialty access forgone due to out-of-pocket costs • Ability of a patient to cover the cost of healthcare services without foregoing other necessities (housing, food, transportation, childcare, etc.) • Affordability of standard insurance • Total costs related to health care (premiums + out-of-pocket costs of care including co-insurance, copayments etc.) • Rates of health care related personal bankruptcy
Convenience	• Distance from residence • Flexible appointment schedules • Accessibility to public transportation • Safety of surrounding environment

Equitable High-Quality Care

SUBDOMAINS	EXAMPLES
Person- and family-centeredness	• Measure and improve patient/individual, family, and caregiver experiences of care, including access and satisfaction and experience of discrimination • Communication and comprehension, especially for individuals with low health literacy, limited English proficiency, or with physical and developmental disabilities or cognitive impairments • Informed and shared decision making • Support for self-care including training in patient activation and chronic care self-management • Availability of patient advisors, advisory councils; patients on governing boards • Include patients on quality improvement, patient safety, and ethics teams
Continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors	• Including but not limited to measures that assess: – Patient outcomes – Patient-reported outcomes • Clinical process of care measures (e.g., mammography) • Clinical intermediate outcome measures (e.g., blood pressure control in hypertensive patients) • Improvement in key behavioral risk factors (e.g., smoking, diet, physical activity, psychological distress, and substance use) • Promotion of healthy and safe communities with environments that support healthy behavior • Improvement in population health (e.g., fewer avoidable hospitalizations, premature disability/deaths, and unintended pregnancies; improved well-being and health status) • Use disparities-sensitive measures
Use of effective interventions to reduce disparities in healthcare quality	Including but not limited to: • Team-based care • Case managers • Nurse-specific measures • Community health workers/navigators/*promotoras(es)* • Culturally tailored interventions • Self-management support • Telehealth • Patient-centered communication skills and cultural competency training

Current Measurement Landscape

The Committee directed an environmental scan to assess the current landscape of measures that can be used to assess progress towards achieving the goals outlined within the domains of measurement. The scan included disparities-sensitive measures and health equity measures (i.e., measures linked to interventions that are known to reduce disparities in populations with social risk factors and/or aligned with the priority domains of measurement outlined in the Committee's measurement roadmap). NQF conducted the environmental scan by searching for measures that assess structures, processes, and outcomes of care for the selected conditions (i.e., cancer, cardiovascular disease, mental illness, infant mortality, low birth weight, diabetes, and chronic kidney disease) and sorting them by the domains of health equity measurement. The environmental scan retrieved 886 performance measures. The majority of measures aligned with the *Equitable High-Quality Care* and *Equitable Access to Care* domains. Far fewer measures aligned with the *Collaboration and Partnerships* domain. NQF obtained input on the findings of the environmental scan from 19 key informants with clinical expertise and knowledge of disparities within each of the selected conditions. The full compendium of measures is included in **Appendix E**. Given significant gaps (between the ideal state and the current state of measurement), the Committee recommended development of health equity performance measures. The following sections further describe the domains of health equity measurement, example measures, gaps in measurement, and potential measure concepts that can be translated into performance measures.

Collaboration and Partnerships

It is common knowledge that a person's health is influenced by factors outside the healthcare system. Collaboration is necessary to address social risk factors that physicians, hospitals, and other healthcare providers are not trained and licensed to address or do not have the resources to address under current payment models. Addressing social risk factors requires partnering with organizations and agencies such as policymakers, communities/neighborhoods, social services, transportation, housing, education, employers, and payers. These collaborations themselves should be grounded in the principles of respect and fairness (e.g., equity in decision making, resources, and information transparency). The Committee noted the role for payers to support greater collaboration and partnerships to advance health equity. Current payment models frequently only reimburse a healthcare provider for clinical services. While some organizations are working to address social risk factors such as housing and food insecurity, this approach may not be feasible over time or scalable to a state or national level.

The environmental scan found very few measures that assess the extent to which healthcare organizations are collaborating with public health programs and other sectors outside of healthcare (e.g., transportation, housing, education, etc.). The subdomain*, community and health system linkages*, focuses on the integration between care settings as a way to reduce disparities. An example of a measure (Table 2) that seeks to improve the integration of medical and behavioral health services is the *Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness"* characteristics of the *Site Self Assessments (SSA) Evaluation Tool,* which is maintained in the AHRQ National Quality Measures Clearinghouse. The measure uses survey data collected from health professionals to assess the level of integration between primary care and mental/behavioral healthcare in a variety of care settings.

The subdomain, *collaboration across health and nonhealth sectors,* assesses how the healthcare system interacts with other sectors to improve healthy equity. One example of a potential area of collaboration is between healthcare and transportation systems. Lack of adequate transportation is a significant barrier to accessing

care, especially for individuals in rural communities and for those with disabilities. The NQF-endorsed Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey includes items that assess the availability of transportation to medical appointments. Future measurement efforts should assess how the healthcare system engages the transportation system to increase the availability of transportation. For example, the 2017 NCQA Patient-Centered Medical Home (PCMH) standards address a variety of criteria for integration between PCMH and the community. These standards can inform the development of measures that address collaboration and partnerships.

The subdomain, *build and sustain social capital and social inclusion*, includes measures that assess the interaction between the healthcare system and communities. Few measures were found that assess the extent to which healthcare institutions work to build social capital and cohesion in communities. Assessing the level of interactions among these entities can be difficult given the variety of community-level settings. There is also little evidence to suggest which community entities are most important for the healthcare system to engage. The Committee discussed the importance of identifying community anchor institutions for partnerships (i.e., hospitals, universities, major employers, and other enduring institutions that play a role in communities and economies) and creating databases of community resources for providers.

The *Collaboration and Partnerships* domain has the largest gaps in measurement. Table 3 below outlines key gap areas in this domain. Key informants selected from NQF's clinical standing committees noted gaps in measures that address the social determinants of health, including education, employment, income, transportation, and housing, etc. These gaps in measurement may be based on insufficient evidence regarding the use of collaborations to address health and healthcare disparities. As gaps in the integration of physical and mental health are addressed, the Substance Abuse and Mental Health Services Administration's Four Quadrant Model can serve as a framework to promote alignment in the development of integrated measures.[24] The Four Quadrant Model describes subsets of the population based on behavioral health and physical health risk and suggests system elements that could be used to meet the needs of each subset of the population. Committee members recognized the potential challenges to developing measures in this domain, noting that it could be difficult to create benchmarks. The Committee recognized the need for quantification but cautioned that threshold levels may change as measures become standardized.

The environmental scan retrieved only seven measures of collaborations and partnerships. Table 4 shows a breakdown of available measures by subdomain. None of these measures addresses cancer; only one measure relates to each of diabetes/chronic kidney disease (CKD) and cardiovascular disease; and five measures apply to mental illness.

TABLE 2. EXAMPLE OF EXISTING COLLABORATION AND PARTNERSHIP MEASURE

Subdomain	Measure Title	Measure Description	Measure Source
Community and health system linkages	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool	This measure is used to assess the total score for the "Integrated Services and Patient and Family-Centeredness" characteristics on the Site Self Assessment (SSA) Evaluation Tool.	AHRQ National Quality Measures Clearinghouse

TABLE 3. EXAMPLE COLLABORATION AND PARTNERSHIP MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Concept Description
Collaboration across health and nonhealth sectors	A measure that assesses the number of partnerships and active projects with nonhealth sector organizations (e.g., schools, transportation, environment, food).
Build and sustain social capital and social cohesion	A measure or measures that assess the following: • Connection to community programs (percent of eligible patients who had a completed referral): – Use of family-based programs to encourage family communication, bonding, lifestyle improvements – Use of school programs to encourage parent, teacher, student involvement – Use of community-based programs in socially disadvantaged communities (e.g., gang rehabilitation, faith-based health programs) • Involvement in neighborhood improvement programs (e.g., parks, social space, sidewalk improvements) • Involvement in neighborhood safety, personal safety programs Involvement in financial literacy, retirement, homeownership programs • Partnerships between healthcare systems and schools • Outreach to marginalized communities (e.g., immigrants, undocumented, LGBTQ), communities living in fear of discrimination, deportation
Community and health system linkages	A measure or measures that assess the following: • Availability of physical/community space at healthcare sites for gatherings of community members to discuss health topics (e.g., support groups) • Financial investment in community organizations, projects • Community outreach gatherings, public health screenings in the community

TABLE 4. PARTNERSHIP AND COLLABORATION SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Collaboration across health and nonhealth sectors	1
Community and health system linkages	6
Build and sustain social capital and social inclusion	0
Promotion of public and private policies that advance equity	0

Culture of Equity

A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, and the creation of environments where all individuals—particularly those from diverse and/or stigmatized backgrounds—feel safe in addressing difficult topics such as racism and advocating for public and private policies that advance equity. The Committee noted that a culture of equity creates emotional safety, such that all persons are respected, all voices are heard, and traditional hierarchies are flattened. This safe environment creates the spaces to discuss difficult topics and creates a foundational atmosphere to address daily behaviors that can undermine policies that promote equity.

Surveys can help in assessing an emotionally safe culture.[25,26] For example, there is a scale to measure moral courage in speaking up which helps create a culture.[27] Emotional safety is a starting point that allows for sharing of experiences of members of disparity groups and uncovering blind spots related to social risk factors. A culture of equity is supported by inclusion of members of disparity groups in key decision making groups (e.g., boards of directors, management, quality improvement teams, etc.). Inclusion in decision making helps ensure that the voices of these groups are heard at all levels. Furthermore, ensuring this type of diversity within decision making groups helps change the conversation. For instance, it is one thing to talk about the importance of wheel chair accessibility and another to discuss this with a person who uses a wheel chair.

The environmental scan identified many measures that assess the concepts within subdomains of the *Culture of Equity* domain, including several NQF-endorsed measures. The majority of measures assess concepts related to *cultural competency*. The Committee adopted a modified definition of cultural competency for this work: the ability to appropriately meet the health and healthcare needs of individuals of diverse backgrounds. The Committee emphasized the importance of measuring bias at both the institutional and provider levels as well as structural racism. Examples include, but are not limited to, cumulative structural disadvantage, bias, and stigma. Improving cultural competency is a key intervention that addresses disparities across all conditions.

There are several NQF-endorsed experience-of-care measures that assess the environment and the manner in which care is received at the provider level. For example, NQF #0008 *Experience of Care and Health Outcomes (ECHO) Survey* (behavioral health, managed care versions) and NQF #0517 *CAHPS® Home Health Care Survey* (experience with care) both assess a patient's experiences with care. These measures can be stratified to ensure that individuals with social risk factors are receiving care in environments that are physically, emotionally, and culturally safe. In addition, the *Communication Climate Assessment Toolkit (C-CAT),* designed for providers, staff, and patients, assesses how well providers help patients cope with stigma.

The Committee also noted the importance of ensuring that equity is a priority at all levels of the healthcare system. For instance, several Committee members agreed that organizations should adopt the national *Culturally and Linguistically Appropriate Services (CLAS) Standards*[28] developed and promulgated by HHS. There are NQF-endorsed measures that can be used to assess the level to which providers are delivering care that complies with CLAS standards. These measures are derived from the *Communication Climate Assessment Toolkit (C-CAT)* and assess the level of patient-centered communication, communication gaps, workforce training, commitment of leadership, and health literacy, among other subdomains relevant to ensure a *culture of equity*. The Committee also discussed the CAHPS Culture Competence Item Set*,* which covers topics such as patient-provider communication; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust; and linguistic competency. The item set is not currently used.

Overall, the scan retrieved 38 *Culture of Equity* measures: 25 specifically for mental illness, one for chronic kidney disease, zero for cardiovascular disease, zero for cancer, four for infant mortality and low birthweight, and eight that apply to multiple conditions. Table 5 includes some key illustrative examples of current measures that address this domain.

Despite the availability of numerous measures and assessment tools, there remain several gaps, highlighted in Table 6. The Committee recommended the development of a measure

that assesses the extent to which resources are allocated to activities that advance health equity. In addition, assessments of the culture of organizations should be routinely stratified by respondent demographic characteristics. There were no measures identified that assess the level to which stakeholders are advocating for public and private policies to advance equity, which represents a gap area. Again, the Committee noted challenges to measure development in this area, including developing measures that have meaningful impact and do not become "check-box" measures. Table 7 shows the available measures by subdomain.

TABLE 5. EXAMPLES OF CULTURE OF EQUITY MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Cultural competency	Language services measure derived from language services domain of the C-CAT	0-100 measure of language services related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)	NQF Quality Positioning System
Cultural competency	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey.	NQF Quality Positioning System

TABLE 6. EXAMPLES OF CULTURE OF EQUITY MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Equity is high priority	A measure that assesses whether health/healthcare equity is explicitly mentioned in institution's mission statement and/or strategic plan
Equity is high priority	A measure that assesses whether an institution has released statements, comment letters, etc. that explicitly discuss the impact of local/state/federal actions on community health and health inequities
Cultural competency	A measure that assesses the extent to which underrepresented groups are present at all levels of the organization (e.g., board, C-suite, support staff)

TABLE 7. CULTURE OF EQUITY SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Equity is high priority	1
Safe and accessible environments for individuals from diverse backgrounds	22
Cultural competency	15
Advocacy for public and private policies that advance equity	0

Structure for Equity

There are critical structures for supporting a culture of health equity. These structures include laws (including statutes and regulations), policies, and procedures that operationalize the culture of equity. They are necessary to promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability for the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess

and objectively measure the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, evaluate their impact, and modify them accordingly. Structures are likely to achieve the greatest impact on equity when leadership and an equitable culture support them. The Committee noted the importance of leading by example and the importance of allocating specific resources to support the work of equity. Structures should create sufficient incentives, financial or otherwise, to move towards equitable health and healthcare. The Committee recognized the need for substantial and systemic funding to enable all of the domains of healthcare equity to be effectively implemented, evaluated, assessed, and monitored.

The environmental scan identified several measures that can assess the concepts within subdomains of the *Structure for Equity* domain. The majority of measures align with the need to assess population health and monitor the outcomes of individuals with social risk factors. The Committee noted the primary importance of collecting data on the health and healthcare of individuals with social risk factors, as the assessment of improvement cannot happen without access to data. There are many known gaps in such data, specifically among health plans. The *NAM Report Accounting for Social Risk Factors in Medicare Payment* found significant gaps in data among public and private health insurers on income, whether beneficiaries lived alone or had social support, sexual orientation, gender identity, and features of the places they live.[29] The Committee highlighted prior recommendations and noted current requirements and incentives for healthcare organizations to build these data collection fields into their electronic health records systems.

Few measures assess data collection efforts to improve health equity. The environmental scan retrieved one measure, NQF #1881 (not endorsed), derived from the C-CAT that captures whether an organization uses standardized qualitative and quantitative collection methods and uniform coding systems to gather valid and reliable information for understanding the demographics and communication needs of the population served. The measure represents an example for measure developers who seek to fill gaps in measurement of data collection. The Office of National Coordinator for Health IT Certification Program requires capture of data regarding race and ethnicity, sexual orientation, gender identity, and social, psychological, and behavioral data that could be used to support measurement in the future.[30]

The Committee also stressed the need for better population health management for individuals with social risk factors. The environmental scan identified many measures that can be used for surveillance to improve strategies for population health management and assess community needs. Examples include measures that assess concepts such as smoking prevalence, cancer screening, infant mortality, and insurance coverage among individuals with social risk factors. NQF #1919 *Cultural Competency Implementation Measure* addresses the ideas of transparency, public reporting, and accountability for efforts to advance equity or the capacity and resources to promote equity. While not a performance measure, the HHS Office of Minority Health CLAS Standard's 15 recommendations specify that institutions "Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public"[31] and could serve as the basis of a future measure.

Overall, the scan identified 46 *Structure of Equity* measures: one for mental health, four for chronic kidney disease, seven for cardiovascular disease, five for cancer, 28 for infant mortality and low birthweight, and one that cuts across condition areas. The majority of the measures found relate to clinical data collection in an effort to reduce disparities, and based on key informant interviews, the most important behaviors to monitor for disparities include tobacco use, alcohol use, opioid abuse, depression, and obesity screening, treatment, and counseling. Table 8 highlights key example measures, while table 9 includes potential gaps in measurement. Table 10 shows available measures by subdomain.

TABLE 8. EXAMPLES OF STRUCTURE OF EQUITY MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Collection of data to monitor the outcomes of individuals with social risk factors	L1A: Screening for Preferred Spoken Language for Health Care	This measure is used to assess the percent of patient visits and admissions where preferred spoken language for healthcare is screened and recorded. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.	NQF Quality Positioning System
Population health management	Adult Current Smoking Prevalence	Percentage of adult (age 18 and older) U.S. population that currently smokes. The measure is stratified by geography.	NQF Quality Positioning System

TABLE 9. EXAMPLES OF STRUCTURE OF EQUITY MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Collection of data to monitor the outcomes of individuals with social risk factors	A measure that assesses the number of individuals enrolled in a health plan during a measurement year for one or more months that has completed a survey with key questions such as income, home ownership, education, race/ethnicity, household size. A measure assessing use of the ICD-10 Z codes for factors influencing health status.
Population health management	A set of measures that assess hospitalizations and readmissions, emergency room use, frequency and intensity of office visits, medication adherence and persistence, emergence of condition-related adverse events, and existence of co-morbidities and other diagnoses by social risk factors. Outcomes should be stratified by key social and behavioral risk factors, such as mental health conditions, alcohol/drug/substance abuse, and other risk factors.

TABLE 10. STRUCTURE FOR EQUITY SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Capacity and resources to promote equity	9
Collection of data to monitor the outcomes of individuals with social risk factors	3
Population health management	34
Systematic community needs assessments	0
Policies and procedures that promote equity	0
Transparency, public reporting, and accountability for efforts to advance equity	0

Equitable Access to Care

The Committee emphasized the need to ensure access to care to advance health equity, as access is a central driver of disparities. Equitable access means that individuals with social risk factors can easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors. This requires systematic examination of organizational policies at multiple levels related to patient out-of-pocket costs (at each juncture), and physical and communicational accessibility. Mechanisms should be in place to elicit meaningful input from patients from different groups regarding equitable access.

Further, to ensure equitable access to healthcare, providers should be available, accessible, and acceptable to patients in order to deliver high-quality care to patients and communities. Healthcare workers must be:

1. equitably distributed (available in all communities, including where populations of greater social risk reside);
2. accessible to populations (available to provide care within a reasonable time period that is convenient for the population (i.e., not waiting three months for an appointment and open for evening hours for people who cannot miss work due to economic constraints); and
3. acceptable to the population (possess the required competency—including knowledge of health disparities and social risk—and empowered and motivated to provide quality care that is socio-culturally appropriate and acceptable).[32]

The Committee also recognized the need to address financial access[33] and noted a need to continue to improve access to health insurance and ensure that premiums, deductibles, and co-pays do not create barriers to care.

The environmental scan found many measures that assess access to care and can be stratified to assess equitable access for individuals with social risk factors. Table 11 highlights example measures in this domain. However, there were notable differences in the availability of access measures by condition as well as by subdomain. The environmental scan did not identify any measures of affordability, and very few that specifically focused on assessing accessibility or convenience. However, the Health Professional Shortage Area and Medically Underserved Area designations of the Health Resources and Services Administration (HRSA) and CMS's definition of network adequacy and essential community providers could serve as starting points for future performance measures. The Healthy People 2020 goals also include important targets related to access to care. Measures should be identified or created to assess U.S. progress toward meeting these goals. Additionally, the CAHPS surveys include items of convenience, timeliness, and accessibility, which could be stratified to assess disparities.

Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities.[34] Primary care plays a unique role in promoting equity through its comprehensive and biopsychosocial focus, longitudinal personal relationships, and its capacity to align intensity of management with patient needs. Primary care capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while aligning resources and services to these needs is vital to improving health equity. In addition, the ability to afford healthcare is closely tied to insurance status, so general measures of insurance status may be able to close disparities related to affordability. However, rapid emergence of high deductible health plans risks creating new cost-related disparities related to affordability even among those persons with commercial insurance.

Equitable access is critical for mental health and substance use disorder services. Mental health services are significantly underused by many racial and ethnic minority group members. Despite

Congressional passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), significant access barriers to these services remain, including those related to community availability, costs, and cultural and linguistic appropriateness. Accelerating integration of primary care with behavioral services offers promise for improving access to these services among disparity groups.

Convenience may be less condition-specific, as it can also be influenced by insurance status, the general availability of primary care providers for preventive care, and the geographic availability and insurance coverage for specialists, particularly for rural and low-income populations. General measures of access to primary care or specialist providers, including measures of geographic access and timeliness of care, or measures around innovative solutions such as telehealth, could be used to assess equitable access at the organization level. Language remains an important barrier for many groups with limited English language proficiency, e.g., Latino and Asian Americans, and for the American Sign Language (ASL)/ deaf population. While several measures assess whether providers or organizations are culturally competent, fewer measures assess the level to which patients have access to culturally competent care (i.e., accessibility). Convenience also includes physical access issues for people with disabilities.

Continuity of care with the same primary care provider (PCP) is an important undermeasured component of access to care. Having a personal, longitudinal relationship between a PCP and patient is particularly important to marginalized, traumatized groups who are at high risk for healthcare disparities. Unfortunately, many individuals with social risk factors are at higher risk for discontinuity in PCP (or mental health) relationships due to receiving care in facilities where turnover is high (e.g., community health centers, residency clinics, student operated clinics, etc.). Therefore, better measurement of continuity of primary care will be essential to reducing disparities.

The environmental scan identified only three access-to-care measures related to cancer, but 17 access measures that could influence infant mortality and low birthweight. There were six measures of access for mental illness, eight for diabetes and chronic kidney disease, six for cardiovascular disease, and zero cutting across condition areas. The bulk of the access measures focus on availability of providers and/or resources (which can also influence accessibility and convenience). Table 12 shows identified gap areas in this domain. Table 13 includes a breakdown of available measures by subdomain.

TABLE 11. EXAMPLES OF EQUITABLE ACCESS TO CARE MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Convenience	Patient-Centered Medical Home Patients' Experiences	Percentage of parents or guardians who reported how often they were able to get the care their child needed from their child's provider's office during evenings, weekends, or holidays	Health Information Warehouse
Availability	Medicare Beneficiaries' Ambulatory Care Sensitive Condition (ACSC) Hospitalizations Hospitalization Rate per 1,000 Medicare Beneficiaries	The number of discharges for ACSC in a county divided by the number of Medicare beneficiaries in a county multiplied by 1,000. The primary independent variable of interest is the number of primary care physicians.	Yu-Hsiu Lin, PhD et al.[35]
Accessibility	HCBS CAHPS Measure (5 of 19): Transportation to Medical Appointments	Transportation to medical appointments: Top-box score composed of three survey items	AHRQ National Quality Measures Clearinghouse

TABLE 12. EXAMPLES OF EQUITABLE ACCESS MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Availability	A measure that assesses the number of primary care visit slots held for same-day appointments or drop-in access. A measure that assesses the number of days to get an appointment (could build on items in the California Health Interview Survey)
Accessibility	A measure that assesses the total number of outpatient or clinic practice locations (weighted by visit volume) within one block of a public transportation stop.
Affordability	A measure that assesses the number of services (weighted by dollar value) billed on the basis of a sliding scale linked to patient income. A patient-reported measure that assesses the level of patients' satisfaction with their healthcare costs. CMS cost-related medication nonadherence scale
Convenience	A measure that assesses the number of appointments with wait times of 15 minutes or less, as reported by patients or patient caregivers.

TABLE 13. EQUITABLE ACCESS TO CARE SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Availability	31
Accessibility	4
Affordability	1
Convenience	4

Equitable High-Quality Care

The Committee emphasized the need to ensure high-quality care within systems that continuously work to reduce disparities. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately eliminating, disparities through effective interventions. The Committee noted a goal of ensuring that everyone receives the highest quality care by routinely monitoring care and outcomes for groups at greatest risk for suboptimal care. One example of success in this regard is the use of measures stratified by race by the Oregon Medicaid program.

The Committee developed a diagram to show how these domains work together to promote health equity (Figure 4a). The 'means' to achieving health equity require improving collaboration and partnerships which complement fostering a culture of equity and building the structure for equity. Equitable high-quality care and equitable access to care are the primary 'outcomes.' Progress can be made independently within each domain, but achievement of goals in all domains is necessary to reach the ultimate goal of health equity.

Measures that address quality of care made up the overwhelming majority of measures found during the environmental scan; however few are currently used to directly assess disparities for accountability purposes. These measures are predominantly clinical process and outcome measures and relate most closely to the subdomain of *continuous improvements across clinical structure, process, and outcome measures.* Far fewer measures were found that specifically assess the concepts outlined in the *effective interventions to reduce healthcare disparities in quality* subdomain. The majority of measures assess the aspects of shared decision making or patient education. The Committee emphasized the importance of stratifying outcome and process measures currently in use to identify disparities.

Other potential measures could be developed to address self-care, effective patient-provider communication, person-centered care, family engagement, etc. One example of a measure that addresses this subdomain is NQF #0519 *Diabetic Foot Care and Patient Education Implemented*. This process measure uses clinical data to determine the "percentage of home health episodes of care in which diabetic foot care and patient/caregiver education were included in the physician-ordered plan of care and implemented for diabetic patients since the previous OASIS assessment." The Committee also recommended the development of measures that assess the percentage of patients using a patient portal, medication errors (adverse events or other safety concerns), and nonadherence.

Measures and measure concepts that address *Equitable High-Quality Care may* face fewer data collection challenges than the other domains discussed in this report. The clinical nature of quality-of-care measures calls for more traditional data sources including claims data, making data collection more feasible. The current lack of social risk factor data collected, including race, language, disability, etc., poses significant data challenges to the ability of these measures to account for disparities. Further research and measure development are needed for measures that assess whether stakeholders are employing interventions that are known to reduce disparities.

The environmental scan for measures found 755 total measures of high-quality care: 158 measures of high-quality care related to cancer, 214 related to cardiovascular disease, 154 related to diabetes/chronic kidney disease, 129 related to infant mortality and low birthweight, 90 related to mental illness, and 10 cutting across condition areas. The majority of these measures related to the first subdomain, *continuous improvements across clinical structure, process, and outcome performance measures stratified by social risk factors*. However, many of these measures are not currently stratified or used in a stratified manner for accountability purposes.

TABLE 14. EXAMPLES OF EQUITABLE HIGH-QUALITY CARE MEASURES

Subdomain	Measure Title	Measure Description	Measure Source
Evidence-based interventions to reduce disparities	Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of Care	Percentage of short-term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	CMS Measure Inventory
Evidence-based interventions to reduce disparities	Depression Care: Percentage of Patients 18 Years of Age or Older with Major Depression or Dysthymia Who Demonstrated a Response to Treatment 12 Months (+/- 30 Days) After an Index Visit	This measure is used to assess the percentage of patients 18 years of age or older with major depression or dysthymia who demonstrated a response to treatment 12 months (+/- 30 days) after an index visit. This measure applies to both patients with newly diagnosed and existing depression.	AHRQ National Quality Measures Clearinghouse

TABLE 15. EXAMPLES OF EQUITABLE HIGH-QUALITY CARE MEASURE CONCEPTS TO FILL GAPS IN MEASUREMENT

Subdomain	Measure Description
Person- and family-centeredness	A measure that assesses the number of adults (>18 years of age) with a documented shared decision making discussion with care provider (useful if had claim encounter code that could be submitted). Questions from the CAHPS survey could potentially be used to fill this gap.
Social risk factors addressed in outcome performance measures	A measure that assesses the number of patients (>18 years of age) with documented social risk factor assessment in medical record Outcome measures (such as complications of surgery) with results stratified by patients with and without social risk factor
Effective healthcare interventions to reduce disparities	A measure that assesses the number of patients with community referral, case management referral, consultation for social work/social services in both the pediatric and adult population

TABLE 16. EQUITABLE HIGH-QUALITY CARE SUBDOMAIN MEASURE AVAILABILITY

Subdomains	Number of available measures
Person- and family-centeredness	44
Continuous improvements across clinical structure, process, and outcome performance measures that could be stratified by social risk factors	684
Use of effective interventions to reduce disparities in healthcare quality	27

This report highlights areas where development of new measures could improve health equity. These include those related to health care affordability; measures assessing value; and prioritization of core behavioral factors. Out-of-pocket costs are growing problem for many disparity groups due to the high costs of new treatments and increase number of high deductible plans. This report found few quality measures that address affordability. Yet, affordability is a major driver for health care disparities. New quality measures could be developed or adapted that assessed percent of a

person's weekly income that a particular treatment cost or whether patients reported foregoing paying other bills in order to pay for needed care or simply avoiding the care (or obtaining a prescription) due to costs.

Value and equity represent over-arching goals of the health care system, but there is dearth of measures that capture the cost side of value or that prioritize use of high value interventions. There is a need for new measures that capture whether insurance or health plans are explicitly designed to promote value and in the process improve equity. For example, new measures could be developed that examined the extent to which insurance programs covered high value care, i.e. value-based insurance design. Such measures when stratified by disparity group the extent to which health plans have incorporated value and equity into the design of its coverage. Examples of value-based design include coverage for statins for persons at high risk. Another approach to value is assessing use of low-value care. There is some evidence for example that blacks are more likely to receive low value care. Last, measures could be developed that assess the extent to which health care systems provide patients with transparency in their health care prices. Such transparency in pricing particularly when coupled with meaningful data on experience in outcomes allows patients/families in conjunction with their clinicians to make informed choices. In addition such transparency could help discourage the practice whereby hospitals charge higher prices to patients without insurance while providing discounted prices to entities with market power.

Last, measures of population health highlighted by the IOM/NAM report, "Vital Signs" underscore measures that have the greatest impact on population health and often also have disparate impact on disparity groups. Examples of these measures include improvement in health behavior, e.g. smoking cessation, reduction in BMI, increases in physical activity, reduction in opioid misuse, prevention of teen and/or unwanted pregnancy, depression and psychological distress. Heightened focus on these core measures could not only advance population health and health equity, but also underscore the need for partnerships between health systems and communities to address underlying social determinants that affect these behavioral determinants.

Incentivize the Reduction of Health Disparities and Achievement of Health Equity

The final action of the roadmap emphasizes the need to incentivize and support the reduction of health disparities and the achievement of health equity. The Committee recognized that performance measurement is increasingly used for accountability purposes and this shift to payment and reporting offers opportunities to advance equity in multiple ways. First, reporting the results of performance measures can promote transparency and help identify and address disparities. Second, the shift to value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities. Further, the shift to global payment, capitated payment, and bundled payment could support the infrastructure for interventions that reduce disparities. Finally, social and population health measures can be used to ensure resources are allocated to counteract the drivers of disparities.

The increased use of performance measures offers a number of way to incentivize the reduction of disparities. Currently reported measures could be reported by strata to show disparities more transparently. Measures that are sensitive to disparities or could assess the use of interventions to reduce disparities could be prioritized for implementation in public reporting and value-based purchasing. Finally, measures used for accreditation could address health equity.

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. The Committee recommended multiple payment strategies

including upfront payments to fund infrastructure necessary to achieve equity, pay-for-performance that rewards reducing disparities in quality and access to care, and mixed payment models that combine different models. The Committee noted that pay for improvement models have been shown to be particularly promising.

The Committee also recommended that public and private payers adjust payments to providers based on social risk factors and noted that some payers are considering increasing payments for hospital services based on social risk factors. In the same vein, health plans should provide additional payments for outpatient services. In many cases, outpatient care represents an opportunity to address social determinants of health upstream and helps a patient to avoid disruptive and costly inpatient care. This recommendation could shift payment from costly avoidable care to upfront payments that prevent development of downstream conditions e.g. support diabetes prevention programs or intensive case-management to prevent hospital re-admission.

The Committee also recognized the potential risks of using payment and measurement to reduce disparities. For example, current value-based purchasing programs could negatively impact safety-net providers and there is the potential to increase measurement burden. Acknowledging, that payment is only one way of incentivizing and supporting the achievement of health equity, the Committee developed a set of recommendations to further support the implementation of goals outlined in the roadmap.

RECOMMENDATIONS

RECOMMENDATION 1:
Collect social risk factor data.

Data are the bedrock of all measurement activities; however, data on social risk factors is currently limited. These limitations can impede effort to find and reduce disparities. As such, stakeholders must invest in the necessary infrastructure to support data collection. There needs to be standard collection of data related to social risks like housing instability, food insecurity, gender identity, sexual orientation, language, continuity of insurance coverage, etc. Examples include the IOM/NAM Report "Capturing Social and Behavioral Domains and Measures in Electronic Health Records and the CMS Accountable Health Communities Screening tool.[36] The Committee emphasized the need to collect these data through electronic health records, whenever possible. Many performance measures rely on administrative claims data and often do not capture data about individuals who are not continuously enrolled in a health plan. One potential strategy to address this is greater use of the ICD-10 codes for factors addressing health status and contact with health services (Z codes found in chapter 21[37]). These codes capture social risk factors such as education, socioeconomic status, employment, social environment, upbringing, and family circumstances. The Committee also noted that payers could help incentivize the collection of data by either requiring data collection or providing additional payments for the collection of social risk data.

In addition to patient-level data, addressing disparities will require collecting neighborhood-level data on social risk factors to better understand the characteristics of the places in which people live, work, and play. Healthcare organizations must work with public health departments and other institutions in the community to collect these data. In addition to collecting individual patient-level data, organizations that are accountable for populations should collect community-level data that inform health needs. For example, federally qualified health centers (FQHC) conduct regular community health needs assessments, and nonprofit hospitals are required to conduct community health assessments. These data should be publicly reported, shared, and used to inform publicly reported action plans to improve health equity.

RECOMMENDATION 2:
Use and prioritize stratified health equity outcome measures.

Stakeholders should first conduct a needs assessment to identify the extent to which they are meeting the goals outlined in the measurement roadmap. The domains should be considered as a whole rather than aiming to make progress in only one area. Stakeholders may find themselves at varying stages in achieving the goals outlined in the roadmap, but progress in all domains is necessary to achieve equity. The Committee acknowledged that the use of outcome measures often depends on the state of the evidence. In some cases, process and structure measures may be used in place of outcome measures where reliable and valid outcome measures do not yet exist. However, relevant stakeholders should identify and develop outcome measures that can assess the extent to which stakeholders are achieving health equity.

The Committee recommended reducing the number of measures that do not promote equity to address measurement burden. In addition, stakeholders must actively identify and decommission measures that have reached ceiling levels of performance and where there are insignificant gaps in performance. Lastly,

health equity performance measures must also be aligned across programs to reduce data collection burden, maximize the influence of the measures, and allow for peer group comparisons. The Committee noted one potential example from the FY 2018 Inpatient Prospective Payment System (IPPS) Proposed Rule. In this rule, CMS sought comments on confidential reporting and future public reporting of two pneumonia measures (NQF #0506 pneumonia readmissions and NQF #0468 pneumonia mortality) currently used in the Hospital Inpatient Quality Reporting (IQR) program stratified by dual eligibility. The goal of this stratification would be to demonstrate differences in outcome rates among patient groups within a hospital and to allow for comparison of potential disparities across hospitals.

RECOMMENDATION 3:
Prioritize measures in the domains of Equitable Access and Equitable High-Quality Care for accountability purposes.

Some domains in the measurement roadmap are more suitable for accountability and others for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. However, the Committee strongly endorsed reporting progress towards meeting the goals outlined in each domain to ensure transparency. Each accountable entity will have various capacities to implement the goals outlined in the structure, culture, and collaboration and partnership domains and should be allowed the flexibility to customize its approach to meeting these goals based on their unique needs. Measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability. Public reporting, transparency, and accountability are important tools for advancing health equity. Thus, these health equity measures should be implemented in existing public reporting and accountability programs.

RECOMMENDATION 4:
Invest in preventive and primary care for patients with social risk factors.

People with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system often rely on continuity with a trusted primary care physician. Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities.[38] Primary care plays a unique role in advancing equity through its comprehensive and biopsychosocial focus, longitudinal personal relationships, and its capacity to align intensity of management with patient needs. Primary care's capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while providing resources and services to align with these needs is vital to improving health equity. This requires minimizing key access barriers to primary care related to cost, location, and physical and linguistic accessibility. It also means ensuring that primary care practices have access to evidence-based programs for tobacco cessation, weight management, diabetes prevention, physical activity promotion and other interventions. Ultimately, provider incentives are needed to prioritize support for traditionally underfunded preventive activities. In addition, reliable and comprehensive measures are needed to assess both potential and realized access to primary care by social disadvantage including disabilities.

RECOMMENDATION 5:
Redesign payment models to support health equity.

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. The Committee recommended multiple payment strategies. For example, health plans can provide upfront payments to fund infrastructure for achieving equity and addressing the social determinants of health. Upfront payments can include advanced payments for providers with a demonstrated need (i.e., serve patients with social risk factors and need resources to build structures to support equity) and global payments (annual or month-to-month) specifically for pursuing the goals outlined in the domains of *Collaboration and Partnerships*, *Culture for Equity*, and *Structure for Equity*. Health plans can implement pay-for-performance payment models that reward providers for reducing disparities in quality and access to care. These types of rewards can be allocated based on improvement over time, an absolute threshold, progress in reducing disparities, or combinations of these approaches. For example, the Medicare Advanced Payment Initiative provided prospective payments to assist organizations with demonstrated need in establishing accountable care organizations (ACOs). A similar approach could be taken for establishing or incorporating health equity strategies into new or existing programs. The Committee noted that purchasers could use mixed model approaches, combining payment models based on their specific goals (e.g., upfront payments and pay-for-performance to reduce disparities). Payment models can also be phased, using pay-for-reporting, then pay-for-performance incentives.

RECOMMENDATION 6:
Link health equity measures to accreditation programs.

Integrating health equity measures into accreditation programs can increase accountability for promoting health equity and reducing disparities. These measures can be linked to quality improvement-related equity building activities. The Committee noted that organizations like the National Committee for Quality Assurance (NCQA) and URAC have already aligned with this strategy. For example, NCQA has incorporated health equity in its patient-centered medical home recognition program, and URAC promotes compliance with the Mental Health Parity and Addiction Equity Act, by reviewing the mental health or substance abuse disorder benefits provided by the health plans it accredits.

However, the Committee recognized a potential need to expand measurement and accreditation to promote health equity. For example, the Committee noted that healthcare within jails, prisons, and detention centers typically falls outside of mandatory accreditation and incentive programs designed to improve care quality and community coordination. Potential steps to address marginalization of correctional care from the rest of healthcare includes development of new quality measures that assess care within these facilities. Examples might include measures for timely exchange of information on entry and release, pre-release care coordination, and 30-day post-release events (e.g., overdose, ED visits, hospitalizations).

RECOMMENDATION 7:
Support outpatient and inpatient services with additional payment for patients with social risk factors.

The fundamental concept is that social risk factors are like clinical risk factors in the sense that they require more time and effort on the part of providers in specific encounters to achieve the same results. If an office visit is more complex (and billed and paid at a higher level) because of clinical complexity in a patient, the same concept could extend to the incorporation of social risk factors and "social complexity" as a payment concept. This recommendation could shift payment from costly avoidable care to upfront payments that prevent development of downstream conditions e.g. support diabetes prevention programs or intensive case-management to prevent hospital re-admission. As one recent example of this concept being implemented, CMS is going to enhance payments to Medicare Advantage plans for patients who are dual eligible, based on recent data analyses showing that the current model underpays plans for the costs of caring for those patients.

Potential strategies for adjusting payments based on social risk factors may include:

- If placement at the time of hospital discharge for a homeless patient or a patient with no social support at home takes two days longer, on average, than a placement for a patient with a good, supportive home situation, then a diagnosis-related group (DRG) payment could be adjusted upward on the basis of the homelessness or lack of support to account the inherent higher cost (i.e. longer length of stay and more social work and discharge planning time).
- Current procedural terminology codes (CPT) codes for evaluation and management (E&M) visits include five levels of complexity, with criteria for billing at each level linked primarily to the clinical complexity of the patient's presentation and the content of the visit. Social complexity factors could be added to the list of criteria for billing higher-level visits, so that if, for example, it takes 30 minutes longer to explain a new drug regimen to a low-literacy, or low-English-proficiency patient, then the visit can be billed at a higher level to reflect that "social complexity". Again, to keep aggregate program spending budget-neutral, a corresponding payment reduction would have to be found.
- If empirical data show that aggregate episode costs (for example, 90-day episode costs for patients undergoing hip replacement surgery) are higher for patients with defined social risk factors, then payments in bundled episode payment models could be adjusted to take those higher costs into account. For example, if a patient with no stable housing or no social support has to spend time in a residential post-acute care (PAC) facility, unlike a clinically similar patient with good housing and good social support who could be safely discharged home, the added costs of that PAC portion of the episode could be included in an adjusted episode bundle payment. Again, to keep program spending budget-neutral, a corresponding adjustment in the opposite direction would have to be made to reflect the lower episode costs of patients with no social risk factors.

RECOMMENDATION 8:
Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.

The Committee recognized that clinicians and providers disproportionately serving individuals with social risk factors can provide high-quality care. However, the growing evidence that social risk can affect a person's health outcomes has raised questions about how to ensure that organizations serving those with social risk are not unfairly penalized. Moreover, safety net organizations with a payer mix with lower reimbursement rates may not

have the infrastructure for improving the quality of care. Protecting organizations disproportionately serving individuals with social risk factors could help to ensure that access to care is not reduced. At the same time, the Committee reiterated the need to ensure that at-risk populations have access to high-quality care. The Committee noted a need for ensuring that value-based purchasing promotes improvements, transparency, and fairness.

The Committee proposed ways to improve the fairness of value-based purchasing programs. First, the Committee noted that a need to risk adjust for social risk factors may exist when appropriate as well as stratify the performance score for social risk factors to ensure transparency and drive improvement. Secondly, the Committee suggested using peer-group comparisons to ensure safety net organizations are fairly compared. The Committee added a caveat that it may be necessary to risk adjust within the peer comparison groups to ensure fairness. Thirdly, the Committee noted the need to prospectively monitor the financial impact of value-based purchasing on organizations caring for individuals with social risk factors. Lastly, incentivizing providers for progress made in care processes and outcomes for disadvantaged groups is another way to allow safety net organizations to compete. When incentives are tied to the size of the disparity group, it has the effect of directly linking the size of the incentive to population level impact for that disparity group. The NAM report on *Accounting for Social Risk Factors in Medicare Payment* found using simulations that this approach had greatest potential for reducing disparities. When this "pay for improvement" approach is combined with standard "pay for performance" approach, i.e., meeting a defined benchmark for performance, there is potential for the unintended consequences of each approach to offset each other.

The Committee also recognized that some safety net providers such as rural hospitals and critical access hospitals are often not included in value-based purchasing programs that offer incentive payments. The Committee recommended that ACO programs, such as the Medicare Shared Savings Program (MSSP) ACO, commercial ACOs, and Medicaid ACOs, take social risk into account so that safety net providers are not excluded or unfairly penalized and have the opportunity to share in the potential improvements and savings. The Committee also noted that Federally Quality Health Centers (FQHCs) and Rural Health Clinics are not eligible to apply to participate in the Comprehensive Primary Care Plus (CPC+) program, and this denies these safety net providers the opportunity to receive the incentives within these innovation efforts as well.

The Committee also noted that payers should consider additional payment for organizational factors that fall outside of the control of safety net organizations and other providers serving individuals with social risk factors. The Committee recognized that addressing disparities can require significant resources and infrastructure. For example, addressing disparities can require providing interpreter services, addressing food shortages and deserts, addressing lack of access to specialty care and pharmacies, and helping patients overcome issues like childcare and transportation. These services can help patients achieve better outcomes and improve their access to care, but they are often not reimbursed under traditional payment models.

The Committee also recognized that these organizations may not have the resources to develop this infrastructure. The Committee suggested that additional payments could assist these facilities in developing the infrastructure to provide high-quality care for people with social risk factors. One potential short-term strategy is to allow nonprofit hospitals to formally report expenditures to address these services as a community benefit on their Schedule H, form 990. Other strategies are for communities to collectively pay for language services to minimize

the unintended consequence of providers finding ways to avoid serving non-English speaking patients due to uncovered costs.

RECOMMENDATION 9:
Fund care delivery and payment reform demonstration projects to reduce disparities.

The evidence base for many care delivery and payment reform interventions to reduce healthcare disparities is still limited.[39] However, payers and purchasers often want concrete evidence of the effectiveness of an intervention before they will support it financially. The Committee stressed the need to better understand what work is being done to reduce disparities, what interventions are effective, and how these interventions could be replicated and implemented more broadly. For example, policy simulations and health impact assessments could provide guidance on how best to support and implement community interventions that could mediate drivers of disparities. The Committee also emphasized the need to collaborate with researchers to ensure that demonstrations are rigorous and scientifically sound. In addition, there is a need for research specifically focused on dissemination and implementation (D&I) of strategies designed to facilitate uptake of equity-advancing interventions across a range of organizations. Such research offers promise for accelerating the update of best practices. The Committee noted that D&I science could help to translate health equity research from theory into practice. One example is a study that examined update of cultural competency policies in hospitals.[40]

RECOMMENDATION 10:
Assess economic impact of disparities from multiple perspectives.

Reducing healthcare disparities often requires a significant investment. The Committee recognized the need for research to quantify the economic impact of disparities on patients, the healthcare system, and society to support these investments. In the current environment where resources can be limited, demonstrating the current costs of inequity and the potential savings that could be generated could help to motivate and incentivize the reduction of disparities. Multiple economic perspectives are critical to understanding the need to include analysis of the potential long-term benefits to society and the business case perspectives of healthcare organizations, payers, and purchasers.

Currently, there is limited understanding of the economic impact of disparities. One study estimated that racial healthcare disparities cost over $200 billion in direct medical expenditures and over $1 trillion in indirect costs associated with illness and premature death in a three-year period.[41] These costs are borne by patients, employers and purchasers, healthcare providers, and local, state, and federal governments, but it is not easy to appreciate the impact of these costs. Quantifying the costs in terms such as lost productivity, quality adjusted life years, readmission rates, emergency department use, etc. could help organizations understand the imperative to invest in equity.

The Committee noted that understanding the economic impact of disparities is crucial as the system moves to payments based on quality and value. The Committee recognized that reducing disparities will take significant investments by the healthcare system as well as investments in public health to address the many drivers of disparities (e.g. adverse childhood experiences, access to care, and structural racism). However, the Committee reiterated that equity is an essential part of quality and must be part of the value equation for healthcare.

PATH FORWARD

Performance measurement and associated policies offer opportunities to assess, support, and incentivize the reduction of disparities and the achievement of health equity. The Committee's roadmap is intended to lay the foundation for a more comprehensive and systematic approach to measuring and advancing health equity. When developing the roadmap, the Committee sought to build on the work of ASPE[42] and NAM[43] while providing concrete guidance on operationalizing health equity measurement. The roadmap lays out four actions, "Four I's for Health Equity," that healthcare stakeholders can employ to reduce disparities:

- Identify and Prioritize Reducing Health Disparities
- Implement Evidence-Based Interventions to Reduce Disparities
- Invest in the Development and Use of Health Equity Performance Measures
- Incentivize the Reduction of Health Disparities and Achievement of Health Equity

To support measurement efforts, the Committee identified five domains of equity measurement: *Partnerships and Collaboration, Culture of Equity, Structures for Equity, Equitable Access to Care, and Equitable High-Quality Care*. Achieving an equitable healthcare system will require progress across all of the domains of measurement identified by the Committee.

Measurement can be a powerful force for change in healthcare. However, stakeholders (such as policymakers, legislators, hospital administrators, hospital delivery systems, community advocates, patient advocate groups, and providers) across the system must be motivated to act on the results of health equity performance measures and drive towards improved performance while ensuring that providers and clinicians have the resources necessary to care for those who are most vulnerable. Reducing disparities requires addressing them at every level of the healthcare system and engaging stakeholders in other sectors.

Stakeholders across the system must prioritize and invest in health equity. Identifying and developing measures that can reveal disparities as well as provide information on the use of interventions to reduce them is a crucial first step in achieving equity. Measurement must also be leveraged to incentivize and support equity. The current shift to value-based purchasing and alternative payment models can incentivize the reduction of disparities and support providers and clinicians working with vulnerable populations. However, such payment strategies must be implemented in ways that support organizations that disproportionately serve populations with social risk and protect access for individuals with social risk factors. Finally, more work is needed to identify and promote the use of effective interventions to reduce disparities.

The roadmap builds on NQF's 10 years of leadership in promoting health equity. The "Four I's for Health Equity" presented in the roadmap lay out four concrete strategies for healthcare stakeholders to reduce disparities and advance health equity. Reducing disparities and achieving meaningful progress towards health equity will require efforts from all stakeholders. NQF is committed to collaborating with stakeholders within healthcare and beyond to achieve health equity.

ENDNOTES

1 Centers for Disease Control and Prevention (CDC). Chronic disease prevention and health promotion website. https://www.cdc.gov/chronicdisease/healthequity/index.htm. Last accessed July 2017.

2 Agency for Healthcare Research and Quality (AHRQ). *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy.* Rockville, MD: AHRQ; 2016. Available at http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html. Last accessed October 2016.

3 HHS, Office of Minority Health. *National Stakeholder Strategy for Achieving Health Equity*. Washington, DC: HHS; 2016. Available at http://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf. Last accessed December 2016.

4 AHRQ. *2016 National Healthcare Quality and Disparities Report.* Rockville, MD: AHRQ; 2017.

5 AHRQ. *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy.* Rockville, MD: AHRQ; 2016. Available at http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html. Last accessed October 2016.

6 President's Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioral Science Research. *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services. Vol 1*. Washington, DC: President's Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioral Science Research; 1983.

7 Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.

8 IOM. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003.

9 HHS. *Performance Management and Measurement.* Washington, DC: Health Resources and Services Administration; 2011. Available at https://www.hrsa.gov/quality/toolbox/methodology/performancemanagement/. Last accessed March 2017.

10 Bilheimer LT, Klein RJ. Data and measurement issues in the analysis of health disparities website. http://www.rwjf.org/en/library/research/2010/10/health-services-research-in-2020-/data-and-measurement-issues-in-the-analysis-of-health-disparitie.html. Last accessed June 2017.

11 Robert Wood Johnson Foundation. Collecting data to identify disparities and measure heart care quality website. http://www.rwjf.org/en/library/articles-and-news/2010/03/collecting-data-to-identify-disparities-and-measure-heart-care-q.html. Last accessed June 2017.

12 Mead H, Cartwright-Smith L, Jones K, et al. *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook.* Washington, DC: The Commonwealth Fund; 2008. Available at http://www.commonwealthfund.org/publications/chartbooks/2008/mar/racial-and-ethnic-disparities-in-u-s--health-care--a-chartbook. Last accessed July 2017.

13 National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: National Academies Press; 2016.

14 Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981;19(2):127-140.

15 National Quality Forum (NQF). *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities*, Washington, DC: NQF; 2008. Available at http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx. Last accessed August 2017.

16 Chin MH, Walters AE, Cook SC, Huang ES. Interventions to reduce racial and ethnic disparities in health care. *Med Care Res Rev*. 2007;64(5 Suppl):7S-28S.

17 Clarke AR, Goddu AP, Nocon RS, et al. Thirty years of disparities intervention research: what are we doing to close racial and ethnic gaps in health care? *Med Care*. 2013;51:1020-1026.

18 Wilson L. *RWJF Progress Report – Finding Answers: Disparities Research for Change*. Princeton, NJ: Robert Wood Johnson Foundation; 2013. Last accessed June 2017.

19 National Academies of Sciences, Engineering, and Medicine. *Communities in Action: Pathways to Health Equity*. Washington, DC: The National Academies Press; 2017.

20 Glasgow L, Ashok M, Porterfield D, et al. *Understanding Options to Reduce Disparities in Cardiovascular Disease through Comparative Effectiveness Research.* Washington, DC: Patient-Centered Outcomes Research Institute (PCORI). Available at https://www.pcori.org/sites/default/files/PCORI-Landscape-Review-Understanding-Options-to-Reduce-Disparities-in-Cardiovascular-Disease-Dec-2013.pdf. Last accessed September 2017.

21 Wyatt R, Laderman M, Botwinick L, et al. *Achieving Health Equity: A Guide for Health Care Organizations.* IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

22 Cooper LA, Hill MN, Powe NR. Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *J Gen Intern Med*. 2002;17(6):477-486.

23 Chin MH, Clarke AR, Nocon RS, et al. A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *J Gen Intern Med*. 2012;27(8):992-1000.

24 Mauer BJ. *Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home*. Washington, DC: National Council for Behavioral Health Care; 2009.

25 Martinez W, Lehmann LS, Thomas EJ, et al. Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. *BMJ Qual Saf*. 2017;[epub].

26 Webb LE, Dmochowski RR, Moore IN, et al. Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. *Jt Comm J Qual Patient Saf*. 2016;42(4):149-164.

27 Martinez W, Bell SK, Etchegaray JM, et al. Measuring moral courage for interns and residents: scale development and initial psychometrics. *Acad Med.* 2016;91(10):1431-1438.

28 HHS. National CLAS Standards website. https://www.thinkculturalhealth.hhs.gov/clas. Last accessed July 2017.

29 National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: National Academies Press; 2016.

30 HHS, Office of the National Coordinator for Health Information Technology. *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule. 80 Fed. Reg. 62602-62759 (October 16, 2015), 45 CFR 170.* Available at https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf. Last accessed May 2017.

31 HHS, Office of Minority Health. The National CLAS Standards website. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. Last accessed May 2017.

32 World Health Organization (WHO). *Global Strategy on Human Resources for Health: Workforce 2030.* Geneva, Switzerland: WHO; 2016. Available at http://apps.who.int/iris/bitstream/10665/250368/1/9789241511131-eng.pdf?ua=1. Last accessed July 2017.

33 Carrillo JE, Carrillo VA, Perez HR, et al. Defining and targeting health care access barriers. *J Health Care Poor Underserved.* 2011;22(2):562-575.

34 Leiyu S, Starfield B, Politzer R, et al. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res*. 2002;37(3):529-550.

35 Lin Y, Ebert JM, Probst JC. Ambulatory care – sensitive condition hospitalizations among Medicare Beneficiaries. *Am J Prev Med*. 2016;51*(4):493-501.*

36 Billioux A, Verlander K, Anthony S, Alley D. *Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool.* Washington, DC: National Academy of Medicine; 2017. Available at https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Last accessed September 2017.

37 Centers for Disease Control and Prevention (CDC). *ICD-10-CM Official Guidelines for Coding and Reporting: FY 2016*. Atlanta, GA: CDC; 2016. Available at https://www.cdc.gov/nchs/data/icd/10cmguidelines_2016_final.pdf. Last accessed July 2017.

38 Shi L, Starfield B, Politzer R, et al. Primary care, self-rated health, and reductions in social disparities in health. *Health Serv Res*. 2002;37(3):529-550.

39 DeMeester RH, Xu LJ, Nocon RS, Cook SC, et al. Solving disparities through payment and delivery system reform: A program to achieve health equity. *Health Aff (Millwood)*. 2017;36(6):1133-1139.

40 Ogbolu Y, Fitzpatrick GA.. Advancing organizational cultural competency with dissemination and implementation frameworks: towards translating standards into clinical practice. *ANS Adv Nurs Sci.* 2015;38(3):203-214.

41 LaVeist TA, Gaskin D, Richard P. Estimating the economic burden of racial health inequalities in the United States. *Int J Health Serv*. 2011;41(2):231-238.

42 HHS, Office of the Assistant Secretary for Planning and Evaluation (ASPE). *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. Available at https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs. Last accessed July 2017.

43 National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors, and Methods.* Washington, DC: National Academies Press; 2016.

APPENDIX A:
Literature Review and Environmental Scan Methodology

NQF conducted a literature review to provide the Disparities Standing Committee with evidence related to health and healthcare disparities and to provide examples of the types of interventions that have proven effective in reducing disparities in health and healthcare outcomes. To support this goal, NQF conducted a search for information sources relevant to the disparities in the five target conditions associated with the social risk factors identified in the NAM report, *Accounting for Social Risk Factors in Medicare Payment*. The Committee provided key information sources and provided preliminary guidance on where to collect sources. Databases for the literature review included Academic Search Premier, PubMed/Medline, Google Scholar, PsychINFO, PAIS International, Ageline, Cochrane Collaboration, and Campbell Collaboration.

NQF conducted a targeted search within these databases using various combinations of keywords that were derived terms related to the target conditions and social risk factors as well as general terms to capture broader work that may include relevant information. NQF also searched by population types including ethnic and racial minorities according to the Office of Management and Budget definitions. The search was confined to U.S.-based work published between 2010 and 2016. The literature review was not meant to be exhaustive, nor does it include all populations affected by health and healthcare disparities. Rather, it highlights examples of disparities and effective interventions within the selected conditions and illustrates the associations found between social risk factors and health and healthcare outcomes. The information from the literature review informed the development of the roadmap to reduce disparities in health and healthcare . The literature review resulted in over 900 sources. After a review of abstracts, about 370 sources were identified as highly relevant. The literature review documented interventions that have shown effectiveness in reducing disparities within the selected conditions as well as interventions that provide lessons on how to counteract multiple social risk factors across a variety of populations.

NQF also conducted an environmental scan for measures. The purpose of the environmental scan was to identify performance measures and measure concepts that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities. These include performance measures that are "disparities-sensitive" (i.e., measures that detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups) and performance measures that aligned with the priority domains of measurement outlined in the Committee's roadmap.

The environmental scan consisted of a search for performance measures in several measure repositories, including but not limited to NQF's portfolio of performance measures (endorsed and not endorsed), the AHRQ National Quality Measures Clearinghouse, the National Guidelines Clearinghouse, the CMS measure inventory, and the Health Indicators Warehouse. NQF conducted a targeted search within these databases using various combinations of keywords that were derived terms related to the selected conditions, interventions known to reduce disparities, and social risk factors, as well as terms associated with the Committee's priority domains of measurement.

NQF prioritized performance measures based on a set of predetermined criteria. In 2012, NQF's Disparities Standing Committee created a **protocol for identifying disparities-sensitive measures**

based on a commissioned paper by the Disparities Solution Center at Massachusetts General Hospital. The process involves examining how prevalent a condition is among a population with social risk factors, the size of the gap in quality of care, the impact that the measurement area has on the population, and the extent to which the care is sensitive to inadequate communication and sensitive to patient and provider preferences. Lastly, performance measures are classified as disparities-sensitive if the underlying outcome is highly dependent on social determinants of health.

NQF solicited feedback from 19 key informants with in-depth knowledge of each selected condition, disparities, and measurement. These experts were selected from NQF's Cardiovascular, Cancer, Renal, Perinatal, Endocrine, and Behavioral Health Standing Committees. They reviewed the measures identified from the environmental scan for completeness and assessed the extent to which they can be used to reduce disparities based on the criteria for identifying disparities-sensitive measures. The experts also provided feedback on gaps in measurement, as well as data needed to develop new performance measures for disparities measurement.

NQF categorized the performance measures found in the environmental scan based on the domains to which they most closely align. The majority of measures found aligned with the *Equitable Access to Healthcare Quality* domain. Many of the subdomains represent concepts that are not yet well measured by the healthcare system. The full compendium of measures is posted to the NQF disparities project webpage.

Following the collection and categorization of measures, NQF solicited input from the Committee to highlight specific "core measures" that can be used to address disparities now. Committee members called out specific measures and developed exclusionary criteria to identify additional measures from the existing compendium. The following criteria were applied to all outcome measures in the *Equitable High-Quality Care* domain in order to identify additional core measures:

1. Measures for which the denominator includes a large number of patients affected by a social risk factor or set of risk factors
2. Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings)
3. Outcome measures where there is a clear link between the outcome being measured and a set of actions

NQF posted the draft comprehensive report for a 30-day public commenting period from July 21 to August 21, 2017. Comments were compiled, sorted into themes, and shared with the Committee. The Committee convened on August 30, 2017 to discuss the comments received and finalize report language.

APPENDIX B:
Definitions and Terms

Domain of measurement: A domain of measurement is a categorization/grouping of high-level ideas and measure concepts that further describes the measurement roadmap, and a subdomain is a smaller categorization/grouping within a domain.

Subdomain: A smaller categorization/grouping within a domain.

Measurement roadmap: a conceptual model to provide structure for organizing currently available measures, identifying areas where gaps in measurement exist, and prioritizing areas for future measure development. The roadmap enables stakeholders to organize ideas about what is important to measure for a topic area and how measurement should take place (e.g., whose performance should be measured, care settings where measurement is needed, when measurement should occur, which individuals should be included in measurement, etc.).

Performance measure: A fully developed metric that includes detailed specifications and may have undergone scientific testing.

Measure concept: An idea for a measure that includes a description of the measure, including planned target and population.

Health disparity: The HHS Office of Minority Health describes a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (based on individuals' gender, age, race, and/or ethnic group, etc.). Healthcare disparities are related to "differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions" (i.e., differences based on discrimination and stereotyping).

Health equity measure: A performance measure that can be linked to an intervention that reduces disparities in health or healthcare.

APPENDIX C:
Disparities Standing Committee Meetings

The Disparities Standing Committee convened four times over the life of the project. NQF hosted an orientation web meeting on October 19, 2016, to discuss the project's objectives and approach. The Committee convened a second time on January 19, 2017, to discuss the findings of the first interim report, **Disparities in Health and Healthcare Outcomes in Selected Conditions**, and how these findings would inform the Committee's roadmap. The Committee also discussed the outline and approach to the second interim report, **Effective Interventions in Reducing Disparities in Healthcare and Health Outcomes in Selected Conditions**.

The Committee met for a two-day, in-person meeting on March 27-28 to identify and prioritize areas of measurement, refine the roadmap for measure development, and provide input on an environmental scan of performance measures that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities. During the meeting and in post-meeting follow-up, the Committee finalized the five domains of measurement for use with the Committee's roadmap. The Committee also discussed the findings of the environmental scan for measures documented in the third interim report, **An Environmental Scan of Health Equity Measures and a Conceptual Framework for Measure Development**.

On June 14-15, the Committee convened again to finalize the roadmap as well as make final recommendations for implementation. Prior to the meeting, members of the Committee submitted ideas for potential measures that could be used to address health equity and minimize disparities. The full list of submitted measure concept ideas is posted to the **NQF disparities project webpage**. During the meeting, the Committee discussed the proposed measure concepts and additional gaps in measurement. The final recommendations made by the Committee during the second in-person meeting are detailed in this report.

The Committee convened on August 30, 2017, to discuss and respond to the comments received during the commenting period (July 21-August 21).

APPENDIX D:
Examples of Disparities-Sensitive Measures

The Committee recognized that disparities exist across many conditions. The disparities-sensitive criteria help identify measures that can help detect disparities in care. However, the Committee noted that stakeholders may need a set of examples to assist in the prioritization of disparities measures. The table below contains examples of disparities-sensitive measures. The selection of these core measures focused on high-impact or highly prevalent conditions as well as measures that cut across conditions and populations.

Committee members proposed specific measures as well as the following criteria to apply to all outcome measures in the *Equitable High-Quality Care* domain in order to identify additional core measures:

1. Measures for which the denominator includes a large number of patients affected by a social risk factor or set of risk factors
2. Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings)
3. Outcome measures where there is a clear link between the outcome being measured and a set of actions

Condition Area	Measure Title	NQF Number
Cross-cutting	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Cross-cutting	LBP: Evaluation of Patient Experience	0308
Cancer	Breast Cancer Screening	0031
Cancer	Breast Cancer Screening	2372
Cancer	Breast Cancer Screening	2372
Cancer	Cervical Cancer Screening	0032
Cancer	Colorectal Cancer Screening	0034
Cardiovascular Disease	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients with ST Segment Elevation Myocardial Infarction (STEMI) or Cardiogenic Shock	0536
Cardiovascular Disease	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients Without ST Segment Elevation Myocardial Infarction (STEMI) and Without Cardiogenic Shock	0535
Cardiovascular Disease	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	0698
Cardiovascular Disease	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	0699
Cardiovascular Disease	Acute Myocardial Infarction (AMI) Mortality Rate	0730
Cardiovascular Disease	Adherence to Statin Therapy for Individuals with Cardiovascular Disease	0543
Cardiovascular Disease	Adherence to Statins	0569
Cardiovascular Disease	Adult Smoking Cessation Advice/Counseling	9999
Cardiovascular Disease	Congestive Heart Failure Rate (PQI 08)	0277
Cardiovascular Disease	Controlling High Blood Pressure	0018

Condition Area	Measure Title	NQF Number
Cardiovascular Disease	Controlling High Blood Pressure for People with Serious Mental Illness	2602
Cardiovascular Disease	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Cardiovascular Disease	Heart Failure Mortality Rate (IQI 16)	358
Cardiovascular Disease	Heart Failure Symptoms Assessed and Addressed	0521
Cardiovascular Disease	Heart Failure: Symptom and Activity Assessment	0077
Cardiovascular Disease	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
Cardiovascular Disease	Hypertension Plan of Care	0017
Cardiovascular Disease	Median Time to ECG	0289
Cardiovascular Disease	Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290
Cardiovascular Disease	Optimal Vascular Care	0076
Cardiovascular Disease	Pediatric All-Condition Readmission Measure	2393
Cardiovascular Disease	Shared Decision Making Process	2962
Diabetes/Chronic Kidney Disease	Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	2467
Diabetes/Chronic Kidney Disease	Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	2468
Diabetes/Chronic Kidney Disease	CAHPS in-Center Hemodialysis Survey	0258
Diabetes/Chronic Kidney Disease	Comprehensive Diabetes Care	0731
Diabetes/Chronic Kidney Disease	Controlling High Blood Pressure	0018
Diabetes/Chronic Kidney Disease	Diabetes Composite	0729
Diabetes/Chronic Kidney Disease	Diabetes Long-Term Complications Admission Rate (PQI 03)	0274
Diabetes/Chronic Kidney Disease	Diabetes: Hemoglobin A1c Poor Control	0059
Diabetes/Chronic Kidney Disease	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
Diabetes/Chronic Kidney Disease	LBP: Patient Education	0307
Diabetes/Chronic Kidney Disease	Monitoring Hemoglobin Levels Below Target Minimum	0370
Diabetes/Chronic Kidney Disease	Patient Education Awareness—Facility Level	0324
Diabetes/Chronic Kidney Disease	Patient Education Awareness—Physician Level	0320
Diabetes/Chronic Kidney Disease	Uncontrolled Diabetes Admission Rate (PQI 14)	0638
Infant Mortality	Adverse Outcome Index	1769
Infant Mortality	Birth Trauma	0742

Condition Area	Measure Title	NQF Number
Infant Mortality	Birth Trauma – Injury to Neonate (PSI 17)	0474
Infant Mortality	Gastroenteritis Admission Rate (PDI 16)	0727
Infant Mortality	Neonatal Intensive Care All-Condition Readmissions	2893
Infant Mortality	Pediatric All-Condition Readmission Measure	2393
Infant Mortality	PICU Standardized Mortality Ratio	0343
Infant Mortality	PICU Unplanned Readmission Rate	0335
Infant Mortality	Unexpected Complications in Term Newborns	0716
Infant Mortality	Unplanned Maternal Admission to the ICU	0745
Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1879
Mental Illness	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1880
Mental Illness	Alcohol Screening and Follow-Up for People with Serious Mental Illness	2599
Mental Illness	Alcohol Use Screening	1661
Mental Illness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365
Mental Illness	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	1364
Mental Illness	Clinical Depression Screening and Follow-Up Reporting Measure	9999
Mental Illness	Depression Remission at Six Months	0711
Mental Illness	Depression Remission at Twelve Months	0710
Mental Illness	Depression Response at Six Months- Progress Towards Remission	1884
Mental Illness	Depression Response at Twelve Months- Progress Towards Remission	1885
Mental Illness	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Mental Illness	Preventative Care and Screening: Screening for Depression and Follow Up Plan	3132
Mental Illness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	0418

APPENDIX E:
Compendium of Measures by Domain

The table below contains the results of a search for measures that can be used to assess the extent to which stakeholders are employing effective interventions to reduce disparities as well as measures that can be used to monitor care associated with conditions that are known to have health and healthcare disparities. NQF conducted the environmental scan by searching for measures in the following databases:

- National Quality Forum – Quality Positioning System (NQF QPS)
- Centers for Medicare & Medicaid Services (CMS) Measures Inventory
- Agency for Healthcare Research and Quality (AHRQ)
  - National Quality Measures Clearinghouse
  - National Guidelines Clearinghouse
- Health Indicators Warehouse (HIW)

The compendium is organized by the priority domains of measurement identified by the NQF Disparities Standing Committee. A spreadsheet containing the information in this appendix can be sorted by selected conditions (i.e., cardiovascular disease [CVD], cancer, infant mortality, low birth weight, mental illness, diabetes, and chronic kidney disease [CKD]). The complete compendium, which includes the measures' specifications and subdomain, can be found on the **NQF disparities project webpage**.

DOMAIN:
Partnerships and Collaboration

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Functional Change: Change in Mobility Score for Skilled Nursing Facilities	Outcome	2774	NQF QPS
Diabetes/CKD	Assessment of Iron Stores	Process	0252	NQF QPS
Mental Illness	Assessment of Integrated Care: Overall Score on the Site Self Assessment (SSA) Evaluation Tool	Process		AHRQ
Mental Illness	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool.	Process		AHRQ
Mental Illness	Closing the Referral Loop: Receipt of Specialist Report	Process		CMS
Mental Illness	Health Education, Suicide Prevention: Schools	Not available		HIW

DOMAIN:
Culture of Equity

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	New Cancer Patient– Intervention Urgency	Outcome	1752	NQF QPS
Cross-cutting	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Outcome	1904	NQF QPS
Cross-cutting	Cross-Cultural Communication Measure Derived from the Cross-Cultural Communication Domain of the C-CAT	Outcome	1894	NQF QPS
Cross-cutting	Health Literacy Measure Derived from the Health Literacy Domain of the C-CAT	Outcome	1898	NQF QPS
Cross-cutting	Individual Engagement Measure Derived from the Individual Engagement Domain of the C-CAT	Outcome	1892	NQF QPS
Cross-cutting	Language Services Measure Derived from Language Services Domain of the C-CAT	Outcome	1896	NQF QPS
Cross-cutting	Leadership Commitment Measure Derived from the Leadership Commitment Domain of the C-CAT	Outcome	1905	NQF QPS
Cross-cutting	Performance Evaluation Measure Derived from Performance Evaluation Domain of the C-CAT	Outcome	1901	NQF QPS
Cross-cutting	Workforce Development Measure Derived from Workforce Development Domain of the C-CAT	Outcome	1888	NQF QPS
CVD	Adult Depression in Primary Care: Percentage of Patients with Cardiovascular Disease with Documentation of Screening for Major Depression or Persistent Depressive Disorder Using Either PHQ-2 or PHQ-9.	Process		AHRQ
CVD	Hypertension Plan of Care	Outcome	0017	NQF QPS
Diabetes/CKD	Anemia of Chronic Kidney Disease: Patient Informed Consent for ESA Treatment	Process		CMS
Diabetes/CKD	Assessment of Health-Related Quality of Life in Dialysis Patients	Process	0260	NQF QPS
Diabetes/CKD	Bipolar Disorder: Assessment for Diabetes	Process	0003	NQF QPS
Diabetes/CKD	CAHPS in-Center Hemodialysis Survey	Outcome: PRO	0258	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	Outcome	2606	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Eye Exam	Process	2609	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	Outcome	2608	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	2607	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	Process	2603	NQF QPS
Diabetes/CKD	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	Process	2604	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Process	1934	NQF QPS
Diabetes/CKD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Process	1932	NQF QPS
Infant Mortality	Hospital Inpatients' Experiences: Percentage of Parents Who Reported How Often Providers Prevented Mistakes and Helped Them to Report Concerns.	Consumer Experience		AHRQ
Infant Mortality	Maternal Depression Screening	Process	1401	NQF QPS
Infant Mortality	Preterm Births, <32 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, 32-33 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, 32-36 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, 34-36 Weeks of Gestation (Percent)	Outcome		HIW
Infant Mortality	Preterm Births, Total (Percent)	Outcome		HIW
Mental Illness	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	Outcome		CMS
Mental Illness	Advanced Care Planning for Patients with Parkinson's Disease	Process		CMS
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Client Preferences" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Community Resources" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Evidence-Based Practice" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Family Education" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Family Involvement" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Stigma" Scale.	Structure		AHRQ
Mental Illness	Competency Assessment Instrument (CAI): Provider's Mean Score on the "Team Value" Scale.	Structure		AHRQ
Mental Illness	HCBS CAHPS Measure (1 of 19): Staff Are Reliable and Helpful	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (10 of 19): Global Rating of Case Manager	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (11 of 19): Would Recommend Personal Assistance/Behavioral Health Staff to Family and Friends	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (12 of 19): Would Recommend Homemaker to Family and Friends	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (13 of 19): Would Recommend Case Manager to Family and Friends	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (14 of 19): Unmet Need in Dressing/ Bathing Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (15 of 19): Unmet Need in Meal Preparation/Eating Due to Lack of Help	Outcome	2267	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	HCBS CAHPS Measure (16 of 19): Unmet Need in Medication Administration Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (17 of 19): Unmet Need in Toileting Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (18 of 19): Unmet Need with Household Tasks Due to Lack of Help	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (19 of 19): Hit or Hurt by Staff	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (2 of 19): Staff Listen and Communicate Well.	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (3 of 19): Case Manager is Helpful	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (4 of 19): Choosing the Services That Matter to You.	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (6 of 19): Personal Safety and Respect	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (7 of 19): Planning Your Time and Activities	Outcome	2267	CMS
Mental Illness	HCBS CAHPS Measure (8 of 19): Global Rating of Personal Assistance and Behavioral Health Staff	Outcome	2267	CMS
Mental Illness	Hospital-Based Inpatient Psychiatric Services: The Total Number of Hours That All Patients Admitted to a Hospital-Based Inpatient Psychiatric Setting Were Maintained in Physical Restraint.	Process	0640	AHRQ

DOMAIN:
Structure for Equity

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cervical Cancer Screening: Percentage of Pap Tests for Which the Time Between the Date the Pap Test is Performed and the Date That Pap Test is Processed by the Laboratory is Less Than or Equal to 14 Days.	Process		AHRQ
Cancer	Melanoma: Continuity of Care – Recall System	Structure	0650	NQF QPS
Cancer	Radical Prostatectomy Pathology Reporting	Process	1853	NQF QPS
Cancer	Radiology: Reminder System for Screening Mammograms	Structure	0509	CMS
Cancer	Statewide Cancer Registries	Process		HIW
Cross-cutting	L1A: Screening for Preferred Spoken Language for Health Care	Process	1824	NQF QPS
CVD	Adult Current Smoking Prevalence	Structure	2020	QPS
CVD	Annual Monitoring for Patients on Persistent Medications (MPM)	Process	2371	QPS
CVD	Atherosclerotic Disease - Lipid Panel Monitoring	Process	0616	QPS
CVD	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Process	1927	QPS
CVD	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Process	1933	QPS
CVD	Carotid Artery Stenting: Evaluation of Vital Status and NIH Stroke Scale at Follow Up	Process	2396	QPS
CVD	Coronary Heart Disease Deaths	Outcome		HIW
CVD	Dyslipidemia New Med 12-Week Lipid Test	Process	0583	QPS
CVD	Functional Change: Change in Self Care Score for Skilled Nursing Facilities	Outcome	2769	QPS
CVD	In-Person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)	Process	2461	CMS
CVD	In-Person Evaluation Following Implantation of a Cardiovascular Implantable Electronic Device (CIED)	Process	2461	QPS
CVD	New Atrial Fibrillation: Thyroid Function Test	Process	0600	QPS
CVD	Participation in a Systematic National Database for General Thoracic Surgery	Structure	0456	QPS
CVD	Patient(s) with Hypertension That Had a Serum Creatinine in Last 12 Reported Months.	Process	0605	QPS
CVD	Prevention and Management of Obesity for Adults: Percentage of Patients with BMI Greater Than or Equal to 25 Who Have 30 Minutes of Any Type of Physical Activity Five Times Per Week Documented.	Process		AHRQ - 008874
CVD	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Process	0541	QPS
Diabetes/CKD	Anemia Management Reporting Measure	Process		CMS
Diabetes/CKD	Chronic Kidney Disease (CKD): Monitoring Calcium	Process	0574	QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Chronic Kidney Disease (CKD): Monitoring Parathyroid Hormone (PTH)	Process	0571	QPS
Diabetes/CKD	Chronic Kidney Disease (CKD): Monitoring Phosphorus	Process	0570	QPS
Diabetes/CKD	Comorbidity Reporting Measure			CMS
Diabetes/CKD	Diabetes and Elevated HbA1C – Use of Diabetes Medications	Process	0630	QPS
Diabetes/CKD	Diabetes: The Relative Resource Use by Members with Diabetes During the Measurement Year.	Cost/ Resource Use		AHRQ
Diabetes/CKD	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1418	QPS
Diabetes/CKD	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	QPS
Diabetes/CKD	Lower-Extremity Amputation Among Patients with Diabetes Rate (PQI 16)	Outcome	0285	QPS
Diabetes/CKD	Per Capita Cost for Beneficiaries with Diabetes	Cost/ Resource Use		CMS
Diabetes/CKD	Relative Resource Use for People with Diabetes (Inpatient Facility Index)	Process	1557	CMS
Diabetes/CKD	Standardized Hospitalization Ratio for Dialysis Facilities	Outcome	1463	QPS
Infant Mortality	Adult Current Smoking Prevalence	Structure	2015	NQF QPS
Infant Mortality	Alcohol Abstinence, Prenatal	Outcome		HIW
Infant Mortality	Anencephaly	Outcome		HIW
Infant Mortality	Breastfeeding at 1 Year	Outcome		HIW
Infant Mortality	Breastfeeding at 6 Months	Outcome		HIW
Infant Mortality	Breastfeeding, Ever	Outcome		HIW
Infant Mortality	Breastfeeding, Exclusively Through 3 Months	Outcome		HIW
Infant Mortality	Breastfeeding, Exclusively Through 6 Months	Outcome		HIW
Infant Mortality	Cigarette Abstinence, Prenatal	Outcome		HIW
Infant Mortality	Deaths: Infants with Down Syndrome	Outcome		HIW
Infant Mortality	Five Minute APGAR Less Than 7	Outcome	0741	NQF QPS
Infant Mortality	Formula Supplementation: Breastfed Newborns	Outcome		HIW
Infant Mortality	Illicit Drug Abstinence, Prenatal	Outcome		HIW
Infant Mortality	Infant Deaths Between 28 Days-1 Year	Outcome		HIW
Infant Mortality	Infant Deaths Within First 28 Days of Life	Outcome		HIW
Infant Mortality	Infant Deaths, All	Outcome		HIW
Infant Mortality	Infant Deaths: Congenital Heart Defects	Outcome		HIW
Infant Mortality	Infant Deaths: Sudden Unexpected/Unexplained Causes	Outcome		HIW
Infant Mortality	Low Birth Weight Rate (PQI 9)	Outcome	0278	NQF QPS
Infant Mortality	PC-05 Exclusive Breast Milk Feeding	Process	0480	NQF QPS
Infant Mortality	Percent of Live Births That Are Low Birth Weight (LBW)	Outcome		HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Percentage of Low Birthweight Births	Outcome	1382	NQF QPS
Infant Mortality	Perinatal Deaths	Outcome		HIW
Infant Mortality	Pregnancies Conceived Within 18 Months of Previous Birth	Outcome		HIW
Infant Mortality	Smoking Abstinence, Preconception	Outcome		HIW
Infant Mortality	Smoking Cessation During Pregnancy	Outcome		HIW
Infant Mortality	Very Low Birth Weight Deliveries (Percent)	Outcome		HIW
Infant Mortality	Worksite Lactation Support Programs	Structure		HIW
Mental Illness	Depression Assessment Conducted	Process	0518	QPS

DOMAIN:
Equitable Access to Care

Condition Area	Measure Title	Measure Type	NQF #	Source
Cancer	Cervical Cancer Screening: Percentage of Women Age 21 Years and Older Screened in Accordance with Evidence-Based Standards.	Process		AHRQ
Cancer	New Cancer Patient– Intervention Urgency	Outcome	1752	NQF QPS
Cancer	Preventive Services: Percentage of Adult Enrolled Members Age 19 Years and Older Who Are Up-to-Date for All Appropriate Preventive Services (Combination 6).	Process		AHRQ
CVD	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Process	0070	NQF QPS
CVD	Duration of Antibiotic Prophylaxis for Cardiac Surgery Patients	Process	0128	NQF QPS
CVD	ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	Process	0661	CMS
CVD	Heart Failure in Adults: Percentage of Heart Failure Patients Who Are Current Smokers or Tobacco Users Who Received Smoking Cessation Advice or Counseling in Primary Care.	Process		AHRQ
CVD	Heart Failure: Post-Discharge Appointment for Heart Failure Patients	Process	2455	NQF QPS
CVD	Relative Resource Use for People with Cardiovascular Conditions (RCA)	Cost/ Resource Use	1558	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Referral to Nephrologist	Process		CMS
Diabetes/CKD	Kidney Transplant Referral Rate for Prevalent Dialysis Patients	Process		CMS
Diabetes/CKD	Kidney Transplant Waitlist Decision Rate for Prevalent Dialysis Patients	Process		CMS
Diabetes/CKD	Per Capita Cost for Beneficiaries with Diabetes	Cost/ Resource Use		CMS
Diabetes/CKD	Percentage of Prevalent Patients Waitlisted (PPPW)	Process		CMS
Diabetes/CKD	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Process	0541	NQF QPS
Diabetes/CKD	Standardized First Kidney Transplant Waitlist Ratio for Incident Dialysis Patients (SWR)	Process		CMS
Diabetes/CKD	Standardized Kidney Transplant Referral Ratio for Incident Dialysis Patients	Process		CMS
Infant Mortality	Birth Dose of Hepatitis B Vaccine and Hepatitis B Immune Globulin for Newborns of Hepatitis B Surface Antigen (HBsAg) Positive Mothers	Process	0479	NQF QPS
Infant Mortality	Chlamydia Screening and Follow Up	Process	1395	NQF QPS
Infant Mortality	Contraceptive Care - Access to LARC	Structure	2904	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Source
Infant Mortality	Contraceptive Care – Most & Moderately Effective Methods	Outcome	2903	NQF QPS
Infant Mortality	Contraceptive Care - Postpartum	Outcome	2902	NQF QPS
Infant Mortality	Frequency of Ongoing Prenatal Care (FPC)	Process	1391	NQF QPS
Infant Mortality	Lactation Care in Birthing Facilities	Structure		HIW
Infant Mortality	Patient-Centered Medical Home Patients' Experiences: Percentage of Parents or Guardians Who Reported How Often They Were Able to Get the Care Their Child Needed from Their Child's Provider's Office During Evenings, Weekends, or Holidays.	Consumer Experience		AHRQ
Infant Mortality	Prenatal & Postpartum Care (PPC)	Process	1517	NQF QPS
Infant Mortality	Prenatal Care, Early and Adequate	Process		HIW
Infant Mortality	Prenatal Care, First Trimester	Process		HIW
Infant Mortality	Preventive Services for Children and Adolescents: Percentage of Newborns Who Have Had Neonatal Screening for Hemoglobinopathies, Phenylketonuria and Hypothyroidism in the First Week of Life.	Process		AHRQ
Infant Mortality	Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity.	Process	0483	NQF QPS
Infant Mortality	Reproductive Health Services Receipt: Sexually Active Females	Process		HIW
Infant Mortality	Structural Attributes of Facility in Which High Risk Women Deliver Newborns: A PQMP Measure	Structure	2896	NQF QPS
Infant Mortality	Under 1500g Infant Not Delivered at Appropriate Level of Care	Outcome	0477	NQF QPS
Infant Mortality	Very Low Birth Weight Infants Born at Level III Hospitals			HIW
Mental Illness	Behavioral Health Care Patients' Experiences: Percentage of Adult Patients Who Reported How Often They Were Seen Within 15 Minutes of Their Appointment.	Patient Experience		AHRQ
Mental Illness	Follow-Up After Hospitalization for Mental Illness	Process	0576	NQF QPS
Mental Illness	Follow-Up After Hospitalization for Schizophrenia (7- and 30-Day)	Process	1937	NQF QPS
Mental Illness	HCBS CAHPS Measure (5 of 19): Transportation to Medical Appointments	Outcome	2267	CMS
Mental Illness	Mental Illness Services Receipt: Homeless Adults			HIW
Mental Illness	Mental Illness Utilization: Number and Percentage of Members Receiving the Following Mental Illness Services During the Measurement Year: Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and Outpatient or ED.			CMS

DOMAIN:
Equitable High-Quality Care

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Adjuvant Chemotherapy is Recommended or Administered Within 4 Months (120 Days) of Diagnosis to Patients Under the Age of 80 with AJCC III (Lymph Node Positive) Colon Cancer	Process	0223	NQF QPS
Cancer	Adjuvant Hormonal Therapy	Process	0220	NQF QPS
Cancer	Age Appropriate Screening Colonoscopy	Efficiency		CMS
Cancer	Appropriate Age for Colorectal Cancer Screening Colonoscopy	Outcome		CMS
Cancer	Appropriate Follow-Up Imaging for Incidental Simple Ovarian Cysts	Process		CMS
Cancer	At Least 12 Regional Lymph Nodes Are Removed and Pathologically Examined for Resected Colon Cancer.	Process	0225	NQF QPS
Cancer	Barrett's Esophagus	Outcome	1854	NQF QPS
Cancer	Biopsy Follow-Up	Process	0645	CMS
Cancer	Breast Cancer Deaths	Outcome		HIW
Cancer	Breast Cancer Resection Pathology Reporting- pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Outcome	0391	NQF QPS
Cancer	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Process	0391	CMS
Cancer	Breast Cancer Screening	Process	2372	CMS
Cancer	Breast Cancer Screening	Process	2372	CMS
Cancer	Breast Cancer Screening	Process		CMS
Cancer	Breast Cancer Screening	Process	0031	NQF QPS
Cancer	Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Process	0387	NQF QPS
Cancer	Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Process	0387	CMS
Cancer	Cancer - Anorexia and Weight Loss: Percentage of Patients Treated with Enteral or Parenteral Nutrition Who Had an Assessment Prior to Starting Nutrition That There Was Difficulty Maintaining Nutrition Due to Significant Gastrointestinal Issues and That Expected Life Expectancy Was at Least One Month.			AHRQ
Cancer	Cancer - Anorexia and Weight Loss: Percentage of Patients Who Presented for an Initial Visit for Cancer Affecting the Oropharynx or Gastrointestinal Tract or Advanced Cancer at a Cancer-Related Outpatient Site for Whom There Was an Assessment for the Presence or Absence of Anorexia or Dysphagia.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cancer - Delirium: Percentage of Hospitalized Patients with Cancer Over the Age of 65 or with Advanced Cancer with Delirium for Whom There Was an Assessment for the Presence or Absence of at Least One of the Following Potential Causes and Their Association with Delirium: Medication Effects, Central Nervous System Disease, Infection, or Metabolic Processes.			AHRQ
Cancer	Cancer - Dyspnea: Percentage of Inpatients with Primary Lung Cancer or Advanced Cancer with Dyspnea on Admission Who Were Offered Symptomatic Management or Treatment Directed at an Underlying Cause Within 24 Hours.			AHRQ
Cancer	Cancer - Dyspnea: Percentage of Outpatients with Primary Lung Cancer or Advanced Cancer Who Reported New or Worsening Dyspnea Who Were Offered Symptomatic Management or Treatment Directed at an Underlying Cause Within One Month.			AHRQ
Cancer	Cancer - Dyspnea: Percentage of Patients in the Hospital Treated for Dyspnea Who Had an Assessment Within 24 Hours That the Treatment Was Effective in Relieving Dyspnea or That a Change in Treatment for Dyspnea Was Made.			AHRQ
Cancer	Cancer - Fatigue/Anemia: Percentage of Known Cancer Patients Who Are Newly Diagnosed with Cancer Who Had an Assessment of the Presence or Absence of Fatigue.			AHRQ
Cancer	Cancer - Fatigue/Anemia: Percentage of Patients Seen for an Initial Visit or Any Visit While Undergoing Chemotherapy at a Cancer-Related Outpatient Site for Whom There Was an Assessment of the Presence or Absence of Fatigue.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Are Admitted to the ICU and Survive 48 Hours for Whom the Patient's Preferences for Care or an Attempt to Identify Them Was Documented in the Medical Record Within 48 Hours of ICU Admission.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Are Mechanically Ventilated in the ICU for Whom the Patient's Preference for Mechanical Ventilation or Why This Information Was Unavailable Was Documented in the Medical Record Within 48 Hours of Admission to the ICU.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Died an Expected Death for Whom There Was Documentation of an Advanced Directive or a Surrogate Decision Maker in the Medical Record.			AHRQ
Cancer	Cancer - Information and Care Planning: Percentage of Patients with Advanced Cancer Who Died an Expected Death Who Were Referred for Palliative Care Prior to Death (Hospital-Based or Community Hospice) or There Was Documentation Why There Was No Referral.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cancer - Nausea and Vomiting: Percentage of Patients Undergoing Moderately or Highly Emetic Chemotherapy or with Cancer Affecting the Gastrointestinal Tract or Abdomen Seen for a Visit in a Cancer-Related Outpatient Setting for Whom the Presence or Absence of Nausea or Vomiting Was Assessed at Every Visit.			AHRQ
Cancer	Cancer - Nausea and Vomiting: Percentage of Patients with Advanced Cancer Affecting the Gastrointestinal Tract or Abdomen Admitted to a Hospital for Whom the Presence or Absence of Nausea or Vomiting Was Assessed Within 24 Hours.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients Who Had a Cancer-Related Outpatient Visit Who Were Screened for the Presence or Absence and Intensity of Pain Using a Numeric Pain Score.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients Whose Outpatient Cancer Pain Regimen Changed for Whom There Was an Assessment of the Effectiveness of the Treatment at or Before the Next Outpatient Visit with That Provider or at Another Cancer-Related Outpatient Visit.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients with Advanced Cancer Who Received Radiation Treatment for Painful Bone Metastases for Whom Single-Fraction Radiation Was Offered OR There Was Documentation of a Contraindication to Single-Fraction Treatment.			AHRQ
Cancer	Cancer - Pain: Percentage of Patients with Cancer Pain Started on Chronic Opioid Treatment Who Were Offered Either a Prescription or Nonprescription Bowel Regimen Within 24 Hours or Had Documented Contraindication to a Bowel Regimen.			AHRQ
Cancer	Cancer - Skin Rash: Percentage of Patients Treated with Agents That Block Epidermal Growth Factor Receptors (EGFRs) for Whom the Presence and Severity of Skin Rash Was Evaluated Within One Month After Starting the Treatments and at Each Visit.			AHRQ
Cancer	Cancer Deaths, Total	Outcome		HIW
Cancer	Cancer Prevalence: Adults (Percent)	Outcome		HIW
Cancer	Cancer Survival	Outcome		HIW
Cancer	Cervical Cancer Screening	Process	0032	CMS
Cancer	Cervical Cancer Screening	Process	0032	CMS
Cancer	Cervical Cancer Screening	Process		CMS
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Non-Squamous Cell Carcinoma Diagnosed in a Year.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Squamous Cell Carcinoma Diagnosed in a Year.			AHRQ
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Non-Squamous Cell Carcinoma Diagnosed in a Year	Process		AHRQ
Cancer	Cervical Cancer Screening: Age Standardized Incidence Rate Per 100,000 Women of Invasive Cervical Cancer—Squamous Cell Carcinoma Diagnosed in a Year.	Process		AHRQ
Cancer	Cervical Cancer Screening: Number of Days at Which 90% of Pap Tests Are Processed by the Lab.			AHRQ
Cancer	Cervical Cancer Screening: Number of Days at Which 90% of Women with a High-Grade Pap Test Result Who Had a Follow-Up Colposcopy.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women Who Have a Subsequent Pap Test Within 3 Years (36 Months) of the Index Test with a Negative Result.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women Who Have a Subsequent Pap Test Within 42 Months of the Index Test with a Negative Result.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women with at Least One Pap Test in a 3-Year Frame.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Eligible Women with at Least One Pap Test in a 42-Month Time Frame.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Invasive Carcinoma of the Cervix Diagnosed at Stage 1 in a 12-Month Period.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Invasive Carcinoma of the Cervix Diagnosed at Stage 1 in a 12-Month Period.	Process		AHRQ
Cancer	Cervical Cancer Screening: Percentage of Pap Test Results That Are Reported as Unsatisfactory in a 12-Month Frame.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Pap Tests with an HSIL+ Result That Have a Histological Confirmation of HSIL, Carcinoma in Situ, or Invasive Carcinoma Within 12 Months of the HSIL+ Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Pap Tests with ASC-H Results That Have a Histological Confirmation of HSIL, Carcinoma in Situ, or Invasive Carcinoma Within 12 Months of the ASC-H Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women Who Had a Colposcopy Within 12 Months of a Pap Test with an ASC-H/HSIL+ Result Who Had a Histologic Investigation Within 12 Months of the ASC-H/HSIL+ Cytological Finding.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with a Cytological Finding of ASC-H/HSIL+ Who Had a Histologic Investigation Within 12 Months of the ASC-H/HSIL+ Cytological Finding.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Cervical Cancer Screening: Percentage of Women with a High-Grade Pap Test Result Who Had a Follow-Up Colposcopy Within 6 Weeks of the Index Pap Test Report Date.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with a Negative ASCUS, LSIL, AGC, ASC-H, HSIL or More Severe Pap Test Result.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Histology of HSIL Per 1000 Women Who Had a Pap Test in the Previous 12 Months.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Greater Than 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Within 0.5 to 3 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Within Greater Than 3 to 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Squamous Cell Carcinoma Who Are Diagnosed Greater Than 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Squamous Cell Carcinoma Who Are Diagnosed Within 0.5 to 3 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Squamous Cell Carcinoma Who Are Diagnosed Within Greater Than 3 to 5 Years Since Previous Pap Test.			AHRQ
Cancer	Cervical Cancer Screening: Percentage of Women with Invasive Cervical Cancer—Non-Squamous Cell Carcinomas Who Are Diagnosed Within Greater Than 3 to 5 Years Since Previous Pap Test.	Process		AHRQ
Cancer	Cervical Cancer Screening: Women 21-65 Years	Process		HIW
Cancer	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Process	0385	CMS
Cancer	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Process	0385	NQF QPS
Cancer	Colonoscopy Use: Adults 50-75 (Percent) (Source: NHIS)	Process		HIW
Cancer	Colonoscopy/Sigmoidoscopy: Adults 50+ (Percent)	Process		HIW
Cancer	Colorectal Cancer Deaths (Per 100,000)	Outcome		HIW
Cancer	Colorectal Cancer Deaths, Including Unspecified Sites	Outcome		HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Colorectal Cancer Resection Pathology Reporting- pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	Outcome	0392	NQF QPS
Cancer	Colorectal Cancer Screening	Process	0034	CMS
Cancer	Colorectal Cancer Screening: Persons 50-75 Years	Outcome		HIW
Cancer	Combination Chemotherapy is Recommended or Administered Within 4 Months (120 Days) of Diagnosis for Women Under 70 with AJCC T1cN0M0, or Stage IB - III Hormone Receptor Negative Breast Cancer.	Process	0559	NQF QPS
Cancer	Communication and Shared Decision-Making with Patients and Families for Interventional Oncology Procedures	Process		CMS
Cancer	Completeness of Pathology Reporting	Process	0224	NQF QPS
Cancer	Diagnostic Imaging: Percentage of Patients Undergoing a Screening Mammogram Whose Information is Entered into a Reminder System with a Target Due Date for the Next Mammogram.	Process	0509	AHRQ
Cancer	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Cost/ Resource Use		CMS
Cancer	External Beam Radiotherapy for Bone Metastases	Process	1822	NQF QPS
Cancer	Follow-Up After Initial Diagnosis and Treatment of Colorectal Cancer: Colonoscopy	Process	0572	NQF QPS
Cancer	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	Process	0379	NQF QPS
Cancer	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	Process	0380	NQF QPS
Cancer	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemia's: Baseline Cytogenetic Testing Performed on Bone Marrow	Process	0377	NQF QPS
Cancer	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	Process	0378	NQF QPS
Cancer	HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	Process	1857	NQF QPS
Cancer	HER2 Testing for Overexpression or Gene Amplification in Patients with Breast Cancer	Process	1878	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	History of Breast Cancer - Cancer Surveillance	Process	0623	NQF QPS
Cancer	History of Prostate Cancer - Cancer Surveillance	Process	0625	NQF QPS
Cancer	Invasive Colorectal Cancer	Process		HIW
Cancer	Invasive Uterine Cervical Cancer: Females	Process		HIW
Cancer	KRAS Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer Who Receive Anti-Epidermal Growth Factor Receptor Monoclonal Antibody Therapy	Process	1859	NQF QPS
Cancer	Late-Stage Breast Cancer: Females	Process		HIW
Cancer	Lung Cancer Deaths	Outcome		HIW
Cancer	Lung Cancer Reporting (Biopsy/Cytology Specimens)	Outcome		CMS
Cancer	Lung, Trachea, and Bronchus Cancer Deaths (Per 100,000)	Outcome		HIW
Cancer	Mammogram: Women 50+ (Percent) (Source: BRFSS)	Process		HIW
Cancer	Mammography Counseling: Women 50-74 Years	Process		HIW
Cancer	Mammography: Women 40+ (Percent) (Source: NHIS)	Process		HIW
Cancer	Mammography: Women 50-74 Years	Process		HIW
Cancer	Melanoma Coordination of Care	Process	0561	NQF QPS
Cancer	Melanoma: Percentage of Patients Who Undergo a Cervical Lymph Node Dissection (LND) or Completion Lymph Node Dissection (CLND) for Melanoma for Whom at Least 15 Regional Lymph Nodes Are Resected and Pathologically Examined.			AHRQ
Cancer	Minimally Invasive Surgery Performed for Patients with Endometrial Cancer	Process		CMS
Cancer	Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection	Process		CMS
Cancer	Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection	Process	0221	NQF QPS
Cancer	Non-Recommended Cervical Cancer Screening in Adolescent Females: Percentage of Adolescent Females 16 to 20 Years of Age Who Were Screened Unnecessarily for Cervical Cancer.			AHRQ
Cancer	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (Paired with 0384)	Process	0383	NQF QPS
Cancer	Oncology: Radiation Dose Limits to Normal Tissues	Process	0382	NQF QPS
Cancer	Oncology: Treatment Summary Communication – Radiation Oncology	Process	0381	NQF QPS
Cancer	Oncology: Cancer Stage Documented	Process	0386	CMS
Cancer	Oncology: Cancer Stage Documented	Process	0386	NQF QPS
Cancer	Oncology: Medical and Radiation - Pain Intensity Quantified	Process	0384	NQF QPS
Cancer	Overuse of Imaging for Staging Breast Cancer at Low Risk of Metastasis	Process		CMS
Cancer	Overutilization of Imaging Studies in Melanoma	Process	0562	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Pap Smears: Women 18+ (Percent) (Source: NHIS)	Process		HIW
Cancer	Pap Smears: Women 18+ Without Hysterectomy (Percent)	Process		HIW
Cancer	Pap Test Counseling: Women 21-65 Years	Process		HIW
Cancer	Pap Test: Women 18+ (Percent)	Process		HIW
Cancer	Patients with Advanced Cancer Screened for Pain at Outpatient Visits	Process		CMS
Cancer	Patients with Early Stage Breast Cancer Who Have Evaluation of the Axilla	Process	0222	NQF QPS
Cancer	Patients with Metastatic Colorectal Cancer and KRAS Gene Mutation Spared Treatment with Anti-Epidermal Growth Factor Receptor Monoclonal Antibodies	Process	1860	NQF QPS
Cancer	Post Breast Conservation Surgery Irradiation	Process	0219	NQF QPS
Cancer	Preoperative Diagnosis of Breast Cancer	Process		CMS
Cancer	Preventive Services for Adults: Percentage of Adolescent Girls and Women Age 21 and Younger Who Undergo Cervical Cancer Screening.	Process		AHRQ
Cancer	Preventive Services for Adults: Percentage of Women Ages 21 to 64 Years Who Have Screening for Cervical Cancer (Pap Test) Every Three Years.	Process		AHRQ
Cancer	Preventive Services for Adults: Percentage of Women Ages 65 to 70 Who Are Screened for Cervical Cancer and Have Undergone Appropriate Screening 10 Years Prior.	Process		AHRQ
Cancer	Preventive Services for Children and Adolescents: Percentage of Sexually Active Women Age 25 Years and Younger Who Have Had Screening for Chlamydia.			AHRQ
Cancer	Preventive Services: Percentage of Adult Enrolled Members Age 19 Years and Older Who Are Up-to-Date for All Appropriate Preventive Services (Combination 3).	Process		AHRQ
Cancer	Proportion Dying from Cancer in an Acute Care Setting	Process	0214	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days	Intermediate Clinical Outcome	0216	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life	Intermediate Clinical Outcome	0213	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Not Admitted to Hospice	Process	0215	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	Process	0210	NQF QPS
Cancer	Proportion of Patients Who Died from Cancer with More Than One Emergency Department Visit in the Last 30 Days of Life	Intermediate Clinical Outcome	0211	NQF QPS
Cancer	Proportion with More Than One Hospitalization in the Last 30 Days of Life	Process	0212	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cancer	Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer Patients	Process	0390	NQF QPS
Cancer	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or Very High Risk Prostate Cancer	Process	0390	CMS
Cancer	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Process	0389	NQF QPS
Cancer	Prostate Cancer: Three-Dimensional Radiotherapy	Process	0388	NQF QPS
Cancer	Pulmonary Resection: Percentage of Patients with Lung Cancer Undergoing Pulmonary Resection Who Have Documentation of at Least One of the Specified Mediastinal Staging Procedures.			AHRQ
Cancer	Quantitative HER2 Evaluation by IHC Uses the System Recommended by the ASCO/CAP Guidelines	Process	1855	NQF QPS
Cancer	Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer	Outcome	1790	NQF QPS
Cancer	Screening Colonoscopy Adenoma Detection Rate	Outcome		CMS
Cancer	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	Process		CMS
Cancer	Thyroid Nodules: Percentage of Patients with a Diagnosis of Thyroid Nodule(s) Who Had a Fine Needle Aspiration Biopsy Performed.			AHRQ
Cancer	Thyroid Nodules: Percentage of Patients with Thyroid Nodule(s) Who Had a Documented Physical Examination Description of the Nodule That Included All of the Following: Measurement, Texture, Mobility, Location and Presence or Absence of Palpable Cervical Lymph Node.			AHRQ
Cancer	Trastuzumab Administered to Patients with AJCC Stage I (T1c) – III and Human Epidermal Growth Factor Receptor 2 (HER2) Positive Breast Cancer Who Receive Adjuvant Chemotherapy	Process	1858	NQF QPS
Cancer	Unnecessary Screening Colonoscopy in Older Adults	Efficiency		CMS
Cancer	Uterine Cervix Cancer Deaths	Process		HIW
Cross-cutting	Care Coordination	Process		CMS
Cross-cutting	Care Coordination	Patient Engagement/ Experience		CMS
Cross-cutting	Cultural Competence	Process		CMS
Cross-cutting	Cultural Competency Implementation Measure	Process		CMS
Cross-cutting	Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator	Process	2842	NQF QPS
Cross-cutting	Family Experiences with Coordination of Care (FECC)-15: Caregiver Has Access to Medical Interpreter When Needed	Process	2849	NQF QPS
Cross-cutting	Follow-Up After ED Visit for Complex Populations	Process		CMS
Cross-cutting	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Cross-cutting	LBP: Evaluation of Patient Experience	Process	0308	NQF QPS
CVD	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients with ST Segment Elevation Myocardial Infarction (STEMI) or Cardiogenic Shock	Outcome	0536	NQF QPS
CVD	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients Without ST Segment Elevation Myocardial Infarction (STEMI) and Without Cardiogenic Shock	Outcome	0535	NQF QPS
CVD	Abdominal Aortic Aneurysm (AAA) Repair Mortality Rate (IQI 11)	Outcome	0359	NQF QPS
CVD	Ace Inhibitor / Angiotensin Receptor Blocker Use and Persistence Among Members with Coronary Artery Disease at High Risk for Coronary Events	Process	0551	NQF QPS
CVD	ACE/ARB Therapy at Discharge for ICD Implant Patients with Left Ventricular Systolic Dysfunction	Process	1522	NQF QPS
CVD	ACEI or ARB for Left Ventricular Systolic Dysfunction- Acute Myocardial Infarction (AMI) Patients	Process	0137	NQF QPS
CVD	Acute Myocardial Infarction (AMI) Mortality Rate	Outcome	0730	NQF QPS
CVD	Acute Myocardial Infarction (AMI): the Risk-Adjusted Rate of All-Cause in-Hospital Death Occurring Within 30 Days of First Admission to an Acute Care Hospital with a Diagnosis of AMI.	Outcome		AHRQ
CVD	Adult Smoking Cessation Advice/Counseling	Process	9999	CMS
CVD	Ambulatory Initiated Amiodarone Therapy: TSH Test	Process	0578	NQF QPS
CVD	Anti-Lipid Treatment Discharge	Process	0118	NQF QPS
CVD	Anti-Platelet Medication at Discharge	Process	0116	NQF QPS
CVD	Anti-Platelet Medication on Discharge	Process	0237	NQF QPS
CVD	Aspirin at Arrival	Process	0286	NQF QPS
CVD	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Process	0132	NQF QPS
CVD	Aspirin Prescribed at Discharge for AMI	Process	0142	NQF QPS
CVD	Aspirin Use and Discussion: Percentage of Members Who Are Currently Taking Aspirin, Including Women 56 to 79 Years of Age with at Least Two Risk Factors for Cardiovascular Disease (CVD); Men 46 to 65 Years of Age with at Least One Risk Factor for CVD; and Men 66 to 79 Years of Age, Regardless of Risk Factors	Process		AHRQ
CVD	Aspirin Use and Discussion: Percentage of Women 56 to 79 Years of Age and Men 46 to 79 Years of Age Who Discussed the Risks and Benefits of Using Aspirin with a Doctor or Other Health Provider.	Process		AHRQ
CVD	Aspirin Use for the Primary Prevention of Cardiovascular Disease and Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Atherosclerotic Disease and LDL Greater Than 100 - Use of Lipid Lowering Agent	Process	0636	NQF QPS
CVD	Atrial Fibrillation - Anticoagulation Therapy	Process	0624	NQF QPS
CVD	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Process	1525	NQF QPS
CVD	Atrial Fibrillation Medicare Beneficiaries (Number)			HIW
CVD	Atrial Fibrillation Medicare Beneficiaries (Percent)			HIW
CVD	Behavioral Counseling Interventions to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Beta Blockade at Discharge	Process	0117	NQF QPS
CVD	Beta Blocker at Discharge for ICD Implant Patients with Left Ventricular Systolic Dysfunction	Process	1529	NQF QPS
CVD	Beta Blocker at Discharge for ICD Implant Patients with a Previous MI	Process	1528	NQF QPS
CVD	Beta Blocker on Discharge	Process	0238	NQF QPS
CVD	Beta-Blocker Prescribed at Discharge for AMI	Process	0160	NQF QPS
CVD	Beta-Blocker Therapy (I.E., Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate) for LVSD Prescribed at Discharge	Process	2438	NQF QPS
CVD	Bilateral Cardiac Catheterization Rate (IQI 25)	Outcome	0355	NQF QPS
CVD	CAD: Beta-Blocker Treatment After a Heart Attack	Process	0072	NQF QPS
CVD	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low Risk Surgery	Efficiency	0669	NQF QPS
CVD	Cardiac Rehabilitation Patient Referral from an Inpatient Setting	Process	0642	NQF QPS
CVD	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	Process	0643	NQF QPS
CVD	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients	Efficiency	0670	NQF QPS
CVD	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	Efficiency	0671	NQF QPS
CVD	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low Risk Patients	Efficiency	0672	NQF QPS
CVD	Cardiac Surgery Patients with Controlled Postoperative Blood Glucose	Process	0300	CMS
CVD	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Outcome	2474	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Chronic Stable Coronary Artery Disease: Antiplatelet Therapy	Process	0067	NQF QPS
CVD	Chronic Stable Coronary Artery Disease: Lipid Control	Process	0074	NQF QPS
CVD	Chronic Stable Coronary Artery Disease: Symptom and Activity Assessment	Process	0065	NQF QPS
CVD	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Outcome: PRO	0209	NQF QPS
CVD	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 Mm Hg)	Outcome	0061	NQF QPS
CVD	Congestive Heart Failure Admission Rate (Per 100,000 Beneficiaries)			HIW
CVD	Congestive Heart Failure Rate (PQI 08)	Process	0277	NQF QPS
CVD	Controlling High Blood Pressure	Outcome	0018	NQF QPS
CVD	Controlling High Blood Pressure for People with Serious Mental Illness	Outcome	2602	NQF QPS
CVD	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	Process	0236	CMS
CVD	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Process	0066	NQF QPS
CVD	Defect Free Care for AMI	Composite	2377	NQF QPS
CVD	Discharge Medications (ACE/ARB and Beta Blockers) in Eligible ICD Implant Patients	Composite	0965	NQF QPS
CVD	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	Process	0090	CMS
CVD	Emergency Medicine: Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Process	0092	NQF QPS
CVD	Evaluation of Left Ventricular Systolic Function (LVS)	Process	0135	CMS
CVD	Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)	Outcome	2881	NQF QPS
CVD	Excess Days in Acute Care (EDAC) After Hospitalization for Heart Failure	Outcome	2880	NQF QPS
CVD	Family Evaluation of Hospice Care	Outcome: PRO	0208	NQF QPS
CVD	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Process	0288	NQF QPS
CVD	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Process	0164	NQF QPS
CVD	Frailty Assessment	Process	9999	CMS
CVD	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	NQF QPS
CVD	Guidelines for the Management of Absolute Cardiovascular Disease Risk.			AHRQ
CVD	Heart Attack Medicare Beneficiaries (Number)			HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Heart Attack Medicare Beneficiaries (Percent)			HIW
CVD	Heart Disease Death (Per 100,000)			HIW
CVD	Heart Disease Death (Percent)			HIW
CVD	Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy	Process	0610	NQF QPS
CVD	Heart Failure - Use of Beta Blocker Therapy	Process	0615	NQF QPS
CVD	Heart Failure (HF) : Assessment of Clinical Symptoms of Volume Overload (Excess)	Process	0078	NQF QPS
CVD	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Process	0081	NQF QPS
CVD	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Process	0083	NQF QPS
CVD	Heart Failure (HF): Detailed Discharge Instructions	Process	0136	CMS
CVD	Heart Failure Mortality Rate (IQI 16)	Outcome	0358	NQF QPS
CVD	Heart Failure Symptoms Assessed and Addressed	Process	0521	NQF QPS
CVD	Heart Failure: Left Ventricular Ejection Fraction Assessment (Outpatient Setting)	Process	0079	NQF QPS
CVD	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization.	Outcome	0505	NQF QPS
CVD	Hospital 30-Day Risk-Standardized Readmission Rates Following Percutaneous Coronary Intervention (PCI)	Outcome	0695	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization for Patients 18 and Older	Outcome	0230	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	Outcome	2558	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization for Patients 18 and Older	Outcome	0229	NQF QPS
CVD	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	Outcome	0330	NQF QPS
CVD	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	Outcome	2515	NQF QPS
CVD	Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD)	Composite	0694	NQF QPS
CVD	Hospital Specific Risk-Adjusted Measure of Mortality or One or More Major Complications Within 30 Days of a Lower Extremity Bypass (LEB).	Outcome	0534	NQF QPS
CVD	Hospitalized Patients Who Die an Expected Death with an ICD That Has Been Deactivated	Process	1625	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	Cost/ Resource Use	2431	NQF QPS
CVD	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	1789	NQF QPS
CVD	Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI)	Outcome	2473	NQF QPS
CVD	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Outcome	2879	NQF QPS
CVD	Hyperlipidemia (Primary Prevention) - Lifestyle Changes and/ or Lipid Lowering Therapy	Process	0611	NQF QPS
CVD	Infection Within 180 Days of Cardiac Implantable Electronic Device (CIED)	Outcome	9999	CMS
CVD	In-Hospital Risk Adjusted Rate of Bleeding Events for Patients Undergoing PCI	Outcome	2459	NQF QPS
CVD	In-Hospital Risk Adjusted Rate of Mortality for Patients Undergoing PCI	Outcome	0133	NQF QPS
CVD	INR for Individuals Taking Warfarin and Interacting Anti-Infective Medications	Process	0556	NQF QPS
CVD	INR Monitoring for Individuals on Warfarin	Process	0555	NQF QPS
CVD	INR Monitoring for Individuals on Warfarin After Hospital Discharge	Process	2732	NQF QPS
CVD	Ischemic Heart Disease Medicare Beneficiaries (Number)			HIW
CVD	Ischemic Heart Disease Medicare Beneficiaries (Percent)			HIW
CVD	Ischemic Vascular Disease (IVD): Blood Pressure Control	Outcome	0073	NQF QPS
CVD	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100 Mg/dL	Outcome	0075	NQF QPS
CVD	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Process	0068	NQF QPS
CVD	Lipid Management in Adults: Percentage of Patients with Established Atherosclerotic Cardiovascular Disease (ASCVD), or 10-Year CHD Risk Greater Than or Equal to 10%, or Diabetes and on Lipid-Lowering Medication Who Have a Fasting Lipid Panel Within 24 Months of Medication Prescription.	Process		AHRQ
CVD	Lipid Management in Adults: Percentage of Patients with Established Atherosclerotic Cardiovascular Disease (ASCVD), or a 10-Year Risk for CHD Greater Than or Equal to 10%, or Diabetes, Who Are on a Statin or Have LDL Less Than 100 Ml/ dL Within a 12-Month Period.	Process		AHRQ
CVD	Lipid Modification: Cardiovascular Risk Assessment and the Modification of Blood Lipids for the Primary and Secondary Prevention of Cardiovascular Disease.	N/A	N/A	N/A

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Long-Term Care Hospital (LTCH) Functional Outcome Measure: Change in Mobility Among Patients Requiring Ventilator Support	Outcome	2632	NQF QPS
CVD	Median Time to ECG	Efficiency	0289	NQF QPS
CVD	Median Time to Fibrinolysis	Process	0287	NQF QPS
CVD	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Process	0290	NQF QPS
CVD	MI - Use of Beta Blocker Therapy	Process	0613	NQF QPS
CVD	Operative Mortality Stratified by the 5 STAT Mortality Categories	Outcome	0733	NQF QPS
CVD	Optimal Vascular Care	Composite	0076	NQF QPS
CVD	Overuse of Percutaneous Coronary Intervention (PCI) in Asymptomatic Patients	Process	9999	CMS
CVD	Patient(s) with an Emergency Medicine Visit for Non-Traumatic Chest Pain That Had an ECG.	Process	0665	NQF QPS
CVD	Patient(s) with an Emergency Medicine Visit for Syncope That Had an ECG.	Process	0664	NQF QPS
CVD	PCI Mortality (Risk-Adjusted) ©	Outcome	9999	CMS
CVD	Pediatric All-Condition Readmission Measure	Outcome	2393	NQF QPS
CVD	Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Process	2631	NQF QPS
CVD	Percutaneous Coronary Intervention (PCI): Comprehensive Documentation of Indications for PCI	Process	2411	NQF QPS
CVD	Percutaneous Coronary Intervention (PCI): Post-Procedural Optimal Medical Therapy	Composite	2452	NQF QPS
CVD	Perioperative Anti-Platelet Therapy for Patients Undergoing Carotid Endarterectomy	Process	0465	CMS
CVD	Perioperative Temperature Management	Process	0454	NQF QPS
CVD	Persistence of Beta-Blocker Treatment After a Heart Attack	Intermediate Clinical Outcome	0071	NQF QPS
CVD	Pharmacologic Treatment of Hypertension in Adults Aged 60 Years or Older to Higher Versus Lower Blood Pressure Targets: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians.			AHRQ
CVD	Post MI: ACE Inhibitor or ARB Therapy	Process	0594	NQF QPS
CVD	Post-Discharge Appointment for Heart Failure Patients	Process	2439	NQF QPS
CVD	Post-Discharge Evaluation for Heart Failure Patients	Process	2443	NQF QPS
CVD	Preoperative Beta Blockade	Process	0127	NQF QPS
CVD	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC)	Process	0464	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	Process	2726	NQF QPS
CVD	Primary and Secondary Prevention of Cardiovascular Disease: Antithrombotic Therapy and Prevention of Thrombosis, 9th Ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines.			AHRQ
CVD	Primary PCI Received Within 90 Minutes of Hospital Arrival	Process	0163	NQF QPS
CVD	Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Process	0632	NQF QPS
CVD	Proportion of Patients Hospitalized with AMI That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Composite	0704	NQF QPS
CVD	Proportion of Patients Hospitalized with Stroke That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Outcome		NQF QPS
CVD	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.	Outcome	0709	NQF QPS
CVD	RACHS-1 Pediatric Heart Surgery Mortality Rate (PDI 06)	Outcome	0339	NQF QPS
CVD	RACHS-1 Pediatric Heart Surgery Volume (PDI 7)	Structure	0340	NQF QPS
CVD	Radiology: Stenosis Measurement in Carotid Imaging Reports	Process	0507	CMS
CVD	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	Outcome	1534	CMS
CVD	Rate of Open Repair of Small or Moderate Abdominal Aortic Aneurysms (AAA) Where Patients Are Discharged Alive	Outcome	1523	CMS
CVD	Risk Adjusted Colon Surgery Outcome Measure	Outcome		NQF QPS
CVD	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	0327	NQF QPS
CVD	Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate	Outcome	2514	NQF QPS
CVD	Risk-Adjusted Deep Sternal Wound Infection	Outcome	0130	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)	Outcome	0120	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR) + CABG Surgery	Outcome	0123	NQF QPS
CVD	Risk-Adjusted Operative Mortality for CABG	Outcome	0119	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair	Outcome	1501	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair + CABG Surgery	Outcome	1502	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement	Outcome	0121	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Mitral Valve (MV) Replacement + CABG Surgery	Outcome	0122	NQF QPS
CVD	Risk-Adjusted Operative Mortality for Pediatric and Congenital Heart Surgery	Outcome	2683	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Risk-Adjusted Postoperative Prolonged Intubation (Ventilation)	Outcome	0129	NQF QPS
CVD	Risk-Adjusted Stroke/Cerebrovascular Accident	Outcome	0131	NQF QPS
CVD	Risk-Adjusted Surgical Re-Exploration	Outcome	0115	NQF QPS
CVD	Risk-Standardized Acute Admission Rates for Patients with Heart Failure	Outcome	2886	NQF QPS
CVD	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Outcome	2888	NQF QPS
CVD	Screening for Peripheral Artery Disease and Cardiovascular Disease Risk Assessment with the Ankle–Brachial Index in Adults: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Secondary Prevention of Cardiovascular Events - Use of Aspirin or Antiplatelet Therapy	Process	0631	NQF QPS
CVD	Selection of Antibiotic Prophylaxis for Cardiac Surgery Patients	Process	0126	NQF QPS
CVD	Shared Decision Making Process	Outcome: PRO	2962	NQF QPS
CVD	Stable Coronary Artery Disease: Percentage of Patients with Cardiovascular Disease Who Received an Annual Influenza Vaccination.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Documentation in the Medical Record of Prognostic Assessment Preceding or Following a Course of Pharmacologic Therapy.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Documentation in the Medical Record of Receiving a Pneumonia Vaccination According to the CDC Recommendations.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Documentation in the Medical Record That an LDL Was Obtained Within the Last 12 Months with an LDL Less Than 100 Mg/dL. Consider Less Than 70 Mg/dL for High-Risk Patient.	Process		AHRQ
CVD	Stable Coronary Artery Disease: Percentage of Patients with Stable Coronary Artery Disease Who Have Demonstrated an Understanding of How to Respond in an Acute Cardiac Event by "Teaching Back" as to How They Would Respond in the Case of Acute Cardiac Event.	Process		AHRQ
CVD	Standardized Adverse Event Ratio for Children < 18 Years of Age Undergoing Cardiac Catheterization	Outcome	0715	NQF QPS
CVD	Statin Prescribed at Discharge	Process	0639	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Statin Therapy for Patients with Cardiovascular Disease: Percentage of Males 21 to 75 Years of Age and Females 40 to 75 Years of Age During the Measurement Year Who Were Identified as Having Clinical ASCVD Who Remained on a High- or Moderate-Intensity Statin Medication for at Least 80% of the Treatment Period.	Process		AHRQ
CVD	Statin Therapy for Patients with Cardiovascular Disease: Percentage of Males 21 to 75 Years of Age and Females 40 to 75 Years of Age During the Measurement Year Who Were Identified as Having Clinical ASCVD Who Were Dispensed at Least One High- or Moderate-Intensity Statin Medication.	Process		AHRQ
CVD	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		9999	CMS
CVD	Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes	Process	9999	CMS
CVD	Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: U.S. Preventive Services Task Force Recommendation Statement.			AHRQ
CVD	Statin Use in Persons with Diabetes	Process	2712	NQF QPS
CVD	Stent Drug-Eluting Clopidogrel	Process	0588	NQF QPS
CVD	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	Process	0241	CMS
CVD	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Process	0325	CMS
CVD	Stroke Education	Process	0440	CMS
CVD	STS Aortic Valve Replacement (AVR) + Coronary Artery Bypass Graft (CABG) Composite Score	Composite	2563	NQF QPS
CVD	STS Aortic Valve Replacement (AVR) Composite Score	Composite	2561	NQF QPS
CVD	STS CABG Composite Score	Composite	0696	NQF QPS
CVD	STS Individual Surgeon Composite Measure for Adult Cardiac Surgery	Composite	3030	NQF QPS
CVD	STS Mitral Valve Repair/Replacement (MVRR) + Coronary Artery Bypass Graft (CABG) Composite Score	Composite	3032	NQF QPS
CVD	STS Mitral Valve Repair/Replacement (MVRR) Composite Score	Composite	3031	NQF QPS
CVD	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	Process	0284	CMS
CVD	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the 5 STAT Mortality Categories	Structure	0732	NQF QPS
CVD	Therapy with Aspirin, P2Y12 Inhibitor, and Statin at Discharge Following PCI in Eligible Patients	Composite	0964	NQF QPS
CVD	Thorax CT—Use of Contrast Material	Process	0513	NQF QPS
CVD	Thrombolytic Therapy	Process	0437	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
CVD	Time to Intravenous Thrombolytic Therapy	Process	1952	NQF QPS
CVD	Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients (with Probable Cardiac Chest Pain) Received Within 60 Minutes of Arrival.	Process	0660	NQF QPS
CVD	Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG)	Process	0134	NQF QPS
CVD	Ventilator-Associated Pneumonia for ICU and High-Risk Nursery (HRN) Patients	Outcome	0140	NQF QPS
Diabetes/CKD	Ace Inhibitor / Angiotensin Receptor Blocker Use and Persistence Among Members with Coronary Artery Disease at High Risk for Coronary Events	Process	0551	NQF QPS
Diabetes/CKD	Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	Process	2467	NQF QPS
Diabetes/CKD	Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	Process	2468	NQF QPS
Diabetes/CKD	Adherence to Statins for Individuals with Diabetes Mellitus	Process	0545	NQF QPS
Diabetes/CKD	Adult Kidney Disease : Patients on Erythropoiesis Stimulating Agent (ESA)—Hemoglobin Level > 12.0 G/dL	Outcome	1666	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Outcome	0323	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Outcome	0321	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Advance Directives Completed	Outcome	9999	CMS
Diabetes/CKD	Adult Kidney Disease: Blood Pressure Management	Intermediate Outcome		CMS
Diabetes/CKD	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis	Outcome		CMS
Diabetes/CKD	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days	Outcome		CMS
Diabetes/CKD	Adult Kidney Disease: Discussion of Advance Care Planning	Process	9999	CMS
Diabetes/CKD	Adult Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level <10g/dL	Outcome	9999	CMS
Diabetes/CKD	Adult Kidney Disease: Hemodialysis Adequacy: Solute	Outcome	0323	CMS
Diabetes/CKD	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	Process	1668	NQF QPS
Diabetes/CKD	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	Outcome	0321	CMS
Diabetes/CKD	Adult Kidney Disease: Transplant Referral	Process	9999	CMS
Diabetes/CKD	Advanced Chronic Kidney Disease (CKD): Percent of Patients with Documentation That Education Was Provided.			AHRQ
Diabetes/CKD	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Process	1662	NQF QPS
Diabetes/CKD	Assessment of Iron Stores	Process	0252	NQF QPS
Diabetes/CKD	Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 Ml/ Kg/Hour)	Process	2701	NQF QPS
Diabetes/CKD	Bloodstream Infection in Hemodialysis Outpatients	Outcome	1460	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	CKD - Lipid Profile Monitoring	Process	0626	NQF QPS
Diabetes/CKD	CKD with LDL Greater Than or Equal to 130 – Use of Lipid Lowering Agent	Process	0627	NQF QPS
Diabetes/CKD	CKD, Diabetes Mellitus, Hypertension and Medication Possession Ratio for ACEI/ARB Therapy	Process	0550	NQF QPS
Diabetes/CKD	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Outcome: PRO	0209	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care	Composite	0731	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 Mm Hg)	Outcome	0061	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Eye Exam	Process	0055	CMS
Diabetes/CKD	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	Process	0055	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Foot Exam	Process	0056	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Outcome	0575	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	0059	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Process	0057	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	Process	0057	CMS
Diabetes/CKD	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Process	0062	NQF QPS
Diabetes/CKD	Comprehensive Diabetes Care: Percentage of Members 18 to 64 Years of Age with Diabetes (Type 1 and Type 2) Whose Most Recent Hemoglobin A1c (HbA1c) Level is Less Than 7.0% (Controlled).			AHRQ
Diabetes/CKD	Controlling High Blood Pressure	Outcome	0018	NQF QPS
Diabetes/CKD	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Process	0066	NQF QPS
Diabetes/CKD	Dehydration Admission Rate (PQI 10)	Outcome	0280	NQF QPS
Diabetes/CKD	Delivered Dose of Hemodialysis Above Minimum	Outcome	0249	NQF QPS
Diabetes/CKD	Delivered Dose of Pediatric Peritoneal Dialysis (PD) Above Minimum	Outcome		CMS
Diabetes/CKD	Delivered Dose of Peritoneal Dialysis Above Minimum	Outcome	0318	NQF QPS
Diabetes/CKD	Diabetes Composite	Composite	0729	CMS
Diabetes/CKD	Diabetes Long-Term Complications Admission Rate (PQI 03)	Outcome	0274	NQF QPS
Diabetes/CKD	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	Process	0417	CMS
Diabetes/CKD	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear	Process	0416	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Diabetes Mellitus: High Blood Pressure Control		0729	CMS
Diabetes/CKD	Diabetes Short-Term Complications Admission Rate (PQI 01)	Outcome	0272	NQF QPS
Diabetes/CKD	Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB	Process	0619	NQF QPS
Diabetes/CKD	Diabetes with LDL-C Greater Than 100 – Use of a Lipid Lowering Agent	Process	0618	NQF QPS
Diabetes/CKD	Diabetes: Foot Exam	Process	0056	CMS
Diabetes/CKD	Diabetes: Hemoglobin A1c Poor Control	Intermediate Outcome	0059	CMS
Diabetes/CKD	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Process	0417	NQF QPS
Diabetes/CKD	Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	Process	0416	NQF QPS
Diabetes/CKD	Diabetic Foot Care and Patient/Caregiver Education Implemented During All Episodes of Care	Process	0519	CMS
Diabetes/CKD	Diabetic Foot Care and Patient Education Implemented	Process	0519	NQF QPS
Diabetes/CKD	Diabetic Foot Care and Patient Education Implemented During Short Term Episodes of Care	Process		CMS
Diabetes/CKD	Diabetic Foot Care and Patient Education in Plan of Care	Process		CMS
Diabetes/CKD	Diabetic Foot Care and Patient/Caregiver Education Implemented During Long Term Episodes of Care	Process		CMS
Diabetes/CKD	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Process	0089	NQF QPS
Diabetes/CKD	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Process	0088	NQF QPS
Diabetes/CKD	Drug Education on All Medications Provided to Patient/ Caregiver During Short Term Episodes of Care	Process	0520	NQF QPS
Diabetes/CKD	End Stage Renal Disease (ESRD): Percentage of a Facility's ESRD Patients Aged 18 Years and Older with Medical Record Documentation of a Discussion of Renal Replacement Therapy Modalities at Least Once During the 12-Month Reporting Period.			AHRQ
Diabetes/CKD	End Stage Renal Disease (ESRD): Percentage of a Physician's ESRD Patients Aged 18 Years and Older with Medical Record Documentation of a Discussion of Renal Replacement Therapy Modalities at Least Once During the 12-Month Reporting Period.	Process		AHRQ
Diabetes/CKD	End Stage Renal Disease (ESRD): Percentage of Medicare Patients with a Mean Hemoglobin Value Greater Than 12 G/dL.			AHRQ
Diabetes/CKD	End Stage Renal Disease (ESRD): Risk-Adjusted Standardized Transfusion Ration (STrR) for Dialysis Facility Patients			AHRQ
Diabetes/CKD	End-Stage Kidney Failure Due to Diabetes			HIW
Diabetes/CKD	End-Stage Kidney Failure: Diabetics			HIW

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	ESRD- HD Adequacy CPM III: Minimum Delivered Hemodialysis Dose for ESRD Hemodialysis Patients Undergoing Dialytic Treatment for a Period of 90 Days or Greater.	Outcome	0250	NQF QPS
Diabetes/CKD	Family Evaluation of Hospice Care	Outcome: PRO	0208	NQF QPS
Diabetes/CKD	Glycemic Control - Hyperglycemia	Outcome	2362	NQF QPS
Diabetes/CKD	Glycemic Control - Hypoglycemia	Outcome	2363	NQF QPS
Diabetes/CKD	Hemodialysis (HD) Adequacy: Delivered Dose of Hemodialysis Above Minimum	Outcome	0249	CMS
Diabetes/CKD	Hemodialysis Adequacy Clinical Performance Measure I: Hemodialysis Adequacy- Monthly Measurement of Delivered Dose	Process	0247	NQF QPS
Diabetes/CKD	Hemodialysis Adequacy Clinical Performance Measure II: Method of Measurement of Delivered Hemodialysis Dose	Process	0248	NQF QPS
Diabetes/CKD	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous Fistula	Process	0259	NQF QPS
Diabetes/CKD	Hemodialysis Vascular Access: Long-Term Catheter Rate	Intermediate Clinical Outcome	2978	NQF QPS
Diabetes/CKD	Hemodialysis Vascular Access: Standardized Fistula Rate	Intermediate Clinical Outcome	2977	NQF QPS
Diabetes/CKD	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients	Process	0060	NQF QPS
Diabetes/CKD	Hemoglobin Greater Than 12 G/dL	Process		CMS
Diabetes/CKD	High Risk for Pneumococcal Disease - Pneumococcal Vaccination	Process	0617	NQF QPS
Diabetes/CKD	Hospital Specific Risk-Adjusted Measure of Mortality or One or More Major Complications Within 30 Days of a Lower Extremity Bypass (LEB).	Outcome	0534	NQF QPS
Diabetes/CKD	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Outcome	1789	NQF QPS
Diabetes/CKD	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Outcome	2879	NQF QPS
Diabetes/CKD	Hypercalcemia Clinical Measure	Outcome	1454	CMS
Diabetes/CKD	Hypertension Diagnosis and Treatment: Percentage of Adult Patients Age Greater Than or Equal to 18 Years Diagnosed with Chronic Kidney Disease Whose Blood Pressure is at SBP Less Than 140 mmHg and DBP Less Than 90 mmHg.			AHRQ
Diabetes/CKD	Influenza Immunization in the ESRD Population (Facility Level)	Process	0226	NQF QPS
Diabetes/CKD	Kt/V Dialysis Adequacy Comprehensive Clinical Measure	Outcome		CMS
Diabetes/CKD	LBP: Patient Education	Process	0307	NQF QPS
Diabetes/CKD	Maximizing Placement of Arterial Venous Fistula (AVF)	Outcome	0257	NQF QPS
Diabetes/CKD	Measurement of nPCR for Pediatric Hemodialysis Patients	Process	1425	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Measurement of Phosphorus Concentration	Process	0255	NQF QPS
Diabetes/CKD	Measurement of Serum Calcium Concentration	Process	0261	NQF QPS
Diabetes/CKD	Medical Evaluation: Chronic Kidney Disease & Diabetes Older Adults			HIW
Diabetes/CKD	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities	Process	2988	NQF QPS
Diabetes/CKD	Method of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1421	NQF QPS
Diabetes/CKD	Mineral Metabolism Reporting Measure	Process		CMS
Diabetes/CKD	Minimizing Use of Catheters as Chronic Dialysis Access	Outcome	0256	NQF QPS
Diabetes/CKD	Minimum Delivered Peritoneal Dialysis Dose	Outcome	2704	NQF QPS
Diabetes/CKD	Minimum spKt/V for Pediatric Hemodialysis Patients	Outcome	1423	NQF QPS
Diabetes/CKD	Monitoring Hemoglobin Levels Below Target Minimum	Outcome	0370	NQF QPS
Diabetes/CKD	Monthly Hemoglobin Measurement for Pediatric Patients	Process	1424	NQF QPS
Diabetes/CKD	National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients Clinical Measure	Outcome		CMS
Diabetes/CKD	Non-Diabetic Nephropathy - Use of ACE Inhibitor or ARB Therapy	Process	0621	NQF QPS
Diabetes/CKD	Optimal End Stage Renal Disease (ESRD) Starts	Process	2594	NQF QPS
Diabetes/CKD	Patient Education Awareness—Facility Level	Process	0324	NQF QPS
Diabetes/CKD	Patient Education Awareness—Physician Level	Process	0320	NQF QPS
Diabetes/CKD	Pediatric Kidney Disease : ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL	Outcome	1667	NQF QPS
Diabetes/CKD	Pediatric Kidney Disease: Adequacy of Volume Management	Process		CMS
Diabetes/CKD	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V	Outcome	2706	NQF QPS
Diabetes/CKD	Percent of Residents with a Urinary Tract Infection (Long-Stay)	Outcome	0684	NQF QPS
Diabetes/CKD	Percentage of Medicare Patients at a Provider/Facility Who Have an Average Hemoglobin Value Less Than 10.0 G/dL	Outcome		CMS
Diabetes/CKD	Periodic Assessment of Post-Dialysis Weight by Nephrologists	Process	1438	NQF QPS
Diabetes/CKD	Peritoneal Dialysis Adequacy Clinical Performance Measure I - Measurement of Total Solute Clearance at Regular Intervals	Process	0253	NQF QPS
Diabetes/CKD	Peritoneal Dialysis Adequacy Clinical Performance Measure II - Calculate Weekly KT/Vurea in the Standard Way	Process	0254	NQF QPS
Diabetes/CKD	Peritoneal Dialysis Adequacy: Delivered Dose of Peritoneal Dialysis (PD) Above Minimum	Outcome	0318	CMS
Diabetes/CKD	Potentially Harmful Drug-Disease Interactions in the Elderly	Process	2993	NQF QPS
Diabetes/CKD	Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Process	0632	NQF QPS
Diabetes/CKD	Proportion of Patients Hospitalized with Pneumonia That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Outcome	0708	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Diabetes/CKD	Proportion of Patients Hospitalized with Stroke That Have a Potentially Avoidable Complication (During the Index Stay or in the 30-Day Post-Discharge Period)	Outcome	0705	NQF QPS
Diabetes/CKD	Proportion of Patients with Hypercalcemia	Outcome	1454	NQF QPS
Diabetes/CKD	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	0327	NQF QPS
Diabetes/CKD	Risk-Adjusted Postoperative Renal Failure	Outcome	0114	NQF QPS
Diabetes/CKD	Risk-Adjusted Standardized Mortality Ratio for Dialysis Facility Patients	Outcome	0369	CMS
Diabetes/CKD	Risk-Standardized Acute Admission Rates for Patients with Diabetes	Outcome	2887	NQF QPS
Diabetes/CKD	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Outcome	2888	NQF QPS
Diabetes/CKD	Standardized Hospitalization Ratio for Admissions	Outcome	1463	CMS
Diabetes/CKD	Standardized Mortality Ratio for Dialysis Facilities	Outcome	0369	NQF QPS
Diabetes/CKD	Standardized Readmission Ratio (SRR) Clinical Measure	Outcome	2496	CMS
Diabetes/CKD	Standardized Readmission Ratio (SRR) for Dialysis Facilities	Outcome	2496	NQF QPS
Diabetes/CKD	Standardized Transfusion Ratio (STrR) Clinical Measure	Outcome		CMS
Diabetes/CKD	Standardized Transfusion Ratio for Dialysis Facilities	Outcome	2979	NQF QPS
Diabetes/CKD	Statin Use in Persons with Diabetes	Process	2712	NQF QPS
Diabetes/CKD	Ultrafiltration Rate > 13 Ml/Kg/Hr.	Process		CMS
Diabetes/CKD	Uncontrolled Diabetes Admission Rate (PQI 14)	Outcome	0638	NQF QPS
Diabetes/CKD	Urinary Tract Infection Admission Rate (PQI 12)	Outcome	0281	NQF QPS
Diabetes/CKD	Use of Iron Therapy for Pediatric Patients	Process	1433	NQF QPS
Diabetes/CKD	Vascular Access Type - AV Fistula Clinical Measure	Process	0257	CMS
Diabetes/CKD	Vascular Access Type Â€“ Catheter >= 90 Days Clinical Measure	Outcome	0256	CMS
Diabetes/CKD	Vascular Access—Catheter Vascular Access and Evaluation by Vascular Surgeon for Permanent Access.	Process	0262	NQF QPS
Diabetes/CKD	Vascular Access—Functional Arteriovenous Fistula (AVF) or AV Graft or Evaluation for Placement	Process	0251	NQF QPS
Infant Mortality	Accidental Puncture or Laceration Rate (PDI #1)	Outcome	0344	NQF QPS
Infant Mortality	Admission to Neonatal Intensive Care Unit at Term.	Outcome	0747	NQF QPS
Infant Mortality	Adverse Outcome Index	Composite	1769	NQF QPS
Infant Mortality	Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery	Process	0473	NQF QPS
Infant Mortality	Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean Section.	Process	0472	NQF QPS
Infant Mortality	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Process	0069	NQF QPS
Infant Mortality	Birth Risk Cesarean Birth Measure	Outcome	2892	NQF QPS
Infant Mortality	Birth Trauma	Outcome	0742	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Birth Trauma – Injury to Neonate (PSI 17)	Outcome	0474	NQF QPS
Infant Mortality	Blood Folate Concentration: Reproductive-Aged Women			HIW
Infant Mortality	CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Event	Outcome	1773	NQF QPS
Infant Mortality	Children with MSI Who Underwent Surgery Under Continued Anesthesia Immediately Following Sedated		2823	NQF QPS
Infant Mortality	Counseling for Women of Childbearing Potential with Epilepsy	Process	1814	NQF QPS
Infant Mortality	Diabetes and Pregnancy: Avoidance of Oral Hypoglycemic Agents	Process	0582	NQF QPS
Infant Mortality	Duration of Sedated MRI for Children with Suspected Deep Musculoskeletal Infection		2825	NQF QPS
Infant Mortality	End Stage Renal Disease (ESRD): Percentage of Patient Months for All Pediatric (< 18 Years Old) in-Center Hemodialysis Patients in Which the Delivered Dose of Hemodialysis (Calculated from the Last Measurement of the Month Using the UKM or Daugirdas II Formula) Was spKt/V ≥ 1.2.	Outcome		AHRQ
Infant Mortality	Fetal Deaths			HIW
Infant Mortality	First NICU Temperature < 36 Degrees Centigrade	Outcome	0482	NQF QPS
Infant Mortality	First Temperature Measured Within One Hour of Admission to the NICU.	Process	0481	NQF QPS
Infant Mortality	Folic Acid Intake: Reproductive-Aged Women			HIW
Infant Mortality	Frequency of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1418	NQF QPS
Infant Mortality	Gastroenteritis Admission Rate (PDI 16)	Outcome	0727	NQF QPS
Infant Mortality	Group B Streptococcal Disease: Newborns			HIW
Infant Mortality	Healthy Weight Prior to Pregnancy			HIW
Infant Mortality	Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	Process	0475	NQF QPS
Infant Mortality	HIV/AIDS: CD4 Cell Count or Percentage Performed	Process	0404	NQF QPS
Infant Mortality	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	Process	0405	NQF QPS
Infant Mortality	HIV/AIDS: Tuberculosis (TB) Screening	Process	0408	NQF QPS
Infant Mortality	Hospital Inpatients' Experiences: Percentage of Parents Who Reported How Often They Got Prompt Help When They Pressed the Call Button.	Consumer Experience		AHRQ
Infant Mortality	Hospital Standardized Mortality Ratio (HSMR): the Ratio of the Actual Number of Acute in-Hospital Deaths to the Expected Number of in-Hospital Deaths, for Conditions Accounting for About 80% of Inpatient Mortality.	Outcome		AHRQ
Infant Mortality	Iatrogenic Pneumothorax Rate (PDI 5)	Outcome	0348	NQF QPS
Infant Mortality	Incidence of Episiotomy	Process	0470	NQF QPS
Infant Mortality	Infant Deaths Due to Birth Defects			HIW
Infant Mortality	Influenza Immunization in the ESRD Population (Facility Level)	Process	0226	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	In-Hospital Neonatal Death	Outcome	0746	NQF QPS
Infant Mortality	In-Hospital Maternal Deaths	Outcome	0743	NQF QPS
Infant Mortality	Initial Risk Assessment for Immobility-Related Pressure Ulcer Within 24 Hours of PICU Admission		3005	NQF QPS
Infant Mortality	Inpatient Perinatal Care: Percent of Live-Born Neonates Less Than 2,500 Grams That Have a Temperature Documented Within 15 Minutes After Their Arrival to a Level 2 or Higher Nursery.	Process		AHRQ
Infant Mortality	Inpatient Perinatal Care: Percent of Live-Born Neonates Less Than 2,500 Grams That Have a Temperature Documented Within the Golden Hour from Birth to 60 Minutes of Age.	Process		AHRQ
Infant Mortality	Inpatient Perinatal Care: The Number of Live-Born Neonates Less Than 2,500 Grams That Arrive to a Level 2 or Higher Nursery Whose Qualifying Temperature Falls Within the Criteria for That Stratum: Cold, Very Cool, Cool, Euthermic, and Overly Warm.			AHRQ
Infant Mortality	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)	Process	1746	NQF QPS
Infant Mortality	Late Sepsis or Meningitis in Neonates (Risk-Adjusted)	Outcome	0303	NQF QPS
Infant Mortality	Late Sepsis or Meningitis in Very Low Birth Weight (VLBW) Neonates (Risk-Adjusted)	Outcome	0304	NQF QPS
Infant Mortality	Maternal and Newborn Care: Proportion of Newborn Screening Samples That Were Unsatisfactory for Testing, by Submitting Hospital and Comparator Groups.	Process		AHRQ
Infant Mortality	Maternal and Newborn Care: Rate of Formula Supplementation from Birth to Discharge in Term Infants Whose Mothers Intended to Exclusively Breastfeed.	Process		AHRQ
Infant Mortality	Maternal Blood Transfusion	Outcome	0750	NQF QPS
Infant Mortality	Measurement of nPCR for Pediatric Hemodialysis Patients	Process	1425	NQF QPS
Infant Mortality	Method of Adequacy Measurement for Pediatric Hemodialysis Patients	Process	1421	NQF QPS
Infant Mortality	Minimum spKt/V for Pediatric Hemodialysis Patients	Outcome	1423	NQF QPS
Infant Mortality	Monthly Hemoglobin Measurement for Pediatric Patients	Process	1424	NQF QPS
Infant Mortality	Multivitamins/Folic Acid Use, Preconception			HIW
Infant Mortality	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Outcome	0138	NQF QPS
Infant Mortality	National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	Outcome	0139	NQF QPS
Infant Mortality	Neonatal Blood Stream Infection Rate (NQI 03)	Outcome	0478	NQF QPS
Infant Mortality	Neonatal Immunization	Process	0485	NQF QPS
Infant Mortality	Neonatal Intensive Care All-Condition Readmissions	Outcome	2893	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Neonatal Zidovudine (ZDV) Prophylaxis: Percentage of Infants Born to HIV-Infected Women Who Were Prescribed ZDV Prophylaxis for HIV Within 12 Hours of Birth During the Measurement Year.	Process		AHRQ
Infant Mortality	Neonate Immunization Administration	Process	0145	NQF QPS
Infant Mortality	Operative Mortality Stratified by the 5 STAT Mortality Categories		0733	NQF QPS
Infant Mortality	Participation in a National Database for Pediatric and Congenital Heart Surgery	Structure	0734	NQF QPS
Infant Mortality	PC-01 Elective Delivery	Process	0469	NQF QPS
Infant Mortality	PC-02 Cesarean Birth	Outcome	0471	NQF QPS
Infant Mortality	PC-03 Antenatal Steroids	Process	0476	NQF QPS
Infant Mortality	PC-04 Health Care-Associated Bloodstream Infections in Newborns	Outcome	1731	NQF QPS
Infant Mortality	Pediatric All-Condition Readmission Measure	Outcome	2393	NQF QPS
Infant Mortality	Pediatric Computed Tomography (CT) Radiation Dose		2820	NQF QPS
Infant Mortality	Pediatric Kidney Disease : ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL		1667	NQF QPS
Infant Mortality	Pediatric Lower Respiratory Infection Readmission Measure		2414	NQF QPS
Infant Mortality	Pediatric Peritoneal Dialysis Adequacy: Achievement of Target Kt/V		2706	NQF QPS
Infant Mortality	Perinatal Care: Proportion of Infants Receiving Enteral Feedings Who Receive Any Human Milk, with or Without Fortifier or Formula, Within 24 Hours Before Discharge, Transfer, or Death.	Process		AHRQ
Infant Mortality	Perioperative Care: Percentage of Patients, Regardless of Age, Who Undergo a Procedure Under Anesthesia and Are Admitted to an ICU Directly from the Anesthetizing Location, Who Have a Documented Use of a Checklist or Protocol for the Transfer of Care from the Responsible Anesthesia Practitioner to the Responsible ICU Team or Team Member.	Process		AHRQ
Infant Mortality	Perioperative Care: Percentage of Patients, Regardless of Age, Who Undergo a Surgical Procedure Under Anesthesia Who Have Documentation That All Applicable Safety Checks from the World Health Organization (WHO) Surgical Safety Checklist Were Performed Before Induction of Anesthesia.	Process		AHRQ
Infant Mortality	Perioperative Care: Percentage of Patients, Regardless of Age, Who Undergo Central Venous Catheter (CVC) Insertion for Whom CVC Was Inserted with All Elements of Maximal Sterile Barrier Technique, Hand Hygiene, Skin Preparation and, If Ultrasound is Used, Sterile Ultrasound Techniques Followed.	Process		AHRQ
Infant Mortality	Perioperative Temperature Management	Process	0454	NQF QPS
Infant Mortality	Perioperative Temperature Management		2681	NQF QPS
Infant Mortality	PICU Severity-Adjusted Length of Stay	Outcome	0334	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	PICU Standardized Mortality Ratio	Outcome	0343	NQF QPS
Infant Mortality	PICU Unplanned Readmission Rate	Outcome	0335	NQF QPS
Infant Mortality	Pneumocystis Carinii Pneumonia (PCP) Prophylaxis: Percentage of Eligible Infants with HIV-Exposure Who Were Prescribed PCP Prophylaxis in the Measurement Year.	Process		AHRQ
Infant Mortality	Pregnancy Test for Female Abdominal Pain Patients.	Process	0502	NQF QPS
Infant Mortality	Pregnant Women That Had HBsAg Testing.	Process	0608	NQF QPS
Infant Mortality	Pregnant Women That Had HIV Testing.	Structure	0606	NQF QPS
Infant Mortality	Pregnant Women That Had Syphilis Screening.	Process	0607	NQF QPS
Infant Mortality	Prenatal Anti-D Immune Globulin	Process	0014	NQF QPS
Infant Mortality	Prenatal Blood Group Antibody Testing	Process	0016	NQF QPS
Infant Mortality	Prenatal Blood Groups (ABO), D (Rh) Type	Process	0015	NQF QPS
Infant Mortality	Pressure Ulcer Rate (PDI 2)	Outcome	0337	NQF QPS
Infant Mortality	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC)	Process	0464	NQF QPS
Infant Mortality	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections		2726	NQF QPS
Infant Mortality	Proportion of Infants 22 to 29 Weeks Gestation Treated with Surfactant Who Are Treated Within 2 Hours of Birth.	Process	0484	NQF QPS
Infant Mortality	Pulmonary Resection: Percentage of Patients Undergoing Pulmonary Resection for Whom Forced Expiratory Volume in One Second (FEV_1) and Diffusing Capacity of Carbon Monoxide (DL_{CO}) Was Obtained Within 365 Days Before Lung Resection.	Process		AHRQ
Infant Mortality	RACHS-1 Pediatric Heart Surgery Mortality Rate (PDI 06)	Outcome	0339	NQF QPS
Infant Mortality	RACHS-1 Pediatric Heart Surgery Volume (PDI 7)	Structure	0340	NQF QPS
Infant Mortality	Retained Surgical Item or Unretrieved Device Fragment Count (PDI 03)	Outcome	0362	NQF QPS
Infant Mortality	Review of Unplanned PICU Readmissions	Process	0336	NQF QPS
Infant Mortality	Rh Immunoglobulin (Rhogam) for Rh Negative Pregnant Women at Risk of Fetal Blood Exposure.	Process	0652	NQF QPS
Infant Mortality	Risk-Adjusted Average Length of Inpatient Hospital Stay	Outcome	0327	NQF QPS
Infant Mortality	Risk-Adjusted Operative Mortality for Pediatric and Congenital Heart Surgery		2683	NQF QPS
Infant Mortality	Spinal Bifida			HIW
Infant Mortality	Standardized Adverse Event Ratio for Children < 18 Years of Age Undergoing Cardiac Catheterization	Outcome	0715	NQF QPS
Infant Mortality	Standardized Mortality Ratio for Neonates Undergoing Non-Cardiac Surgery	Outcome	0714	NQF QPS
Infant Mortality	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the 5 STAT Mortality Categories	Structure	0732	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Infant Mortality	Thermal Condition of Low Birthweight Neonates Admitted to Level 2 or Higher Nurseries in the First 24 Hours of Life: A PQMP Measure	Outcome	2895	NQF QPS
Infant Mortality	Third or Fourth Degree Perineal Laceration	Outcome	0748	NQF QPS
Infant Mortality	Time from Triage to MRI for Children with Suspected Deep Musculoskeletal Infection		2824	NQF QPS
Infant Mortality	Transfusion Reaction Count (PDI 13)	Outcome	0350	NQF QPS
Infant Mortality	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	process	0651	NQF QPS
Infant Mortality	Unanticipated Operative Procedure	Outcome	0749	NQF QPS
Infant Mortality	Unexpected Complications in Term Newborns	Outcome	0716	NQF QPS
Infant Mortality	Unplanned Maternal Admission to the ICU	Outcome	0745	NQF QPS
Infant Mortality	Use of Iron Therapy for Pediatric Patients	Process	1433	NQF QPS
Infant Mortality	Uterine Rupture During Labor	Outcome	0744	NQF QPS
Infant Mortality	Ventilator-Associated Pneumonia for ICU and High-Risk Nursery (HRN) Patients	Outcome	0140	NQF QPS
Infant Mortality	Ventriculoperitoneal (VP) Shunt Malfunction Rate in Children	Outcome	0713	NQF QPS
Infant Mortality	Ventriculoperitoneal (VP) Shunt Malfunction: Percentage of Initial VP Shunt Placement Procedures Performed on Children Between 0 and 18 Years of Age That Malfunction and Result in Shunt Revision Within 30 Days of Initial Placement.	Outcome		AHRQ
Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Intermediate Outcome	1879	NQF QPS
Mental Illness	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Process	1880	NQF QPS
Mental Illness	Alcohol & Other Drug Use Disorder Treatment at Discharge	Process		CMS
Mental Illness	Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge	Process		CMS
Mental Illness	Alcohol Drug Use: Assessing Status After Discharge			CMS
Mental Illness	Alcohol Screening and Follow-Up for People with Serious Mental Illness	Process	2599	NQF QPS
Mental Illness	Alcohol Use Brief Intervention	Process	1663	CMS
Mental Illness	Alcohol Use Screening	Process	1661	CMS
Mental Illness	Annual Parkinson's Disease Diagnosis Review	Process	9999	CMS
Mental Illness	Antidepressant Medication Management (AMM)	Process	0105	NQF QPS
Mental Illness	Antipsychotic Use in Children Under 5 Years Old	Process	2337	NQF QPS
Mental Illness	Antipsychotic Use in Persons with Dementia	Process	2111	NQF QPS
Mental Illness	Assessment of Integrated Care: Overall Score on the Site Self Assessment (SSA) Evaluation Tool			AHRQ
Mental Illness	Assessment of Integrated Care: Total Score for the "Integrated Services and Patient and Family-Centeredness" Characteristics on the Site Self Assessment (SSA) Evaluation Tool.			AHRQ
Mental Illness	Avoidance of Dopamine-Blocking Medications in Patients with Parkinson's Disease	Process	9999	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	Process	2601	NQF QPS
Mental Illness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	1365	CMS
Mental Illness	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	Process	1364	NQF QPS
Mental Illness	Clinical Depression Screening and Follow-Up Reporting Measure	Process	9999	CMS
Mental Illness	Closing the Referral Loop: Receipt of Specialist Report			Wyoming's PCMH Program
Mental Illness	Cognitive Impairment Assessment Among Older Adults (75 Years and Older)	Process	9999	CMS
Mental Illness	Cognitive Impairment or Dysfunction Assessment for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Continuity of Pharmacotherapy for Alcohol Use Disorder	Process	3172	NQF QPS
Mental Illness	Continuity of Pharmacotherapy for Opioid Use Disorder	Process	3175	NQF QPS
Mental Illness	Counseling Patients with Parkinson's Disease About Regular Exercise Regimen	Process	9999	CMS
Mental Illness	Depression Care: Percentage of Patients 18 Years of Age or Older with Major Depression or Dysthymia Who Demonstrated a Response to Treatment 12 Months (+/- 30 Days) After an Index Visit.	Outcome	1885	AHRQ
Mental Illness	Depression Interventions Implemented During All Episodes of Care	Process		CMS
Mental Illness	Depression Interventions Implemented During Long Term Episodes of Care	Process		CMS
Mental Illness	Depression Interventions Implemented During Short Term Episodes of Care	Process		CMS
Mental Illness	Depression Interventions in Plan of Care	Process		CMS
Mental Illness	Depression Remission at Six Months	Outcome	0711	NQF QPS
Mental Illness	Depression Remission at Twelve Months	Outcome	0710	NQF QPS
Mental Illness	Depression Response at Six Months- Progress Towards Remission	Outcome	1884	NQF QPS
Mental Illness	Depression Response at Twelve Months- Progress Towards Remission	Outcome	1885	NQF QPS
Mental Illness	Depression Screening by Primary Care Providers: Adults			HIW
Mental Illness	Depression Utilization of the PHQ-9 Tool	Process	0712	NQF QPS
Mental Illness	Discharged to the Community with Behavioral Problems	Outcome		CMS
Mental Illness	Evaluation or Interview for Risk of Opioid Misuse	Process		CMS
Mental Illness	Follow-Up After Discharge from the Emergency Department for Mental Illness or Alcohol or Other Drug Dependence.	Process		CMS
Mental Illness	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Process	2605	NQF QPS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	Process		CMS
Mental Illness	Follow-Up After Hospitalization for Mental Illness: Percentage of Discharges for Patients 6 Years of Age and Older Who Were Hospitalized for Treatment of Selected Mental Illness Disorders and Who Had an Outpatient Visit, an Intensive Outpatient Service, or Partial Hospitalization with a Mental Illness Provider Within 30 Days of Discharge.	Process	0576	AHRQ
Mental Illness	Follow-Up After Hospitalization for Mental Illness: Percentage of Discharges for Patients 6 Years of Age and Older Who Were Hospitalized for Treatment of Selected Mental Illness Disorders and Who Had an Outpatient Visit, an Intensive Outpatient Service, or Partial Hospitalization with a Mental Illness Provider Within 7 Days of Discharge.	Process	0576	AHRQ
Mental Illness	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Process	0108	CMS
Mental Illness	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome	2483	NQF QPS
Mental Illness	HBIPS-1 Admission Screening	Process	1922	NQF QPS
Mental Illness	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Process	0560	NQF QPS
Mental Illness	HBIPS-6 Post Discharge Continuing Care Plan Created	Process	0557	NQF QPS
Mental Illness	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	Process	0558	NQF QPS
Mental Illness	Improvement in Anxiety Level	Outcome		CMS
Mental Illness	Improvement in Behavior Problem Frequency	Outcome		CMS
Mental Illness	Improvement in Confusion Frequency	Outcome		CMS
Mental Illness	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: A. Initiation, B. Engagement	Process	0004	NQF QPS
Mental Illness	Major Depressive Disorder (MDD): Percentage of Patients Aged 18 Years and Older with a Diagnosis of MDD Who Have a Depression Severity Classification and Who Receive, at a Minimum, Treatment Appropriate to Their Depression Severity Classification at the Most Recent Visit During the Measurement Period.			N/A
Mental Illness	Major Depressive Disorder: Suicide Risk Assessment	Process	0104	NQF QPS
Mental Illness	Medication Continuation Following Inpatient Psychiatric Discharge	Process	3205	NQF QPS
Mental Illness	Medication Reconciliation on Admission	Composite	3207	NQF QPS
Mental Illness	Mental Illness: Risk-Adjusted Rate of Readmission Following Discharge for a Mental Illness.	Cost/ Resource Use		AHRQ
Mental Illness	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Process	2800	NQF QPS
Mental Illness	Parkinson's Disease Rehabilitative Therapy Options	Process	9999	CMS

Condition Area	Measure Title	Measure Type	NQF #	Information Source
Mental Illness	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)		0726	AHRQ
Mental Illness	Patient Experiences of Psychiatric Care: Percent of Patients Who Responded Positively to the "Dignity" Domain on the Inpatient Consumer Survey (ICS).			AHRQ
Mental Illness	Patient Experiences of Psychiatric Care: Percent of Patients Who Responded Positively to the "Outcome of Care" Domain on the Inpatient Consumer Survey (ICS).			AHRQ
Mental Illness	Patient Experiences of Psychiatric Care: Percent of Patients Who Responded Positively to the "Participation in Treatment" Domain on the Inpatient Consumer Survey (ICS).			AHRQ
Mental Illness	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Process		CMS
Mental Illness	Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	Process	2806	NQF QPS
Mental Illness	Preventative Care and Screening: Screening for Depression and Follow Up Plan	Process	3132	NQF QPS
Mental Illness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	0418	NQF QPS
Mental Illness	Preventive Care and Screening: Unhealthy Alcohol Use - Screening	Process	9999	CMS
Mental Illness	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process	2152	CMS
Mental Illness	Preventive Care and Screening-Tobacco Use-Screening and Cessation Intervention (eMeasure)	Process	3185	NQF QPS
Mental Illness	Psychiatric Symptoms Assessment for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Querying About Parkinson's Disease Medication-Related Motor Complications	Process	9999	CMS
Mental Illness	Querying About Sleep Disturbances for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Querying About Symptoms of Autonomic Dysfunction for Patients with Parkinson's Disease	Process	9999	CMS
Mental Illness	Social-Emotional Support Lacking: Adults (Percent)			HIW
Mental Illness	Stabilization in Anxiety Level	Outcome		CMS
Mental Illness	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Process	1664	NQF QPS
Mental Illness	Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Process	2600	NQF QPS
Mental Illness	Treatment: Adults with Major Depressive Episode			HIW
Mental Illness	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	Process		CMS
Mental Illness	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Process	2801	NQF QPS

APPENDIX F:
Disparities Standing Committee and NQF Staff Roster

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APPENDIX G:
Public Comments

NQF received 64 comments from 17 organizations representing a variety of stakeholders. The table below includes the 64 public comments that were submitted on the draft report between July 21st and August 21st 2017. The Disparities Standing Committee discussed the public comments during the post-comment web meeting on August 30th and worked to address the comments and questions in the initial components of the roadmap. The comments submitted on the draft report were generally positive and represent seven themes: general comments, social risk factors, data and reporting, measure recommendations, effective interventions, measurement gaps, and specificity of recommendations.

Social Risk Factors

Several commenters expressed a desire to consider additional social risk factors, including health literacy and language as well as the intersectionality of these factors with the existing risk factors. Many comments specifically noted the desire for a greater focus on disability as a social risk factor. Others requested greater specificity when defining certain groups, especially Asian and Pacific Islander populations.

Data and Reporting

Comments that addressed data and reporting were supportive overall and generally addressed the first action, Identify and Prioritize Reducing Health Disparities. Comments highlighted issues that the Committee had previously addressed including small sample size and lack of data for addressing disparities and populations with social risk. Several methods of measurement were recommended including oversampling and multi-pooling across years to address small sample sizes. Commenters also expressed support for the Committee's recommendation for accountability and transparency. The Committee agreed that these methods could alleviate some of the data challenges. The report has been updated to reflect these suggestions.

Measure Recommendations

Several comments recommended additional measures to include in the report. One comment, which the Committee discussed specifically, noted that the measures were overly adult-focused and that the report included too few pediatric measures. The Committee agreed that the compendium of measures focuses on adults and mentioned that during earlier deliberations the Committee discussed and considered the effects of adverse childhood experiences and their impact on disparities.

Effective Interventions

Commenters provide suggestions for effective interventions to reduce disparities. One comment focused on dual eligible financial alignment demonstrations as an effective intervention. The Committee specifically addressed comments that called for the engagement of community-based organizations to link individuals to social services, supporting their inclusion in the report. The report has been updated to further highlight this intervention.

Measurement Gaps

Comments that highlighted measurement gaps focused on the dearth of measures from clinic-community linkages projects, specifically in the community and health system linkages sub-domain. The Committee agreed that more measures are needed to address these important areas of health equity measurement.

Specificity of Recommendations

One comment called for clearer language on certain pieces of the report including the sub-domains. These changes have been incorporated into the report. Another comment called for more specificity on the accountably entities to which the implementations strategies and recommendations would most apply. The comment requested additional recommendations or guidance on how providers at every level can work to reduce disparities. The comment also questioned how current methods used by CMS and others fairly report and pay for those health care systems and providers who care for at-risk populations. The Committee agreed that such clarifications are necessary and could be included in any future work of the Disparities Standing Committee.

Prioritize Disparities-Sensitive Measures

America's Health Insurance Plans

Richard Bankowitz

We support this provision.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

Overall, the Asian & Pacific Islander American Health Forum appreciates the intersectional framework the Committee took that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and healthcare disparities. While there are valid and important considerations about patient privacy in the context of small populations, we encourage the Committee to consider adding that where such concerns may prevent the public reporting of data, that methodologies such as oversampling and multi-year pooling techniques be considered. Overall, we agree that even if such data cannot be reported publicly, that should not be an excuse for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders who face different disparities compared to other groups and experience different disparities within specific subgroups (e.g. Native Hawaiians compared to aggregated Asian Americans).

California Pan-Ethnic Health Network

Caroline Sanders

CPEHN appreciates the broad, intersectional framework the Committee provides which is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health.

CPEHN appreciates the work of the Committee in demonstrating that it is possible to address health disparities while also alleviating measurement burden. We understand this is a very real barrier for health plans, hospitals and practitioners in engaging in this work. This was part of the challenge California's health benefit exchange faced when deciding how it would prioritize the elimination of health disparities as part of its quality improvement strategy. NQF's revised set of Disparities-Sensitive Measure Selection criteria (below) which we strongly support will help practitioners reduce measurement burden while identifying where to begin in addressing health disparities as part of quality improvement efforts:

The prevalence is great

Disparities are large and well-documented

There is strong evidence linking quality improvement to better health outcomes

The measures selected are actionable

The Criteria is intuitive, but also carefully laid out to assist those interested in achieving health equity in an evidence-based prioritization process that will result in measurable, demonstrable results.

We agree with the authors that even data for smaller subpopulations should be collected and stratified internally, even if data is too small to be publically reported for privacy reasons or lack of statistical significance. This is especially true for smaller subpopulations such as American Indian and Alaska Native (AIAN) and Asian and Pacific Islander

(API) where specific measures may yield very small numbers. This qualitative information is important and can still be used to inform interventions and improve the quality of care.

Community Catalyst

Ann Hwang, MD

The number of measures that currently exist can be challenging to navigate, we agree that measures should be prioritized in order to help facilitate quality data from providers and healthcare systems. However, while we agree that there is a proliferation of measures, there is also a serious lack of the "right" measures – measures that would more broadly capture system performance in a way that is meaningful to consumers. We note that the Institute of Medicine's Vital Signs report (Vital Signs: Core Metrics for Health and Health Care Progress, 2015) suggested a slate of measures that are broad in their scope yet parsimonious in number. And we would emphasize the need to look beyond the health care sector in assessing quality and disparities.

Hassanah

Janice Tufte

I was involved with the federal mandated "Ten Year Plan to End Homelessness" specifically related to efforts in Washington State. I want to say that our initial successes were because of effective leadership and collaborative development of system implementation changes. I agree with Chin et al; "interventions employed by government, communities, organizations, and providers (with improved patient/individual outcomes as the ultimate target of interventions).14 By leveraging multiple stakeholders throughout the system, these interventions can lead to improved outcomes for people with social risk factors, helping to demonstrate measurable progress towards achieving health equity"

Justice in Aging

Georgia Burke

Justice in Aging endorses the Committee's decision to prioritize measures that help to identify disparities and believes that the Committee's approach to tackling these issues is a sound one. We support the Committee's view that collecting stratifying data is critical to identifying disparities in ways that allow for targeted interventions. When small population sizes are involved, there are challenges, but it is important to find solutions and work-arounds. Otherwise health disparities can be masked.

SNP Alliance

Deborah Paone

We agree that it is important to prioritize disparities-sensitive measures. We appreciate the four criteria outlined to select such measures, however we note several challenges to using these criteria. First, populations with social risk factors are very diverse--in age, language, culture, medical, behavioral, functional conditions, community-level characteristics, and other conditions. Given this diversity of populations, we are concerned that there is not enough research to guide the answers to the four criteria/questions posed on prevalence, size, impact, and feasibility. For example, a condition may be prevalent among a subgroup of persons dually eligible—e.g., those under age 65 with a physical disability--where this condition is central to health outcomes and drives behavioral health management, social support, and medical care. However the same condition may not be prevalent among another subgroup of persons who are dually eligible—e.g., age 80+ with significant medical comorbidities or functional limitations. This leads to a key question: How will stratification of "at risk" groups be defined--to allow for meaningful application of the other criteria? Paucity of data and evidence comparing quality improvement efforts of meaningful "at-risk" subgroups to the group with "the highest quality ratings" will be the limiting factor in applying all of these criteria. This is a significant limitation. We would suggest three steps to begin: (1) greater attention to defining and stratifying population subgroups using clinical, functional AND social risk characteristics, (2) quality reporting for current measures applied to those subgroups (e.g., under current payment programs) done at the population subgroup level (i.e., compare ratings for similar population groups and to overall population). This could help illuminate measures that are sensitive to specific social risk factors (as well as highlight measure specification anomalies), or at least provide

insight into current measures—are they indeed meaningful measures of quality for these population subgroups (stratified according to similar clinical, functional, and social risk characteristics)? After population stratification, (3) report the stratification mix by provider and plan. This will increase the utility of reporting—allowing for comparison of measurement results among organizations with similar population distributions. Such stratification would also help identify opportunities or promising practices for more tailored care or effective approaches to addressing unique subgroup issues that impact health status.

SPAN/Family Voices NJ

Lauren Agoratus

We support the set of criteria including prevalence, size of disparity, impact of quality process, and ease/feasibility of improving. We are concerned that some common measures such as disparities for those with developmental disabilities and even developmental screening inequities aren't listed, even though early intervention is the key to best outcomes. (Source: CDC https://www.cdc.gov/ncbddd/disabilityandhealth/features/unrecognizedpopulation.html.)

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE applauds the use of the intersectional framework the Committee created that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and health care disparities. While there are valid and important considerations about patient privacy in the context of small populations, we encourage the NQF to consider adding language to the effect that such concerns can be ameliorated by using such methodologies as oversampling and multi-year pooling techniques. We agree that even if such data cannot be reported publicly, that should not be a rationale for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders, as well as subgroups of African descent, such as Ethiopians, who may face different disparities compared to other groups and experience different disparities within the racial/ethnic categories to which they belong.

Identify Evidence-Based Interventions to Reduce Disparities

America's Health Insurance Plans

Richard Bankowitz

We support this provision.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

Overall, the Asian & Pacific Islander American Health Forum agrees that reducing disparities requires multi-level and sectorial interventions that address both resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome the need for interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that patients are whole people who experience multiple factors that influence their health in different ways.

California Pan-Ethnic Health Network

Caroline Sanders

CPEHN appreciates the Committee's decision to modify the Social-Ecological Model (SEM) to better apply to health systems. The need for interventions employed by government, communities, organizations and providers has been clearly demonstrated by Chin et al. We agree with the Committee that leveraging multiple stakeholders throughout the system can improve outcomes for people with social risk factors.

We also agree with the Committee that intersectionality is important. As individuals and communities, we each hold different identities, relating to such factors as our race and ethnicity, language, gender, age, sexual orientation, national origin and ability. As multi-identity, multi-cultural individuals and communities, we encounter systems differently, in ways that either support or hinder our health. We appreciate the expansive nature of the Committee's spectrum which focuses on disparities beyond race and ethnicity to include age, gender, income, nativity, language, sexual orientation, gender identity, disability and geographic location amongst other social risk factors. Because of these multiple and at times overlapping identities, we strongly support the idea espoused by the Committee of addressing disparities for more than one social risk factor.

Community Catalyst

Ann Hwang, MD

As stated in the report, findings from the literature review on evidence based interventions to reduce disparities demonstrate need for further investment in research and pilot projects to better understand the mediators of disparities. We believe that this is a critical step to create a validated evidence base to develop meaningful measures.

Hassanah

Janice Tufte

I think it is very important to develop measures that address improving our health systems to effectively tackle disparities in populations with social risk factors. It is true most measures are written focusiing on individual patients' engagement, lifestyle and activation. I am of the belief that changing the culture of the health system with "buy in from the top",support of clinic and insttution change champions, should move equitable research and cultue change along faster.

I appreciate the mention of encoraging future research specifically looking at individuals with differing abilities (disabiities), income levels, social networks, comunity context and health literacy. These are very important areas to develop as comparators within the individuals who live in the same area (zip code), and or from the same population to derive some significant findings that might be utilized for common good, better health and health care outcomes

Justice in Aging

Georgia Burke

Justice in Aging particularly appreciates the recognition in this section of the report on the importance of tailored interventions, many of which are not purely medical. For low-income older adults, issues of economic security, access to stable affordable housing, and reliable transportation to medical appointments are critical to positive health outcomes. In the dual eligible financial alignment demonstrations that CMS currently is undertaking, there has been an emphasis on care coordination that includes help for beneficiaries to access housing, food service, transportation, pest control and other services. See CMS, Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative (March 2017) at 16-17, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf Person-centered approaches that are culturally competent and language concordant are key and must be tested and evaluated.

SNP Alliance

Deborah Paone

We wholeheartedly agree with the Committee's findings that there needs to be significantly more resources focusing on developing and testing integrated approaches and interventions at the system level—across settings, disciplines, and services—that are tailored to meaningful population subgroups and take into account community and organizational context. These interventions need to take into account the multiple chronic conditions, functional limitations, and social risk factors that characterize the population subgroups. We have noted that these population subgroups need to be defined with as much specificity as possible to be meaningful and to guide efforts to address

the multiple factors that impact health outcomes. Implementation and quality evaluation of such interventions or approaches would need to attend to the interaction between person, conditions, characteristics, and context. While challenging, this is work that is desperately needed to guide efforts to tailor care, increase positive health outcomes, and reduce health disparities.

Population stratification—using information to more effectively group individuals with similar medical, behavioral, long-term care, AND social risk factors—offers the opportunity for tailoring care and support. Care approaches being developed and best practices already tested need to take into account functional and social risk factors in addition to medical/clinical diagnoses. Those developing "best practice" programs or models need guidance to ensure robust examination and reporting of their testing results among various population subgroups (consistently defined) in order to highlight similarities or differences arising from population characteristics—independent of the program model. There may need to be customized tailoring of "best practices" to accommodate differences within the population—in order to achieve intended results. Guidance on program translation and customization of program approaches will help ensure fidelity, while also recognizing the diversity of intended population groups.

SPAN/Family Voices NJ

Lauren Agoratus

We are concerned that the literature review focuses on outcomes "in populations socially at risk" but "existing interventions…focus on patient education, lifestyle modification, and culturally tailored programs. Far fewer…address…social risk factors." We acknowledge that targets are "based on race and ethnicity" but are concerned that "few…are based on disability status…health literacy." As previously mentioned, we know that there are health disparities for individuals with disabilities. In addition, health literacy is the single largest factor affecting health care access. We appreciate the acknowledgement that multiple conditions increases risk.

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE agrees that reducing disparities requires multi-level interventions that address resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that health care consumers patients have many experiences that influence their health in different ways.

Select and Use Health Equity Performance Measures

America's Health Insurance Plans

Richard Bankowitz

We support this provision and the domains of health equity performance measurement described in the report. We feel it would be helpful to develop standardized performance measures in these areas to facilitate collaboration between health plans, providers, and other stakeholders. The committee should also provide guidance on how to demonstrate that measurement goals are being met, how to distinguish between good and poor performance, and how to determine the impact of measurement. Measures that address structure for equity, culture of equity and partnerships and collaboration are much harder to identify compared to measures that address high-quality care and access to care.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

We at the Asian & Pacific Islander American Health Forum welcome the scanning of existing performance measures that can be used in quality improvement programs. Such measures aim to

minimize measurement burden on covered entities, while leveraging existing measurement infrastructure. In addition, we appreciate the identification and consideration given to gaps in measures that must be developed. We encourage NQF to consider, as done with this Report, broad stakeholder input in the development of such measures to address these gaps. Similarly, we welcome the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the healthcare delivery system, play a role in achieving health equity and provide critical supports to patients.

We strongly support the finalization of four domains of health equity. In particular, we emphasize the "Collaborate with other organizations or entities that influence the health of individuals" and inclusion of measures that address the social determinants of health in concrete and actionable ways. One such area is the community and services linkage, which has the potential to improve quality for persons who are limited English proficient. As outlined in our "Connecting Limited English Proficient Indviudals to Healthcare Systems Report," (available at www.apiahf.org), there is a recognition amongst various sectors of the need to include community-based organizations (CBOs) within the healthcare system, yet operational challenges to doing so.

CBOs and other trusted community partners play a vital role in supporting a person's "whole health" as they relate to language access, faith, mental and social support, education, financial security, etc. As noted in the Report, it is critical that there be collaboration and linkage amongst health providers of different types and amongst those who are in non-health/non-clinical areas. Such non-health/non-clinical entities provide essential services that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain prescription drugs. These services are often provided with little to no reimbursement or resources to the CBO and are relied upon by racial and ethnic minorities and those with limited literacy, health literacy and English proficiency.

Although more LEP individuals have coverage, language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

CBOs serving Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) communities often focus on providing services to specific AA and NHPI ethnic subgroups that are most represented in the community. Others provide services for segments in a community, such as immigrants and refugees, that often have a large proportion of individuals who came to the U.S. from an Asian or Pacific Island nation. Many of these individuals are LEP, and therefore CBOs frequently have multilingual staff and volunteers who come from the community with the necessary cultural understand to competently provide in-language assistance to the individuals they serve.

CBOs can function as a hub for LEP individuals who want to access care, but who need culturally and linguistically appropriate assistance to navigate the health care system. Although CBO staff may not be certified community health workers (CHWs), they still provide culturally competent in-language enrollment assistance and assistance in helping people access care and navigate the health care system. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP individuals and receive compensation for services provided by staff, just as CHWs are compensated for helping individuals navigate the health care system. This compensation could come in the form of contracts between CBOs and

hospitals, insurers, and provider networks in which CBO staff provide interpretation and health system navigation for LEP individuals. Health plans could contract with CBOs to help their LEP members find providers, describe services covered under their plan, make appointments with providers, and provide interpretation assistance during clinic visits.

With respect to the "Culture of Equity" subdomain, we support protecting access to care though critical public programs, including Medicaid and the Children's Health Insurance Program (CHIP). Similarly, with respect to "Equitable Access to Care," we welcome the addition of language accessibility as a measurement and strongly agree with equity in access to care as being a core tenant in achieving health equity.

With respect to the "Structures of Equity" subdomain, we agree with the integrated nature of data, both in terms of collection, reporting and analysis and having the systems and infrastructure in place to support robust, timely and accurate data collection.

Overall, the equity measures provide concrete ways to operationalize a drive to improve health equity and should be leveraged so that payers have an incentive to integrate them into their quality improvement programs. These measures are critical to assessing progress and eventually, as the report notes, creating incentives for adoption.

California Pan-Ethnic Health Network

Caroline Sanders

CPEHN agrees with the need for disparities sensitive measures and measures that directly assess equity. We support including measures of Collaboration and Partnerships including collaboration across health and non-health sectors, community and health system linkages, building and sustaining social capital and social inclusion. We support the Committee's framework of measurement beyond clinical settings, structures, and processes of care to include for example, an assessment of collaboration between healthcare and other sectors (e.g., schools, social services, transportation, housing, etc.) to reduce the impact of social risk factors. A hospital may discharge a patient in "good condition." However without the social supports needed to recuperate such as adequate housing and access to healthy foods, that patient has a much higher likelihood of being readmitted.

As the Committee notes, "achieving equity is a process and that different organizations may be in different places in that process and have different resources available" (p. 11). The Committee's Domains of Health Equity Performance Measurement is a helpful tool as it takes into account these differences in organizational progress and capacity towards meeting these ambitious goals.

Community Catalyst

Ann Hwang, MD

We are pleased to see the following domains in the report as a way to achieve equity: collaboration and partnership, culture of equity, structure for equity, equitable access to care and equitable high-quality care. We note that there are critical gaps in the available measures in these domains, particularly for consumer-centered measures that capture overall system performance, and we urge NQF to create or identify measures that will more fully assess performance in these domains.

We are encouraged to see importance placed on stratifying outcome and process measures to identify disparities. We urge stratification by the spectrum of disparities identified on page 6 of the report.

Family HealthCare Center

Paul Nelson

Of the performance measures listed, there is a recurring emphasis on measures related to infant mortality. I found none related to maternal mortality. State by state, the last data set available is 2001-2006, maternal mortality rates are highly related to a state's poverty level. Given the UN/WHO/IMF report for 2015, our nation ranks 41st out of the 51 advanced/developed nation's. Given the best 10 of these nations, we would need to reduce our nation's maternal mortality incidence by 70% to rank among these nations. We are the ONLY developed nation with a worsening maternal mortality incidence for 25 years.

* Its possible that I missed a Lead Poisoning indicator. But if not, it is highly correlated with poverty.

Hassanah

Janice Tufte

Ensuring equitable access to care and actual equitable delivery of care are going to prove challenging from EHR patient portals to system non-interoperability. Patients involved with measurement subject matter prioritization, the development of equitable and balancing measures, will assist in ensuring that more relevant and effective measures will be utilized. Rural, Urban, Suburban health care providers and patients from diverse demographic, socio economic and nativity backgrounds should be involved.

RE Figure 4B Sub Domains: Community and Health System Linkages. I was a Patient Co-Investigator on the PCORI funded GHRI/ KPWHRI "Learning to Integrate Neighborhoods with Clinical Care-LINCC" project. I have noticed as missing measures from clinic-community linkages projects are the actual outcomes, documentation of useage, or utilization of community resorces once provided. If a CBO refers a client to a health system there is a record of some sort to gather data on, it is a bigger challenge to have a patient report back on if they have utilzed a community resource, and or access data from that CBO.

"Linking medical care with community services to connect patients to resources more effectively" how to measure this? A community liaison or community resource specialist might refer to local resources though that resource has perhaps dried up, or takes months or even years to access. One way to address this accessibility gap is to build and nurture valuable community partnerships that might come from unlikely corners sometimes.

Justice in Aging

Georgia Burke

In this section, Justice in Aging particularly appreciates the work of the Committee on the Culture of Equity domain and subdomains, the Equitable Access to Care domain and subdomains and the Equitable High Quality Care domain and subdomains. For dual eligible beneficiaries, who rely on both Medicare and Medicaid, improvements in these areas, and measures that track progress, are critically important. We strongly encourage continued measures development in these areas.

SNP Alliance

Deborah Paone

We support the Committee's recognition that to reduce disparities, factors outside of the healthcare system must be included. A growing body of evidence shows that community resources, education, employment, and the justice system can signficantly affect health status. These influences may persist over a lifetime or even over generations. Achieving health equity requires collaboration. Healthcare providers and plans in resource-poor communities, disproportionately serving low-income and social risk populations especially need help.

We appreciate the subdomains and the environmental scan to find relevant measures. The collaboration and partnership domain is an area of particular interest, specifically, the integration between care settings. Special needs plan members (consumers) frequently require home services, medical care, and behavioral health support. These "systems" of care are still largely separate (not integrated) and this fragmentation adversely affects these individuals. To integrate effectively, policy, regulatory, and payment changes are needed—for example allowing for streamlined information transfer across settings, paying for services outside of current benefit definitions, and identifying consumer decisions on goals that impact the ability to follow standard condition-based guidelines. States currently drive Medicaid benefit definitions for low-income individual and the federal government sets Medicare benefit criteria. When a person is in both these programs, there are overlapping and conflicting policies--this can impact what, how, and when the individual receives care. Quality measures also do not align.

We agree with Avedis Donabedian's framework for quality, attending to availability, accessibility, accommodation, amenability, and affordability—however many of the current "quality" measures, even when they focus on these issues, do not take into account the diversity of social risk populations and their ability to participate in quality surveys. For example, HOS or CAHPS self-report survey data has known limitations arising from: survey instrument and survey design elements that do not match the diverse dual population (e.g., 2-year look-back longitudinal survey), lack of robust language accommodation,

inadequate methods of administration (assumes communication device, stability in residence, health or other literacy), and sampling (lack of oversampling of ethnic/language diverse populations)—all limitations which may bias results. We urge attention to refining these tools and methods to accommodate diverse and social risk populations. Then stratifying the results by social risk groups will be the second step to ensuring meaningful interpretation of results that could help drive health equity improvement.

SPAN/Famiy Voices NJ

Lauren Agoratus

We agree that equity can be achieved by "collaborating and partnering with other organizations." We would suggest partnering with federally funded Family-to-Family Health Information Centers which are family-staffed organizations that assist families of children with specialhealth care needs and the professionals who serve them. We also strongly support a "culture of equity." We agree this will be enhanced by creating "structures that support…equity, equitable access to healthcare, and high-quality care." We are concerned that "few measures assess data collection efforts to improve health equity."

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE welcomes the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the health care delivery system, play a role in achieving health equity and provide critical support to health care consumers.

Community based organizations and other trusted community partners play a vital role in supporting a person's "whole health" as they relate to language access, wellness promotion and disease prevention, mental and social support, education, financial security, etc. It is critical that there be collaboration and linkage among health providers of different types and among those who are in non-medical/ non-clinical areas. Such entities provide essential services now that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment in coverage, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain prescription drugs, as well as such wellness promotion services as nutrition education, stress management, etc. These services are often provided with little to no reimbursement or resources to the CBO and yet are relied upon by racial and ethnic minorities and those with limited literacy and health literacy and English proficiency.

Language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP, Medicaid and other individuals with special needs. They should therefore be able to receive compensation for services provided by staff, just as community health workers and other outreach personnel are compensated for helping individuals navigate and fully benefit from the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, health plans, clinics and provider networks.

Incentivize the Reduction of Health Disparities and Achievement of Health Equity

America's Health Insurance Plans

Richard Bankowitz

We support this provision. We support the recommendation that health equity measures be incorporated into accountability programs and aligned across payers to facilitate adoption. We also support the recommendation that social determinants of health be an integral part of any efforts to address health disparities.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

The Asian & Pacific Islander American Health Forum agrees that data are the bedrock of all measures and ability to understand, access, monitor and eliminate disparities and that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data is collected: clinical (Claims or administrative; patient-reported data; community and systems level). Moreover, we underscore the Committee's recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care. It is difficult to imagine patients being able to play active, empowered roles in quality improvement without access to data most useful for the patient and provided in a form and manner that is responsive to patients (e.g. health literacy and linguistic competency).

APIAHF underscores performance measures can be used to continuously identify disparities in health and healthcare, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve quality and have a patient population that experiences a multitude of risk factors.

As such, we recognize the importance of adjusting for social risk factors in payment programs and share concern about both the burden on clinicians who disproportionately serve those with more social risk factors, while at the same time not creating lower standards for improving health outcomes in disadvantaged populations. We agree that one method of doing so is to directly adjust payment for social risk factors, stratify data across social risk factor groups to provide transparency and link health equity measures to accreditation programs.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited English proficient. We agree that there is a need to conduct such demonstration projects to determine how to effectively integrate CBOs into the healthcare delivery system, how to create sustainable funding models and ensure partnerships with payers and providers.

California Pan-Ethnic Health Network

Caroline Sanders

We agree with the Committee that financial incentives are an important policy lever to hold health plans, hospitals and providers accountable for reducing disparities and achieving health equity. Large payers like Medicaid and Medicare are increasingly turning to payment incentives as a strategy for improving quality by holding health plans, providers, and hospitals accountable for measurable results. We agree with the Committee that value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities as does the shift to global payment, capitated payment, and bundled payment.

Additionally we support the use of social and population health measures to ensure appropriate resource allocation to counteract the causes of social risk. We agree with the Committee that stratification of disparities-sensitive measures can

promote transparency and help identify and address disparities.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. Researchers for example with RWJ's Finding Answers: Disparities Research for Change project conducted an exhaustive review and evaluation of promising practices for reducing racial and ethnic disparities in care. These models should be encouraged and supported and the results widely shared.

California Pan-Ethnic Health Network

Caroline Sanders

We agree with the Committee that financial incentives are an important policy lever to hold health plans, hospitals and providers accountable for reducing disparities and achieving health equity. Large payers like Medicaid and Medicare are increasingly turning to payment incentives as a strategy for improving quality by holding health plans, providers, and hospitals accountable for measurable results. We agree with the Committee that value-based purchasing represents a chance to reward providers for reducing disparities or for the use of effective interventions to reduce disparities as does the shift to global payment, capitated payment, and bundled payment.

Additionally we support the use of social and population health measures to ensure appropriate resource allocation to counteract the causes of social risk. We agree with the Committee that stratification of disparities-sensitive measures can promote transparency and help identify and address disparities.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities.

Community Catalyst

Ann Hwang, MD

We are encouraged to see in the report detailed recommendations on incentivizing the reduction of disparities and achieving health equity. Promoting payment models that will address disparities with a goal to achieve health equity is a step in the direction of an equitable healthcare system for vulnerable populations.

Hassanah

Janice Tufte

This section is well thought out with very effective strategies and recomendations. Thank you I will read a couple times to digest the full report

Justice in Aging

Georgia Burke

The Committee accurately notes that performance measurement is increasingly used for accountability including for determining payments under Medicare and Medicaid. Justice in Aging believes that this trend increases the importance of the work of the Committee, particularly the implementation strategies in this section. Looking at the policy recommendations in this section, we particularly support the recommendation of supporting organizations that disproportionately serve individuals with social risk factors. It is our experience that many safety net providers, though making do with inadequate funding, have developed innovative culturally competent programs and effective interventions to address disparities. Providing these programs with stable support at reasonable levels is important. It is important that payment models do not unfairly penalize them because they disproportionately serve the very populations that are most in need of culturally competent, qualify care.

SNP Alliance

Deborah Paone

We applaud the Committee for attending to the ASPE and NAM reports and recognizing the danger that current value based payment methods add to inequities in resource distribution. The safety net providers and plans that disproportionately serve low-income and social risk populations may be negatively impacted, as these independent research committees and experts have concluded. The Disparities Committee rightly points out that low reimbursement rates or lack of bonus payments can end up restricting resources to the providers and

plans that are serving the most at-risk populations.

We particularly note the opportunities to add social complexity factors to risk adjustment and payment models and the need to support organizations that disproportionately serve these individuals with social risk factors (Strategies 2 and 3). The recommendations offer practical approaches that could be implemented under current statutory authority by the Secretary.

We agree that there needs to be standardization in data elements and definitions related to social risk factors. We note the existing challenges with accessing electronic health record information—additional technical support and capacity will be needed to effectively add and collect uniform social risk data. In addition, we note that individuals (consumers/patients) may resist the collection of some of these data elements—as they may not understand why or agree with the need for healthcare providers to have information about their employment, marital, education, or housing status. As others have pointed out, the need for person-level data to identify risk areas and address underlying issues that impact health status will have to be balanced with individual rights to privacy.

Plans and providers serving unique special needs populations may have small tailored programs that are customized to these unique groups. We hope that any collection or reporting of quality measurement data recognizes and respects the uniqueness of specialty populations and allows for accommodation in care. Small sample sizes within any one organization are a limitation, but pooling information may assist in quality improvement strategies. With a better understanding of the subgroups within populations--needs, characteristics, preferences, and what works--we will be able to more effectively target resources and tailor care.

SPAN/Famiy Voices NJ

Lauren Agoratus

We understand that "performance measurement is increasingly used for accountability." However, what appears to be missing is that by reducing health disparities, the result is cost savings and more importantly, better health outcomes for underserved populations. We support the strategies developed to address equity through implementation of health equity measures, incentivized payment, support of organizations that disproportionately serve individuals with social risk factors, and demonstration projects.

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

SHIRE agrees that data are the bedrock of all measures and are essential to understand, access, monitor and eliminate disparities. We concur that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data are collected: clinical claims or administrative data; patient-reported data; community and systems level data. Moreover, we underscore the Report's recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care at the patient-level. It is difficult to imagine how patients might play active, empowered roles in quality improvement without access to data provided in a form (e.g. linguistically and culturally appropriate) that meets their needs.

SHIRE underscores the recommendation that performance measures can be used to continuously identify disparities in health and health care, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve quality and have a patient population that experiences a multitude of risk factors.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited

English proficient. We agree that there is a need to conduct such demonstration projects to determine how to effectively integrate CBOs into the health care delivery system, how to create sustainable funding models and ensure partnerships with payers and providers. For maximum effectiveness, these programs should be funded adequately and over a sufficient period of time to be able to document results.

Thank you for the opportunity to comment on this Report. If you have questions, please contact Ruth Perot, Executive Director/CEO at rperot@shireinc.org.

General Comments

ACL/NIDILRR

Amanda Reichard

Congratulations! You have made great strides in addressing the difficult task of reducing health and health care access disparities. The document is well-organized, easy to read, and comprehensive.

Please consistently include people with disabilities as a health disparity group of interest. Although this group is named in some places throughout the document, the document does not regularly use examples of the unique needs of individuals with disabilities and discussion of what solutions are necessary to eliminate disparities. As a result, people with disabilities are underemphasized, and as it is written now, the reader could easily forget this population as an important one for which to address health disparities.

The literature clearly documents the disparities experienced by this group (Krahn & Fox 2014; Reichard, Stolzle & Fox, 2011; Horner-Johson, et al., 2014), their disproportionately higher levels of health care need and cost (Reichard, Gulley, Rasch & Chan, 2015), and frequently provides evidence and suggested solutions to the group's unique needs (e.g. Krahn & Fox, 2014). However, this group typically does not receive a consummate level of attention in policy and practice as a health disparity group with substantial and frequently unique needs (Krahn, Walker, Correa-de-Araujo, 2016). Thus, it is crucial that we continue to work toward addressing health and health care disparities experienced by people with disabilities.

Below are some examples of where you could highlight the disability population more consistently throughout the document:

(p. 4). At the bottom of the second paragraph: add in a similar disability example. The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities (2005) is a great resource for such examples.

(p. 5). In the last paragraph before Project Overview, add into the sentence that begins "For example": implement universal design to improve physical access.

(p. 6). In the first paragraph under Measurement Framework, add in a sentence about disability with supporting documentation, (similar to what is written about race/ethnicity). The Surgeon General's Report (referenced above) and the Surgeon General's Report, Closing the Gap (2001), also provide great examples for use here.

(p. 9). Bottom of the last paragraph, it is important to specify the disparity groups here rather than listing them as "social risk".

(p. 13). Collaboration and Partnership: The subdomain "Build and sustain social capital and social inclusion" could benefit from some example concepts that highlight topics relevant to people with disabilities, specifically. Some ideas for inclusion:

Improvement of physical accessibility of housing, to improve ability of people with disabilities' to enter/exit their home, and to make houses in the community more visitable by people with physical limitations

Improvement of transportation (e.g., physical accessibility of public transit, greater affordable and reliable paratransit systems), to improve ability of people with disabilities ability participate in necessary health care activities (e.g., health promotion, health care visits, health education).

(p. 14). Safe and accessible environments for individuals from diverse backgrounds.

1. Recommend separating out accessibility from safety, and rename this subdomain to: "Safe environments for all."

2. Add new Subdomain could/should for accessibility; including it with safety minimizes its importance in establishing equity. However, this Subdomain should

be included under the Domain: Structure for Equity, as accessibility environments are critical to ensuring that people with disabilities can use all components of the environment (e.g., transportation, housing) necessary for managing, improving, and maintaining their health.

The title could be: Accessible environments. Example Concepts could include:

Systematic identification of physical access barriers related to receiving necessary care (e.g. transportation, health care buildings, examination tables)

Systematic identification of physical access barriers to health promotion activities (e.g. inaccessible exercise facilities, reliable/accessible transportation, inaccessible sidewalks)

(p. 14). Culture of Equity/Cultural Competency. This subdomain could benefit from a bullet addressing the need for Disability Etiquette competency.

(P. 14). Policies and procedures that advance equity. This subdomain could benefit from a bullet such as: * Require cultural competency training, including disability etiquette

(p. 15). Structure for Equity/Collection of data to monitor the outcomes of individuals with social risk factors.

1. Recommend changing the name of this subdomain: Collection of data to monitor the outcomes of groups with known health disparities.

2. This subdomain's example concepts would benefit from a disability-related bullet, such as "Ensuring that metrics include means for accurately identifying the groups (especially disability identifiers) experiencing health disparities." Disability identifiers in surveys continue to presents barriers to monitoring outcomes for this population. (see Altman, 2014; Burkhauser et al., 2014; McDermott & Turk, 2011).

(p. 15). Systematic community needs assessments. I recommend adding a phrase such as "as well as additional equity priorities" to the end of the third bullet. Although it is very important to target interventions to the community-prioritized needs, the community may have blind spots for additional areas that must be addressed to create equity.

(p. 17). Use of effective interventions to reduce disparities in healthcare quality. Add a reference to expanding/changing programs designed to address the needs of people without disabilities to be able to accommodate people with disabilities (e.g. Rimmer et al).

(p. 20). I recommend adding in the highlighted words to the last bullet in the table:

Community outreach gatherings, public health screenings in accessible community settings

In addition, we strongly suggest that the report summarize the findings of the NQF HCBS Quality Group in the background section with an emphasis on the HCBS quality framework, quality domains, gaps analysis http://www.qualityforum.org/Measuring_HCBS_Quality.aspx

Finally, the section on cultural competency should include a broader discussion on the disparities cross-culturally. An emerging literature that refines cultural variation across an number of disciplines (e.g. cognitive psychology, sociology, anthropology, etc.) suggests that some of the things that are taken as human universals may not resonate well outside the relatively narrow cultural grouping of large scale industrialized, western societies. For instance, there is significant variation across the individual/collectivist continuum which may have implications for many aspects of health care conceptualization, delivery, and measurement.

References

Altman, Barbara M. "Another perspective: capturing the working-age population with disabilities in survey measures." Journal of Disability Policy Studies 25.3 (2014): 146-153.

Burkhauser, Richard V., Andrew J. Houtenville, and Jennifer R. Tennant. "Capturing the elusive working-age population with disabilities: Reconciling conflicting social success estimates from the Current Population Survey and American Community Survey." Journal of Disability Policy Studies 24.4 (2014): 195-205.

Horner-Johnson, Willi, et al. "Breast and cervical cancer screening disparities associated with disability severity." Women's Health Issues 24.1 (2014): e147-e153.

Krahn, Gloria, and Vincent A. Campbell. "Evolving views of disability and public health: The roles of advocacy and public health." Disability and health

journal 4.1 (2011): 12-18.

Krahn, Gloria L., and Michael H. Fox. "Health disparities of adults with intellectual disabilities: what do we know? What do we do?." Journal of Applied Research in Intellectual Disabilities 27.5 (2014): 431-446.

Krahn, Gloria L., Deborah Klein Walker, and Rosaly Correa-De-Araujo. "Persons with disabilities as an unrecognized health disparity population." American journal of public health 105.S2 (2015): S198-S206.

McDermott S., Turk M. (2011). The myth and reality of disability prevalence: Measuring disability for research and service. Disability and Health Journal, 3, 1–5.

Reichard, Amanda, Hayley Stolzle, and Michael H. Fox. "Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States." Disability and health journal 4.2 (2011): 59-67.

Reichard, Amanda, et al. "Diagnosis isn't enough: understanding the connections between high health care utilization, chronic conditions and disabilities among US working age adults." Disability and health journal 8.4 (2015): 535-546.

Rimmer, J. H., Vanderbom, K. A., Bandini, L. G., Drum, C. E., Luken, K., Suarez-Balcazar, Y., & Graham, I. D. (2014). GRAIDs: a framework for closing the gap in the availability of health promotion programs and interventions for people with disabilities. Implementation Science, 9(1), 100.

American Association on Health and Disability

E. Clarke Ross

Recognition of Disability

We appreciate the acknowledgement of persons with disabilities - Pages 2, 6, 10, 16. However, completely missing from the report is a discussion of disability as a disparity factor/consideration. We encourage the addition of a discussion of this topic. Such as discussion could include a summary of the following peer reviewed professional journal literature and related materials:

1. NQF disparities committee member, Lisa Iezzoni, M.D.. Among her many articles are April 2017 Disability and Health Journal on "Do prominent quality measurement surveys capture the concerns of persons with disabilities;" 2016 Disability and Health Journal on "Trends in Colorectal Cancer Screening Over Time for Persons with Chronic Disability;" and similar journal articles on breast cancer and disability, physical access barriers, and treatment disparities facing Medicare beneficiaries.

2. Former CDC NCBDDD division director Gloria Krahn, Ph.D. Among her many publications are February 2015 American Journal of Public Health on "Persons with Disabilities As An Unrecognized Health Disparity Population;" and September 8, 2015 CMS OMH health equity symposium presentation and resources on health inequity and persons with disabilities.

3. Froehlich-Grobe et al, October 2016 Disability and Health Journal on "Impact of Disability and Chronic Conditions on Health."

4. Henan Li, et al, March 2017 Disability and Health Journal on "Health of U.S. Parents with and without Disabilities."

5. Havercamp, et al, 2015 Disability and Health Journal on "National Health Surveillance of Adults with Disabilities, Adults with Intellectual and Development Disability, and Adults with No Disabilities."

6. Ohio Disability and Health Program 2015 free-standing publication with references, "The Double Burden: Health Disparities Among People of Color Living with Disabilities."

7. Network for Public Health Law-CDC 2017 webinar materials including April 20 on "The Built Environment as a Social Determinant of Health" and May 18 on "Housing as a Social Determinant of Health."

Further, an analysis of disparities should examine the NQF MAP December 2012 identified "high need" subgroups of persons dually eligible for Medicare and Medicaid: (1) persons with physical or sensory disabilities; (2) persons with serious mental illness and/or substance use disorder; (3) persons with cognitive impairment (e.g., dementia; intellectual disability and/or developmental disability); and (4) "medically complex adults age 65 or older with functional limitations and co-occurring chronic conditions."

Person and Family Centeredness and Experience of Care

We appreciate the pages 16-17 importance of person and family centeredness; page 21 recognition of NQF endorsed experience of care, including ECHO and CAHPS HCBS Experience of Care Survey; page 27 – the potential of CAHPS surveys on convenience, timeliness, and accessibility; and page 28 – the importance of Patient-Centered Medical Homes Patients' Experience and CAHPS HCBS Experience of Care Survey

When examining persons with disabilities, two disability quality measurement programs have each operated for over 20 years - the National Core Indicators and Personal Outcome Measures. These programs were initially designed for persons with intellectual and other developmental disabilities, but have evolved for other populations of persons with disabilities over recent years. Other NQF committees and workgroups have examined the NCI & POM and should be referenced in the disparities report.

Recognition of Mental Illness/Mental Health

Thank you for the pages 5, 24, 27, and 30 recognition of mental illness. We particularly applaud the page 19 focus – Gaps in the integration of physical and mental health and recognition of the SAMHSA 4 Quadrant Model.

Recognition of Low-Birth Rate

Thank you for the page 5 and 24-28 recognition of low-birth rate.

Importance of Collaboration Between Health Care and Community/Social Sectors

Particularly important are the page 7 importance of Collaboration Between Health Care and Community/Social Sectors; page 11 – Influence of Community Organizations; page 11 – health care sectors must collaborate and partner with other organizations and agencies that influence the health or individuals; page 13 – Collaboration Across Health and Health Care Sectors, Community and Health Systems Linkages, Social Inclusion; pages 18-20 discussion of Collaborations and Partnerships; and pages 36 & 37 – a step to incentivize the reduction of health disparities and achievement of health equity includes: (1) ensure that organizations that disproportionately serve individuals with social risk factors can compete in value-based purchasing, and (2) consider additional payment for organizations that fall outside the control of safety net organizations and providers.

Pivotal Role of Continuity of Care

Thank you for the page 27 identification of the pivotal role of continuity of care

Pivotal Role of Primary Care

We agree with the page 27 – pivotal role of primary care and page 34 – a step to incentivize the reduction of health disparities and achievement of health equity includes direct investment in preventive and primary care for patients with social risk factors

Population Health Management

We agree with the page 15 observation – importance of population health management – and pages 24-26 – need for better population health for individuals with social risk factors as an important measure gap.

American Association on Health and Disability and Lakeshore Foundation, part 3, Clarke Ross

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American Optometric Association

Christopher Quinn, O.D.

The American Optometric Association (AOA) appreciates the opportunity to comment on the draft report, "A Roadmap to Reduce Health and Healthcare Disparities through Measurement" from the National Quality Forum (NQF).

The AOA represents approximately 33,000 doctors of optometry and optometry students. Doctors of optometry are eye and vision care professionals who diagnose, treat and manage diseases, injuries and disorders of the eye, surrounding tissues and visual system and play a major role in a patient's overall health and well-being by detecting and helping to prevent complications of systemic diseases such as hypertension, cardiovascular disease, neurologic disease, and diabetes - the leading cause of acquired blindness. Doctors of optometry serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities we are the only eye doctors available. Providing more than two-thirds of all primary eye and vision health care in the United States, doctors of optometry deliver up to 80 percent of all primary vision and eye health care provided through Medicaid. Recognized as Medicare physicians for more than 25 years, doctors of optometry provide medical eye care to nearly six million Medicare beneficiaries annually.

The AOA generally supports NQF's efforts to

reduce disparities in health and health care. Eye and vision health is no different from the rest of health – disparities in both health and healthcare exist for a variety of reasons. Furthermore, a number of systemic diseases with disparate health outcomes and experiences for different groups manifest with ocular symptoms and doctors of optometry play a key role in the management of those diseases. Diabetes is a particular concern for our doctors - diabetic retinopathy, the most common microvascular complication of diabetes, is the leading cause of new cases of blindness and low vision for Americans ages 20 to 74 and accounts for about twelve percent of all new cases of blindness each year. [1] As the draft report identified, there are significant socioeconomic disparities in the prevalence of diabetes that must be addressed.

[1] Klein R, Klein B. Vision disorders in diabetes. In: National Diabetes Data Group, ed. Diabetes in America, 2nd ed. Bethesda, MD: National Institutes of Health, National Institutes of Diabetes and Digestive and Kidney Disease; 1995: 293-337

However, we are concerned that the eye exam measures for patients with diabetes that NQF identifies as part of the compendium of measures remain flawed, as we have expressed to NQF previously. NQF measure #0055, Comprehensive Diabetes Care: Eye Exam, measures the number of individuals who have had an eye exam in the measure year OR who had an eye exam that was negative for retinopathy in the previous measure year. This effectively endorses a schedule of an eye exam every two years for patients with diabetes, which is counter to current best practices for these patients. The evidence-based clinical practice guideline for Eye Care of the Patient with Diabetes Mellitus indicates that patients with diagnosed diabetes should receive a dilated, comprehensive eye exam at least annually and this frequency should be reflected in the NQF's quality measures. More frequent examination may be needed depending on changes in vision and the severity and progression of diabetic retinopathy. [2]

Relying on a flawed measure to improve disparities in care does a disservice to those the NQF is trying to help. The best way to improve the health outcomes of disadvantaged populations is to ensure that they're receiving the accepted standard of care – and the only way to know that is if the measures accurately reflect that standard. The AOA supports NQF's efforts to reduce disparities, but urges a critical review of the relied-upon measures.

[2] http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus

America's Health Insurance Plans

Richard Bankowitz

We appreciate the compendium of measures by domain in Appendix D, and feel that providing a link to the measure specifications would be useful.

Asian & Pacific Islander American Health Forum

Kathy Ko Chin

The Asian & Pacific Islander American Health Forum (APIAHF) is the nation's leading health policy group working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AAs and NHPIs) across the U.S. and territories. As such, APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage. APIAHF appreciates the opportunity to review and comment on the draft report "A Roadmap to Reduce Healthcare Disparities Through Measurement," (Report).

Overall, we wish to express our strong support for and adoption of the Report and the National Quality Forum's (NQF) work to develop an integrated roadmap to identifying and eventually eliminating health and healthcare disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the healthcare delivery system and underscores, as outlined in the Report, the need for integration and emphasis of achieving health equity as an explicit goal in the process. Having performance measures that are evidence-based, broad in their scope so as to address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and

quality health care, is critical to monitoring, assessing, evaluating and eventually eliminating disparities. Performance measures are a critical lever in achieving health equity and APIAHF welcomes NQF's Report on the issue.

We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles, assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can serve as aggregators of information and resources and trusted messengers.

California Pan-Ethnic Health Network

Caroline Sanders

The California Pan-Ethnic Health Network (CPEHN) strongly supports the National Quality Forum's (NQF) "A Roadmap to Reduce Health and Healthcare Disparities through Measurement," Draft Report, July 21, 2017. CPEHN is a statewide multicultural health advocacy organization dedicated to improving access to health care and eliminating health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color in California.

Health disparities are pervasive, particularly among communities of color and limited English proficient communities. Recent data from the Agency on Quality Health Care Research shows that despite consistent calls to end health disparities they continue to worsen among certain populations. Rather than continuing to see quality improvement and disparities reduction as separate objectives, health equity and quality improvement must be linked. Even the Centers for Medicare and Medicaid Services (CMS) now recommend that agencies evaluate the impact of disparities and integrate equity solutions across all programs. Without an explicit focus on disparities reduction, quality interventions run the risk of leaving disparities constant or could have the unintended consequence of worsening them.

While a consensus is forming that eliminating disparities must be prioritized, figuring out how to do so requires knowledge of the appropriate measures, interventions and incentives. This draft Report provides a critical roadmap for health care purchasers, plans and practitioners who desire to prioritize health equity as part of their quality improvement strategies. The Report lays out a clear four-step process that includes:

Prioritizing disparities-sensitive measures

Identifying evidence-based interventions to reduce disparities

Selecting and using health equity performance measures

Incentivizing the reduction of health disparities and achievement of health equity

If followed carefully and thoughtfully, this process will lead towards achievement of the Triple Aim of the National Quality Strategy: better quality of care, healthy people and communities, and affordable care.

Community Catalyst

Ann Hwang, MD

Community Catalyst appreciates the opportunity to comment on the 2017 draft report: A Roadmap to Reduce Health and Healthcare Disparities through Measurement.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the U.S. health system. The Center for Consumer Engagement in Health Innovation (the Center) is a hub devoted to teaching, learning, and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to enhance their skills and power to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals, and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

The Center has placed high priority on addressing disparities and achieving health equity, as

evidenced by our policy priorities (https://www.communitycatalyst.org/resources/publications/document/Consumer-Policy-Platform-for-HST-web.pdf?1473712433). We appreciate NQF's continued focus and investment in addressing health and healthcare disparities. Overall, we believe the framework outlined in the draft report is a step in the right direction. We agree that health is influenced beyond the factors in control by traditional healthcare system. The social and economic determinants are a major player in determining health outcomes. The role of structural racism is also key to understanding the impacts on health disparities, as noted in the report. We encourage continued research and application of measures that can unearth the systemic causes of health disparities. The compendium of measures shows that we have a long way to go—while there are numerous highly granular measures that measure narrow aspects of quality, we note the serious deficit in "big-dot" consumer-centered measures that would allow consumers, providers, policymakers, and payers alike to understand the overall performance of the health system. We urge NQF to actively engage diverse consumers, consumer advocates and the community when developing measures. We believe that the strong participation of patients, families, caregivers, and communities will be critical to ensuring that we create measures that are meaningful to consumers and help achieve equity.

Family HealthCare Center

Paul Nelson

In 1960, health spending as a portaion of our nation's economy (GDP) was 5.0%. By 2016, it was 16.2%. All of the other OECD nation's cluster around 12.0% of their GDP for their health spending. The difference for our nation was @$ 1 Trillion in 2016. Furthermore, we have largely solved the scientific mandate for the health care of Complex Healthcare Needs to the detriment of our nation's humanitarian mandate for the health care of each citizen's Basic Healthcare Needs. The current Paradigm Paralysys of our nation's healthcare industry also means that there is unlikely to be any benefit from an effort to reverse the current level of health inequity.

Prominent for any paradigm shif to improved the cost and quality problems of our nation's healthcare, I recommend a need to clarify for Quality purposes a clear definition for CARING RELATIONSHIPS, COLLECTIVE ACTION, COMMON GOOD, HEALTH, INSTITUTION and SOCIAL CAPITAL. As a prelude to improved capitalization of Primary Healthcare, I would recommend that a set of qualifying criteria be proposed to recognize its capability to participate in a community's equitably available, ecologically accessible, justly efficient and reliably effective healthcare for their citizen's Basic Healthcare Needs. Ultimately, the success of improved Primary Healthcare will be related to their community's effort to support the Social Capital required for improving the level of its Common Good.

Any definition of Social Capital must recognize the long-term character of its impact, basically very poorly measurable given current research strategies. I offer the following as a definition for Social Capital: The prevalence of caring relationships occurring throughout the generational networks of a community's citizens that promotes a spontaneous expression of collaboration, reciprocity and trust for resolving the social dilemmas encountered daily by each citizen within their community's civil life.

In effect, this definition for Social Capital implies that the cost and quality problems of our nation's health spending will not be solved without a community by community driven strategy. The Cooperative Extension Service intiated in 1914 by Congress for agriculture would be a relavent model. The Design Principles for managing a common pool resource should be applied. Defined originally by Nobel Prize (2009) winner Professor Elinor Ostrom, they have been tested and validated by many of her colleagues.

Federation of American Hospitals

Jayne Chambers

The Federation of American Hospitals ("FAH") appreciates the opportunity to comment on the National Quality Forum report: A Roadmap to Reduce Health and Healthcare Disparities through Measurement. FAH and our members continue to work toward reducing health and healthcare disparities. To that end, FAH hoped that the report would provide practical guidance on current issues in addition to the conceptual model and measures proposed. We urge the Committee to

provide recommendations on how to improve the current methods used by the Centers for Medicare & Medicaid Services (CMS) and others to fairly report and pay for those healthcare systems and providers who care for these at risk populations. Many of the current and future activities can lead to negative unintended consequences, particularly the current practices around accounting for social risk in performance measures and payment programs. FAH encourages the Committee to address steps that can be taken to mitigate and minimize this potential harm to our healthcare system and patients.

FAH also notes that the report is not specific on which healthcare entities can drive the greatest improvements through the proposed measure concepts and recommendations. Currently, it appears that the report focuses on what larger systems such as health plans and accountable care organizations can do since many of the measures and measure concepts identified under the subdomains of the health equity section would only be applicable at the system level. Additional recommendations or guidance on how providers at every level can work to reduce disparities would be beneficial and help all of us move toward the collective goal.

FAH supports that many of the measure concepts are considered appropriate for quality improvement (QI) only and not accountability. In addition, several of the concepts are focused on structures and processes and at times it is difficult to know how each proposed concept can positively impact patient outcomes. For example, it is not clear how the concept calling for equity to be explicitly stated in the mission statement and/or strategic plan can drive improvements and reduce disparities. Many of the measure concepts seem to be more suited as best practices rather than measures for QI.

FAH thanks the Disparities Standing Committee for their thoughtful report. The comments we provide are intended to further improve and refine this work.

Institute for Healthcare Improvement

Amy Reid

Thank you for your incredible work to advance equtiy. We're grateful for the time you took and the opportunity to dialogue through this open comment period.

1. Domains to advance equity: In the report, the committee proposes five domains of measurement that should be used together to advance equity: collaboration and partnerships, culture of equity, structures for equity, equitable access to care, and equitable high-quality care. The Institute for Healthcare Improvement has outlined the following 5 pillars for health care to advance equity: 1) make equity a strategic priority, 2) infrastructure that supports equity, 3) impacting multiple determinants of health over which healthcare can have an impact (eg improving clinical processes, improving SES of employees), 4) address institutional racism, and 5) community partnerships.

There is overlap in our frameworks in the following areas: equity culture/priority, supportive equity structures, partnerships, and equitable care. You may consider two additional areas: 1) other determinants of health that healthcare can impact to advance equity such as SES and educational attainment of employees, and 2) addressing institutional racism – equitable access to care is one part of that. We suggest explicitly naming racism, socializing an institution to these discussions, and reviewing policies, practices, decisions, and regulations with a racial equity lens to understand differential impact of institutional policies.

2. Simplifying measures: Currently, equity is not regarded as strategically important by the majority of policy-makers, payers or health system leaders. One or two measures tied to reimbursement and accreditation would have an important impact and promote a pragmatic approach. We suggest a clear emphasis on stratification. REAL data may not be granular enough to fuel true community partnerships. It will be key to move towards collection and understanding the self-identified race and ethnicity of individuals served by the system as a standard – e.g., Chinese, Japanese, etc instead of 'Asian', Hmong, Somali, Mexican American, etc.

In addition, we want to move beyond cultural competency to cultural sensitivity or humility.

3. Simplifying implementation guidance:
Pairing suggested measures with comments on implementation is incredibly helpful. We suggest that a simplification would aid utilization. Perhaps 'pay for reporting of stratified data' and 'adjust payment for social risk factors' and 'link health equity measures

to accreditation programs' all under the rubric of 'redesign payment models to support equity'. The main issues do not relate to defining a reasonable measure set, but rather how to deploy and collect them without unduly burdening health systems, and your work in this area will be of great value.

James P. Scanlan, Attorney at Law

James Scanlan

In its current form, the July 21, 2017 Draft Report (DR) titled "A Roadmap to Reduce Health and Healthcare Disparities through Measurement" will do a great disserve to health and healthcare (HHD) disparities research, as the NQF's Commissioned Paper: Healthcare Disparities Measurement (CP) also did.

Standard measures of differences between health and healthcare (HHC) outcome rates tend to be systematically affected by the prevalence of an outcome. As HHC generally improves, relative differences in favorable outcomes (e.g., survival, receipt of appropriate care) tend to decrease, while relative differences in the corresponding adverse outcomes (e.g., mortality, non-receipt of appropriate care) tend to increase. Thus, as the NCHS recognized more than a decade ago, whether HHC disparities are deemed to be increasing or decreasing commonly turns on whether one examines relative differences in the favorable outcome or relative differences in the adverse outcome.

Absolute differences tend also to be affected by the prevalence of an outcome, though in a more complicated way than the two relative differences. Roughly, as uncommon outcomes become more common, absolute differences tend to increase; as common outcomes become even more common, absolute differences tend to decrease.

All measures may change in the same direction as prevalence changes. But anytime a relative difference and the absolute difference change in opposite directions, the other relative difference will necessarily change in the opposite direction of the first relative difference and the same direction of the absolute difference. See references below.

See ref. 2 (at 337-339) and 5 (slides 113-118) regarding Massachusetts's inclusion of a disparities element in its Medicaid P4P program that would tend to increase healthcare disparities.

See ref. 2 (at 343-344) regarding that fact that, while CP recognized that different measures might yield different conclusions about directions of changes in disparities, it failed to recognize patterns by which the measures tend to be affected by the prevalence of an outcome and the need to consider those patterns when determining what observed patterns indicate about underlying processes. See ref. 6 urging withdrawal of the CP.

The DR, however, fails even to indicate that choice of measure might make a difference in determining whether HHC disparities are increasing or decreasing.

1. http://www.jpscanlan.com/images/The_Mismeasure_of_Health_Disparities_JPHMP_2016_.pdf

2. http://jpscanlan.com/images/Race_and_Mortality_Revisited.pdf

3. https://www.regulations.gov/document?D=USBC-2016-0003-0135

4. http://jpscanlan.com/images/2013_Fed_Comm_on_Stat_Meth_paper.pdf

5. http://jpscanlan.com/images/Univ_Mass_Medical_School_Seminar_Nov._18,_2015_.pdf

6. http://jpscanlan.com/images/Harvard_et_al._Commissioned_Paper_Letter.pdf

Justice in Aging

Georgia Burke

Justice in Aging appreciates the opportunity to comment. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources.

We are most appreciative of the thorough and thoughtful analysis that went into the report. We encourage the Committee to continue to focus on developing and implementing measurements to address health disparities and prioritizing those measures. As the Committee report demonstrates, measures are not an end in themselves. They exist to promote the development and implementation of effective person-centered interventions that improve lives and reduce disparities. We support continued efforts to develop and refine disparities-related measures and to incorporate those measures into program evaluations.

Men's Health Network

Colin Stephenson

Thank you for the opportunity to comment. At Men's Health Network we believed that disparities in health care have been correlated with the prevalence of many chronic diseases. Furthermore, inadequate health care could affect individual's overall health and quality of life. We appreciate that the Report focuses on disparities-sensitive measures and other research to design evidence-based interventions. One of the solutions suggested, incentivizing providers to use interventions for health equity through payment reform, is beneficial because numerous healthcare programs in the past have shown successful outcomes by using incentives to motivate healthy behaviors. In order to successfully implement the program, it would be very important to promote the intervention to the providers and health care institutes before the implementation. The Report summary states that some of the health equity measurement would be obtained from surveys and it would be helpful to see a sample of survey(s) for the patients and providers along with the measurement description of the draft report.

There are many factors that are linked to disparities in health and health care and MHN would like to emphasize gender barriers including gender minorities and sexual orientation."Modern American males are conditioned from a young age to view health care as falling under the purview of women. Part of this is due to men's anthropologically ingrained predisposition to ignore pain and discomfort, to 'play through it,' and to be providers of their family unit"(Giorgianni et al., pg. 2, 2013). It is often underestimated how difficult it is to correctly diagnose the opposite sex. Poor patient-provider communication could be caused by a gender barrier as much as lack of cultural or linguistic competence in health care setting. Health care providers, both male and female, claim that they do not feel comfortable communicating health issues with men. The poor patient-provider communication is linked to healthcare disparities and there needs to a specialized health care practitioner for males.

Again, thank you for this opportunity to provide comments on the Report.

SNP Alliance

Deborah Paone

As the Committee points out, health disparities arise as a symptom of deeper issues, and need to be addressed in collective action. The medical, behavioral health, long-term care, and social services systems will need to join with public health and other community efforts. Policy, legislative and regulatory changes, advocacy, and local action will be needed to make progress in connecting efforts to improve health equity outcomes--across settings and services, government and private agencies, and with individuals and the communities affected.

While these efforts are underway, we need to be judicious about how we measure and who we determine is accountable for measurement results. A core set of meaningful structure, process, and outcome measures should be used across settings and over time. To be useful for quality improvement, this core set of measures must be amenable to action/change from one reporting period to the next. Focusing across services on one set of core measures for key vulnerable population groups that require care and support across settings/disciplines--will combine and enhance rather than splinter efforts around quality improvement. Reducing the number of measures to focus on what is meaningful for at-risk populations will help target action.

We underscore the importance of taking action to recognize that organizations serving a high proportion of individuals with social risk factor issues on top of medical, long-term care, and behavioral health needs—are currently being penalized in quality measurement and value-based payment systems.

The Committee's examination and recommendations are well thought out and provide a blueprint for addressing vital issues in addressing health disparities through increased attention to social risk factors in vulnerable populations.

Thank you for the opportunity to comment. We are pleased to assist you in any way in the future.

SPAN/Family Voices NJ

Lauren Agoratus

In general, we appreciated the framework based on the National Academy of Medicine (NAM) Conceptual Framework of Social Risk Factors and Performance Indicators for Value-Based Payment regarding access to care including affordability, availability, accessibility, and accommodation. We agree with using the NAM domains of quality including effectiveness, safety, timeliness, patient/family-centeredness, access, and efficiency. However, we are deeply concerned with the current climate regarding cutting healthcare protections and Medicaid both under the ACA repeal and budget. We were unable to locate any measures on insurance status. The NJ Hospital Association conference on the uninsured indicated that individuals without coverage could be diagnosed on average 2-4 years after their insured peers, when disease is less treatable and most costly, resulting in increased morbidity and mortality.

Looking through the appendices, we are deeply concerned that the focus is mostly on adults as illness affect the pediatric population differently (e.g. renal disease can cause cognitive and growth adverse effects.) In addition, there was no focus on children with special health care needs, yet 1 in 5 children have special needs (Source: CAHMI http://childhealthdata.org/) other than some condition-specific information on sickle cell, cardiac, and renal disease. We did appreciate inclusion of mental health. We were also unable to locate measures regarding screening other than adult screenings for cancer, obesity, etc.; besides developmental screenings, other screenings of importance for children are newborn screenings, immunizations, and lead particularly with the recent findings of lead in water, even in schools.

Overall, we strongly support addressing health disparities but unless some of the key factors previously mentioned are addressed, there will continue to be underserved populations resulting in poorer health outcomes.

Summit Health Institute for Research and Education, Inc. (SHIRE)

Ruth Perot

Summit Health Institute for Research and Education, Inc. (SHIRE) has been involved in combating disparities in health and health care for twenty years with focus directed toward improving the health status of communities of color. Since 2013, SHIRE has worked in concert with AmeriHealth Caritas District of Columbia to implement data collection/reporting strategies at the community level. SHIRE has conducted Wellness Circles for AmeriHealth members who have diabetes and hypertension. The collection and analysis of health outcomes data, including weight loss, blood pressure indicators, and HbAic levels, plays an essential role in determining to what extent gaps in chronic disease rates between Medicaid beneficiaries of color and the total District of Columbia population are narrowing. Thus, our organization has first-hand knowledge of the importance of measuring and monitoring health disparities and progress toward their elimination. Accordingly, we appreciate the opportunity to review and comment on the draft report "A Roadmap to Reduce Healthcare Disparities Through Measurement" (the Report).

We are pleased to express our strong support for the Report and for the work of the National Quality Forum (NQF) to develop an integrated roadmap to identifying and eventually eliminating health and health care disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the health care delivery system and underscores, as outlined in the Report, the need for integration and emphasis on achieving health equity as an explicit goal in the process. It is essential to have performance measures that are evidence-based and broad in their scope. These measures can address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and quality health care. Such measures are critical to monitoring, assessing, evaluating and eventually eliminating disparities. We believe that

performance measures are a critical lever in achieving health equity. SHIRE welcomes NQF's Report on these critically important issues.

We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles, assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can play an important role in identifying and even aggregating information and resources in their role as trusted messengers and community partners.

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September 2017 | Fact Sheet

Key Facts about the Uninsured Population

The Affordable Care Act (ACA) led to historic gains in health insurance coverage by extending Medicaid coverage to many low-income individuals and providing Marketplace subsidies for individuals below 400% of poverty. Under the law, the number of uninsured nonelderly Americans decreased from 44 million in 2013 (the year before the major coverage provisions went into effect) to 28 million as of the end of 2016. Recent efforts to alter the ACA or fundamentally change the structure of Medicaid may pose a challenge to further reducing the number of uninsured and may threaten coverage gains seen in recent years. This fact sheet describes how coverage has changed under the ACA, examines the characteristics of the uninsured population, and summarizes the access and financial implications of not having coverage.

Summary: Key Facts about the Uninsured Population

How has the number of uninsured changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance. Beginning in 2014, the ACA expanded coverage to millions of previously uninsured people through the expansion of Medicaid and the establishment of Health Insurance Marketplaces. Data show substantial gains in public and private insurance coverage and historic decreases in uninsured rates under the ACA. Coverage gains were particularly large among low-income people living in states that expanded Medicaid. Still, millions of people—28.2 million in 2016— remain uninsured.

Why do people remain uninsured?

Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2016, 45% of uninsured adults said that they remained uninsured because the cost of coverage was too high. Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Some people who are eligible for financial assistance under the ACA may not know they can get help, and undocumented immigrants are ineligible for Medicaid or Marketplace coverage.

Who remains uninsured?

Most uninsured people are in low-income families and have at least one worker in the family. Reflecting the more limited availability of public coverage in some states, adults are more likely to be uninsured than children. People of color are at higher risk of being uninsured than non-Hispanic Whites.

How does the lack of insurance affect access to health care?

People without insurance coverage have worse access to care than people who are insured. One in five uninsured adults in 2016 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

What are the financial implications of lacking coverage?

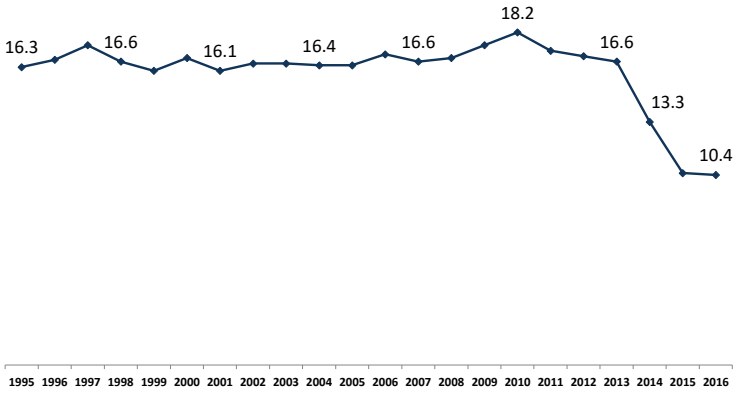
The uninsured often face unaffordable medical bills when they do seek care. In 2016, uninsured nonelderly adults were over twice as likely than their insured counterparts to have had problems paying medical bills in the past 12 months. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

How has the number of uninsured changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during periods of economic downturns. By 2013, more than 44 million people lacked coverage. Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have expanded their programs, and tax credits are available for people who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income adults living in states that expanded Medicaid. Still, millions of people—28.2 million nonelderly individuals in 2016—remain without coverage.[1]

Figure 1

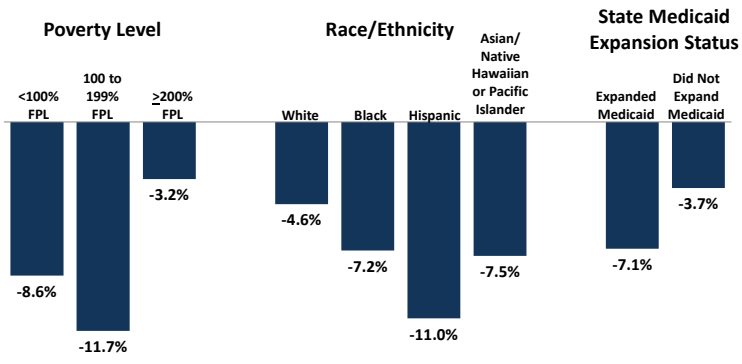
Uninsured Rate Among the Nonelderly Population, 1995-2016



NOTES: Includes nonelderly individuals ages 0-64.
SOURCE: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf.

Figure 2

Percentage Point Change in Uninsured Rate among the Nonelderly Population by Selected Characteristics, 2013-2016



NOTES: Includes nonelderly individuals ages 0-64.
SOURCE: Kaiser Family Foundation analysis of the 2013 and 2016 National Health Interview Survey.

Key Details:

- The share of the nonelderly population that was uninsured hovered around 16% between 1995 and 2007, then peaked during the ensuing economic recession (Figure 1). As early provisions of the ACA went into effect in 2010, and as the economy improved, the uninsured rate began to drop. When the major ACA coverage provisions went into effect in 2014, the uninsured rate dropped dramatically and continued to fall in subsequent years. In 2016, the nonelderly uninsured rate was 10.4%, the lowest in decades.
- Coverage gains from 2013 to 2016 were particularly large among groups targeted by the ACA, including adults and poor and low-income individuals. The uninsured rate among nonelderly adults, who are more likely than children to be uninsured, dropped from 20.4% in 2013 to 12.4% in 2015, a 39% decline. In addition, between 2013 and 2016, the uninsured rate declined substantially for poor and near-poor nonelderly individuals (Figure 2). People of color, who had higher uninsured rates than non-Hispanic Whites prior to 2014, had larger coverage gains than non-Hispanic Whites. Though uninsured rates dropped across all states, they dropped more in states that chose to expand Medicaid (Figure 2). (See Appendix A for state-by-state data on changes in the uninsured rate).
- Coverage gains were seen in new ACA coverage options. As of February 2017, over 10 million people were enrolled in state or federal Marketplace plans,[2] and as of June 2017, Medicaid enrollment had grown by over 17 million (29%) since the period before open enrollment (which started in October 2013).[3]

Why do people remain uninsured?

Most of the nonelderly in the United States obtain health insurance through an employer, but not all workers are offered employer-sponsored coverage or, if offered, can afford their share of the premiums. Medicaid covers many low-income individuals, and financial assistance for Marketplace coverage is available for many moderate-income people. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage without financial assistance. Some people who are eligible for coverage under the ACA may not know they can get help, and others may still find the cost of coverage prohibitive.

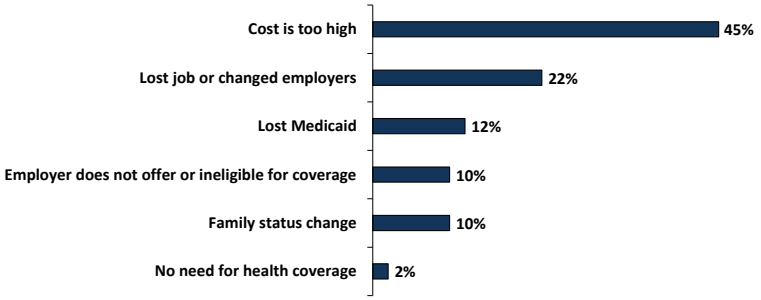
Key Details:

- Cost still poses a major barrier to coverage for the uninsured. In 2016, 45% of uninsured nonelderly adults said they were uninsured because the cost is too high, making it the most common reason cited for being uninsured (Figure 3). Though financial assistance is available to many of the remaining uninsured under the ACA,[4] not everyone who is uninsured is eligible for free or subsidized coverage. In addition, some uninsured who are eligible for help may not be aware of coverage options or may face barriers to enrollment.[5] Outreach and enrollment assistance was key to facilitating both initial and ongoing enrollment in ACA coverage, but these programs face challenges due to funding cuts and high demand.[6]

Figure 3

Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2016

Share who say they are uninsured because:



NOTES: Includes nonelderly adults ages 18-64. Respondents can select multiple reasons. Status change includes marital status change, death of spouse or parent, or ineligible due to age or leaving school.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

- Access to health coverage changes as a person's situation changes. In 2016, 22% of uninsured nonelderly adults said they were uninsured because the person who carried the health coverage in their family lost their job or changed employers (Figure 3). One in ten was uninsured because of a marital status change, the death of a spouse or parent, or loss of eligibility due to age or leaving school (10%), and some lost Medicaid because of a new job/increase in income or the plan stopping after pregnancy (12%).
- As indicated above, not all workers have access to coverage through their job. In 2016, 74% of nonelderly uninsured workers worked for an employer that did not offer health benefits to the worker.[7] Moreover, nine out of ten uninsured workers who do not take up an offer of employer-sponsored coverage report cost as the main reason for declining (90%).[8] From 2006 to 2016, total premiums for family coverage increased by 58%, and the worker's share increased by 78%, outpacing wage growth.[9]
- Medicaid and CHIP are available for low-income children, but eligibility for adults is more limited. As of January 2017, 31 states plus DC had expanded Medicaid eligibility for adults under the ACA.[10] However, in states that have not expanded Medicaid, eligibility for adults remains limited, with median eligibility level for parents at just 44% of poverty and adults without dependent children ineligible in most cases.[11] Millions of poor uninsured adults fall in a "coverage gap" because they earn too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits.[12]
- Undocumented immigrants are ineligible for Medicaid or Marketplace coverage.[13] While lawfully-present immigrants under 400% of poverty are eligible for Marketplace tax credits, only those who have passed a five-year waiting period after receiving qualified immigration status can qualify for Medicaid.

Who remains uninsured?

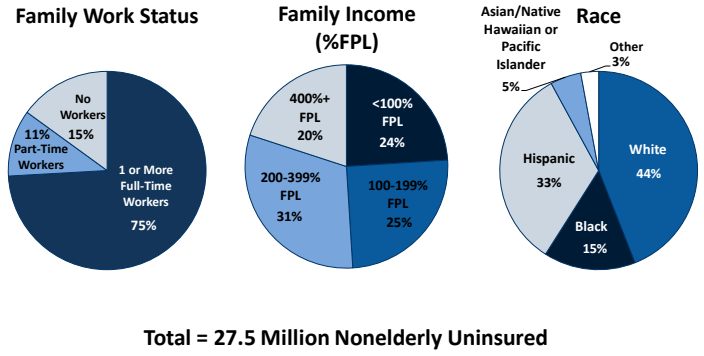
Most remaining uninsured people are in working families, are in families with low incomes, and are nonelderly adults.[14] Reflecting income and the availability of public coverage, people who live in the South or West are more likely to be uninsured. Most who remain uninsured have been without coverage for long periods of time.

Key Details:

- In 2016, three quarters of the uninsured (75%) had at least one full-time worker in their family, and an additional 11% had a part-time worker in their family (Figure 4).
- Individuals below poverty[15] are at the highest risk of being uninsured. In total, eight in ten of the uninsured were in families with incomes below 400% of poverty in 2016 (Figure 4).
- While a plurality (44%) of the uninsured are non-Hispanic Whites, people of color are at higher risk of being uninsured than Whites. People of color make up 42% of the nonelderly U.S. population but account for over half of the total nonelderly uninsured population (Figure 4). Hispanics and Blacks have significantly higher uninsured rates (16.9% and 11.7%, respectively) than Whites (7.6%).[16]
- Most (85%) of the uninsured are nonelderly adults. The uninsured rate among children was just 5% in 2016, less than half the rate among nonelderly adults (12%),[17] largely due to broader availability of Medicaid/CHIP for children than for adults.
- Most of the uninsured (78%) are U.S. citizens, and 22% are non-citizens.[18] Uninsured non-citizens include both lawfully present and undocumented immigrants. Undocumented immigrants are ineligible for federally funded health coverage, but legal immigrants can qualify for subsidies in the Marketplaces and those who have been in the country for more than five years are eligible for Medicaid.[19]
- Uninsured rates vary by state and by region, with individuals living in the South and West the most likely to be uninsured. The eight out of the twelve states with the highest uninsured rates in 2016 were in the South (Figure 5 and Appendix A). This variation reflects different economic conditions, state expansion status, availability of employer-based coverage, and demographics.
- Over two-thirds (68%) of the remaining uninsured in 2016 have been without coverage for more than a year.[20] People who have been without coverage for long periods may be particularly hard to reach in outreach and enrollment efforts.

Figure 4

Characteristics of the Nonelderly Uninsured, 2016

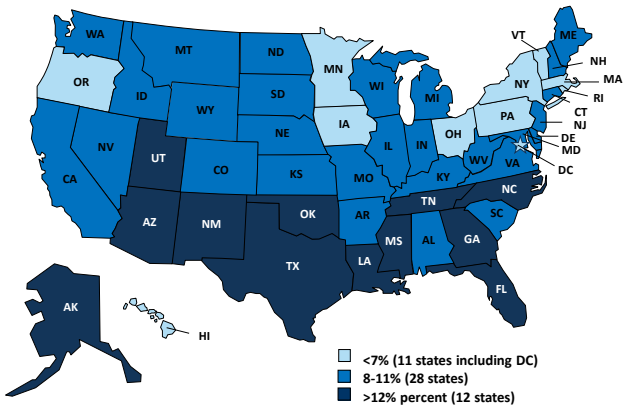


Total = 27.5 Million Nonelderly Uninsured

NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016. Data may not total 100% due to rounding. Persons of Hispanic origin may be of any race; all other race/ethnicity groups are non-Hispanic.
SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Figure 5

Uninsured Rates Among the Nonelderly by State, 2016



NOTES: Includes nonelderly individuals ages 0-64.
SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

How does the lack of insurance affect access to health care?

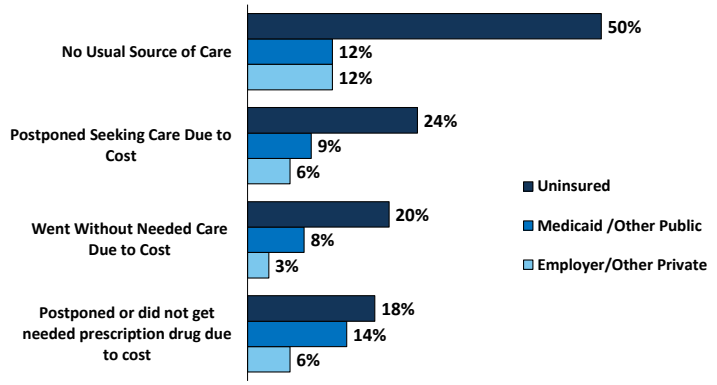
Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Key Details:

- Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.[21, 22] One in five (20%) nonelderly adults without coverage say that they went without care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage. Part of the reason for poor access among the uninsured is that many (50%) do not have a regular place to go when they are sick or need medical advice (Figure 6).

Figure 6

Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2016



NOTE: Includes nonelderly adults ages 18-64. Includes barriers experienced in past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between uninsured and insurance groups are statistically significant ($p < 0.05$).
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

- Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2016, uninsured nonelderly adults were three times as likely as adults with private coverage to say that they postponed or did not get a needed prescription drug due to cost (18% vs. 6%).[23] And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.[24]
- Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[25,26,27,28]
- Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.[29] A comprehensive review of research on the effects of the ACA Medicaid expansion finds that expansion led to positive effects on access to care, utilization of services, the affordability of care, and financial security among the low-income population.[30]
- Public hospitals, community clinics and health centers, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.[31,32]

What are the financial implications of lack of coverage?

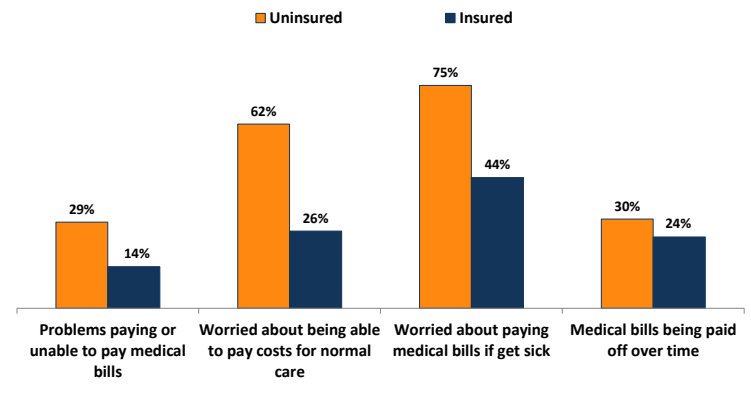
The uninsured often face unaffordable medical bills when they do seek care. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.[33]

Key Details:

- Those without insurance for an entire year pay for one-fifth of their care out-of-pocket.[34] In addition, hospitals frequently charge uninsured patients much higher rates than those paid by private health insurers and public programs.[35,36]
- Medical bills can put great strain on the uninsured and threaten their financial well-being. In 2016, nonelderly uninsured adults were over twice as likely as those with insurance to have problems paying medical bills (29% vs. 14%; Figure 7) with two thirds of uninsured who had medical bill problems unable to pay their medical bills at all (67%).[37] Uninsured adults are also more likely to face negative consequences due to medical bills, such as using up savings, having difficulty paying for necessities, borrowing money, or having medical bills sent to collection.[38]

Figure 7

Problems Paying Medical Bills by Insurance Status, 2016



NOTE: Includes nonelderly adults ages 18-64. All differences between uninsured and insured groups are statistically significant ($p < 0.05$).
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

- Uninsured nonelderly adults are also much more likely than their insured counterparts to lack confidence in their ability to afford usual medical costs and major medical expenses or emergencies. Uninsured nonelderly adults are over twice as likely as insured adults to worry about being able to pay costs for normal health care (62% vs. 26%; Figure 7). Furthermore, three quarters of uninsured nonelderly adults (75%) say they are very or somewhat worried about paying medical bills if they get sick or have an accident, compared to 44% of insured adults.
- Lacking insurance coverage puts people at risk of medical debt. In 2016, three in ten (30%) of uninsured nonelderly adults said they were paying off least one medical bill over time (Figure 7). Medical debts contribute to over half (52%) of debt collections actions that appear on consumer credit reports in the United States[39] and contribute to almost half of all bankruptcies in the United States.[40] Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[41]
- Though the uninsured are typically billed for medical services they use, when they cannot pay these bills, the costs may become bad debt or uncompensated care for providers. State, federal, and private funds defray some but not all of these costs. With the expansion of coverage under the ACA, providers are seeing reductions in uncompensated care costs, particularly in states that expanded Medicaid.[42]
- Research suggests that gaining health coverage improves the affordability of care and financial security among the low-income population. Multiple studies of the ACA have found larger declines in trouble paying medical bills in expansion states relative to non-expansion states. A separate study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies.[43]

Conclusion

Millions of people have gained coverage under the ACA provisions that went into effect in 2014, and current debate over rolling back ACA coverage threaten these gains in coverage and make it difficult to reach the 28 million who remain without coverage. Proposed policies to change the structure of the Medicaid program or cut back subsidies for Marketplace coverage may lead to even more uninsured individuals. On the other hand, if additional states opt to expand Medicaid as allowed under the ACA, there may be additional coverage gains as low-income individuals gain access to affordable coverage. Going without coverage can have serious health consequences for the uninsured because they receive less preventive care, and delayed care often results in serious illness or other health problems. Being uninsured also can have serious financial consequences. The outcome of current debate over health coverage policy in the United States has substantial implications for people's coverage, access, and overall health and well-being.

Appendix A: Uninsured Rate Among the Nonelderly by State, 2013-2016				
	2013 Uninsured Rate	2016 Uninsured Rate	Change in Uninsured Rate	Change in Number of Uninsured
Expansion States	**13.6%**	**8.1%**	**-5.5%**	**-9,110,784**
Alaska	15.8%	15.2%	-0.5%	-4,605
Arizona	21.2%	14.0%	-7.1%	-383,719
Arkansas	17.8%	9.1%	-8.7%	-206,013
California	16.4%	8.7%	-7.6%	-2,526,529
Colorado	13.8%	10.8%	-3.1%	-139,372
Connecticut	11.8%	7.2%	-4.6%	-145,215
Delaware	8.3%	10.6%	2.3%	20,756
District of Columbia	8.9%	5.9%	-2.9%	-15,885
Hawaii	5.7%	6.3%	0.6%	7,414
Illinois	11.9%	8.6%	-3.3%	-403,107
Indiana	14.6%	7.6%	-7.0%	-382,508
Iowa	9.5%	6.2%	-3.3%	-87,375
Kentucky	16.3%	7.2%	-9.1%	-351,749
Louisiana	16.4%	12.1%	-4.3%	-158,238
Maryland	13.3%	7.2%	-6.0%	-309,202
Massachusetts	3.6%	6.4%	2.7%	161,492
Michigan	12.1%	7.4%	-4.8%	-412,911
Minnesota	7.9%	6.9%	-1.0%	-52,380
Montana	19.0%	8.5%	-10.4%	-85,493
Nevada	22.0%	10.2%	-11.8%	-270,526
New Hampshire	13.2%	7.6%	-5.6%	-65,367
New Jersey	13.4%	9.0%	-4.4%	-339,457
New Mexico	19.5%	13.0%	-6.5%	-112,780
New York	11.1%	6.6%	-4.5%	-775,319
North Dakota	12.1%	8.9%	-3.2%	-19,617
Ohio	13.9%	6.5%	-7.4%	-708,788
Oregon	14.2%	6.2%	-8.0%	-257,142
Pennsylvania	11.6%	5.7%	-5.9%	-647,343
Rhode Island	10.7%	5.8%	-5.0%	-43,871
Vermont	9.1%	6.5%	-2.6%	-13,549
Washington	13.4%	8.1%	-5.4%	-299,746
West Virginia	14.2%	8.8%	-5.4%	-82,642
Non-Expansion States	**18.1%**	**13.3%**	**-4.8%**	**-4,575,853**
Alabama	17.8%	10.1%	-7.7%	-305,483
Florida	22.0%	14.6%	-7.5%	-1,128,462
Georgia	18.5%	13.7%	-4.7%	-334,624
Idaho	16.8%	10.2%	-6.6%	-87,058
Kansas	11.5%	9.8%	-1.7%	-41,999
Maine	11.3%	8.7%	-2.6%	-30,792
Mississippi	16.4%	13.9%	-2.6%	-63,174
Missouri	13.1%	9.8%	-3.2%	-168,358
Nebraska	10.6%	8.2%	-2.4%	-38,713
North Carolina	17.3%	12.4%	-5.0%	-377,650
Oklahoma	18.1%	12.4%	-5.7%	-163,857
South Carolina	18.9%	10.8%	-8.1%	-297,343
South Dakota	11.6%	9.4%	-2.2%	-15,268
Tennessee	15.2%	13.2%	-2.0%	-90,107
Texas	22.8%	17.1%	-5.7%	-1,191,130
Utah	13.7%	13.5%	-0.2%	16,342
Virginia	13.1%	11.5%	-1.7%	-125,841
Wisconsin	10.4%	8.3%	-2.2%	-98,298
Wyoming	17.5%	11.2%	-6.3%	-34,040

SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Appendix Table B: Characteristics of the Nonelderly Uninsured, 2016					
	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total Nonelderly	271.1	100.0%	27.5	100.0%	10.1%
Age					
Children - Total	78.2	28.8%	4.2	15.3%	5.4%
Nonelderly Adults - Total	192.9	71.2%	23.3	84.7%	12.1%
Adults 19 - 25	29.8	11.0%	3.9	14.2%	13.1%
Adults 26 - 34	39.7	14.7%	6.2	22.7%	15.7%
Adults 35 - 44	40.0	14.8%	5.3	19.1%	13.1%
Adults 45 - 54	42.0	15.5%	4.3	15.8%	10.3%
Adults 55 - 64	41.3	15.2%	3.5	12.8%	8.5%
Annual Family Income					
<$20,000	35.9	13.3%	6.7	24.3%	18.6%
$20,000 - <$40,000	43.1	15.9%	6.8	24.9%	15.9%
$40,000 +	192.1	70.8%	13.9	50.8%	7.3%
Family Poverty Level					
<100%	36.5	13.5%	6.5	23.6%	17.7%
100% - <200%	44.2	16.3%	6.8	24.7%	15.3%
200% - <400%	78.8	29.1%	8.6	31.4%	10.9%
400%+	111.6	41.2%	5.6	20.4%	5.0%
Household Type					
Single Adults Living Alone	45.0	16.6%	6.7	24.5%	15.0%
Single Adults Living Together	35.7	13.2%	4.9	17.7%	13.6%
Married Adults	37.1	13.7%	3.2	11.5%	8.5%
1 Parent with Children	23.4	8.6%	2.2	8.1%	9.5%
2 Parents with Children	83.4	30.7%	5.5	19.9%	6.6%
Multigenerational	14.2	5.2%	1.6	5.9%	11.4%
Other with Children	32.3	11.9%	3.4	12.4%	10.5%
Family Work Status					
2+ Full-time	93.4	34.4%	6.8	24.8%	7.3%
1 Full-time	131.1	48.4%	13.7	49.9%	10.4%
Only Part-time	19.4	7.2%	2.9	10.7%	15.1%
Non-Workers	27.2	10.0%	4.0	14.6%	14.7%
Race/Ethnicity					
White	157.5	58.1%	12.0	43.9%	7.6%
Black	34.9	12.9%	4.1	14.9%	11.7%
Hispanic	53.6	19.8%	9.1	33.0%	16.9%
Asian/N. Hawaiian and Pacific Islander	17.1	6.3%	1.4	5.2%	8.3%
American Indian/Alaska Native	2.1	0.8%	0.4	1.5%	18.9%
Two or More Races	5.8	2.1%	0.4	1.6%	7.4%
Citizenship					
U.S. Citizen - Native	233.7	86.2%	19.8	72.3%	8.5%
U.S. Citizen - Naturalized	15.7	5.8%	1.6	6.0%	10.4%
Non-U.S. Citizen, Resident for <5 Years	5.9	2.2%	1.4	5.0%	23.2%
Non-U.S. Citizen, Resident for 5+ Years	15.8	5.8%	4.6	16.7%	29.0%
Health Status					
Excellent/Very Good	186.8	68.9%	16.9	61.5%	9.0%
Good	61.9	22.8%	8.0	29.0%	12.9%
Fair/Poor	22.4	8.3%	2.6	9.5%	11.7%

NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016. Parent includes any person with a dependent child. Multigenerational/other families with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own. Part-time workers were defined as working <35 hours per week. Respondents who identify as mixed race who do not also identify as Hispanic fall into the "Two or More Races" category. All individuals who identify as Hispanic ethnicity fall into the Hispanic category regardless of race.
SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Endnotes

[1] Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January – March 2017* (Hyattsville, MD: National Center for Health Statistics, August 2017), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf

[2] State Health Facts. "Total Marketplace Enrollment and Financial Assistance, February 2017." Kaiser Family Foundation, 2017, http://kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/

[3] State Health Facts. "Total Monthly Medicaid and CHIP Enrollment." Kaiser Family Foundation, June 2017, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/.

[4] Rachel Garfield, Anthony Damico, Cynthia Cox, Gary Claxton, and Larry Levitt, *New Estimates of Eligibility for ACA Coverage among the Uninsured* (Washington, DC: Kaiser Family Foundation, Jan 2016), http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/

[5] Bianca DiJulio, Jamie Firth, and Mollyann Brodi, *Kaiser Health Tracking Poll: December 2015*, (Washington, D.C.: Kaiser Family Foundation, Dec 2015), http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-december-2015/

[6] Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee. *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Washington, DC: Kaiser Family Foundation, June 2016), http://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/

[7] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[8] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[9] Kaiser Family Foundation. *2016 Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation, September 2016), http://kff.org/report-section/ehbs-2016-summary-of-findings/

[10] State Health Facts. "Status of State Action on the Medicaid Expansion Decision." Kaiser Family Foundation, 2017, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[11] Tricia Brooks, Karina Wagnerman, Samantha Artiga, Elizabeth Cornachione, and Petry Ubri, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey* (Washington, DC: Kaiser Family Foundation, January 2017), http://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey/

[12] Rachel Garfield and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update* (Washington, DC: Kaiser Family Foundation, January 2016), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

[13] Samantha Artiga and Anthony Damico, *Health Coverage and Care for Immigrants* (Washington, DC: Kaiser Family Foundation, July 2017), http://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/

[14] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[15] $19,318 for a family of three in 2016

[16] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[17] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[18] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[19] Samantha Artiga and Anthony Damico, *Health Coverage and Care for Immigrants* (Washington, DC: Kaiser Family Foundation, July 2017), http://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/

[20] Kaiser Family Foundation analysis of the 2016 National Health Interview Survey

[21] Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition." *JAMA* 297, no. 10 (March 2007):1073-84.

[22] Stacey McMorrow, Genevieve M. Kenney, and Dana Goin,"Determinants of Receipt of Recommended Preventive Services: Implications for the Affordable Care Act," *American Journal of Public Health* 104, no. 12 (Dec 2014): 2392-9.

[23] Kaiser Family Foundation analysis of the 2016 National Health Interview Survey

[24] Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *JAMA* 297, no. 10 (March 2007): 1073-84.

[25] Fizan Abdullah, et al., "Analysis of 23 Million US Hospitalizations: Uninsured Children Have Higher All-Cause In-Hospital Mortality," *Journal of Public Health* 32, no. 2 (June 2010): 236-44.

[26] Andrew Wilper, et al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99, no. 12 (December 2009): 2289-2295.

[27] Wendy Greene, et. al., "Insurance Status is a Potent Predictor of Outcomes in Both Blunt and Penetrating Trauma." *American Journal of Surgery* 199, no. 4 (April 2010): 554-7.

[28] Sarah Lyon, "The Effect of Insurance Status on Mortality and Procedural Use in Critically Ill Patients," *American Journal of Critical Care Medicine* 184, no. 7 (October 2011): 809-15.

[29] Amy Finkelstein, et. al, "The Oregon Health Insurance Experiment: Evidence from the First Year" (National Bureau of Economic Research, July 2011), http://www.nber.org/papers/w17190

[30]Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, Jun 2016), http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/

[31] Mark Hall, "Rethinking Safety Net Access for the Uninsured," *New England Journal of Medicine 364 (January 2011):7-9.*

[32] John Holahan and Brenda Spillman, *Health Care Access for Uninsured Adults: A Strong Safety Net is not the Same as Insurance* (Washington, DC: The Urban Institute, January 2002), http://www.urban.org/research/publication/health-care-access-uninsured-adults

[33] Sherry Glied and Richard Kronick, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* (Washington, DC: Office of Assistant Secretary for Planning and Evaluation, HHS, May 2011), http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.pdf

[34] The Kaiser Commission on Medicaid and the Uninsured, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*, (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf

[35] Glenn Melnick, "Fair Pricing Law Prompts Most California Hospitals to Adopt Policies to Protect Uninsured Patients from High Charges," *Health Affairs* 32, no. 6 (Jun 2013); 1101-8.

[36] Stacie Dusetzina, Ethan Basch, and Nancy Keating, "For Uninsured Cancer Patients, Outpatient Charges Can Be Costly, Putting Treatments out of Reach," *Health Affairs* 34, no. 4 (April 2015): 584-591, http://content.healthaffairs.org/content/34/4/584.abstract

[37] Kaiser Family Foundation analysis of 2016 National Health Interview Survey

[38] Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey,* (Washington, D.C.: Kaiser Family Foundation, Jan 2016), http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/

[39] Consumer Financial Protection Bureau, "Consumer Credit Reports: A Study of Medical and Non-Medical Collections." (Consumer Financial Protection Bureau: December 2014), http://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf

[40] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Med*icine, 122, no. 8 (2009): 741-6, http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

[41] Ibid.

[42] Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, Jun 2016), http://kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review-issue-brief/

[43] Ibid.

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The Affordable Care Act Medicaid Expansions and Personal Finance

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Abstract

Using a novel data set from a major credit bureau, we examine the early effects of the Affordable Care Act Medicaid expansions on personal finance. We analyze less common events such as personal bankruptcy, and more common occurrences such as medical collection balances, and change in credit scores. We estimate triple-difference models that compare individual outcomes across counties that expanded Medicaid versus counties that did not, and across expansion counties that had more uninsured residents versus those with fewer. Results demonstrate financial improvements in states that expanded their Medicaid programs as measured by improved credit scores, reduced balances past due as a percent of total debt, reduced probability of a medical collection balance of $1,000 or more, reduced probability of having one or more recent medical bills go to collections, reduction in the probability of experiencing a new derogatory balance of any type, reduced probability of incurring a new derogatory balance equal to $1,000 or more, and a reduction in the probability of a new bankruptcy filing.

Keywords

Medicaid, Affordable Care Act, personal finance, health insurance, uninsured, health policy, state policy, health

Introduction

An estimated 16.9 million previously uninsured Americans gained health insurance coverage as a result of the Affordable Care Act (ACA) between mid-2013 and early 2016, 6.5 million of which enrolled in Medicaid (Carman, Eibner, & Paddock, 2015).

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This health insurance expansion increased access to health care for the newly insured (Wherry & Miller, 2016) and may have simultaneously improved the finances of those directly, or even indirectly, affected. This is because one of the fundamental functions of insurance is to protect against unexpected and potentially costly events, or in this context decrease the risk of medical out-of-pocket spending. This risk, or changes therein, may even "spill over" to family members whose health and/or health insurance status does not change, but who share finances with those gaining coverage. However, the way in which medical out-of-pocket spending risk changes with health insurance largely depends on the type of coverage.

Medicaid is unique compared with other types of health insurance. With few exceptions, Medicaid beneficiaries pay no premiums for their coverage and pay no copayments or coinsurance for covered services. As a result, Medicaid decreases the risk of *any* out-of-pocket spending for covered medical services and equipment compared with more conventional policies designed to protect against *higher* levels of spending. Medicaid may also have an income effect for those previously insured by less generous policies by lowering the amount paid on premiums and care. In short, we hypothesize that the Medicaid expansions reduced the risk of medical out-of-pocket spending and consequently improved the financial position for new beneficiaries.

Indeed, recent research from the Oregon Health Insurance Experiment suggests that some of the most immediate and measurable impacts of the ACA's Medicaid expansions could be reduced risk of medical expenditures and medical debt accumulation (Finkelstein et al., 2012). Likewise, there is evidence that previous Medicaid expansions decreased the rate of personal bankruptcy (Gross & Notowidigdo, 2011). Furthermore, the Massachusetts insurance expansions, which targeted a broader population, have been shown to reduce several indicators of financial stress (Mazumder & Miller, 2016). And a very recent paper that studied the ACA Medicaid expansions found that the expansions significantly decreased the amount owed for *nonmedical* debt to third-party collections agencies (Hu, Kaestner, Mazumder, Miller, & Wong, 2016).

Using a novel data set from one of the three major credit bureaus, this work aims to study the effect of the ACA Medicaid expansions on personal finance. To test whether the expansions improved beneficiaries' financial position, we study multiple outcomes directly related to medical out-of-pocket spending such as unpaid medical bills sent to third-party collectors as well as more general indicators such as credit scores. We estimate models that simultaneously compare these outcomes in two ways. First, we compare individuals in counties that expanded Medicaid under the ACA with similar individuals in counties that did not, before and after the expansions. Second, we compare individuals in Medicaid-expansion counties that had larger uninsured populations to counties with small uninsured populations. This work is important for policy makers considering additional state expansions, limited future expansions, or even possible roll back of existing expansions. It illuminates a broader range of costs and benefits related to the expansion—beyond health outcomes and access to health care.

Overall our findings suggest that the ACA Medicaid expansions provide meaningful financial protection to the low-income uninsured. Across all individuals age 18 to 64 in states that expanded Medicaid, results show that the expansions improved credit

scores (0.1%), reduced balances past due as a percent of total debt (2.9%), reduced probability of a medical collection balance of $1,000 or more (1.3%), reduced probability of having one or more recent medical bills go to collections (3.3%), reduced the probability of experiencing a new derogatory balance of any type (1.4%), reduced probability of incurring a new derogatory balance equal to $1,000 or more (2.6%), and reduction in the probability of a new bankruptcy filing (2.8%). Given that those affected by the Medicaid expansions comprise a much smaller group than those ages 18 to 64, these estimates suggest much larger effects for those who newly enrolled in Medicaid as a result of the expansions.

Previous Research

The existing literature on the effect of health insurance on personal finance is much less developed than the corresponding literature on access to care and health outcomes. Nonetheless, as the burden of health care costs has grown, more attention has focused on the burden that those costs place on families' income (e.g., Blumberg, Waidmann, Blavin, & Roth, 2014; Caswell, Waidmann, & Blumberg, 2012) and whether that burden may change with the ACA's Medicaid expansion (e.g., Caswell, Waidmann, & Blumberg, 2014; Hill, 2015). The number of empirical papers that specifically study the causal effect of health insurance expansions on financial outcomes related to personal credit, debt, and bankruptcy, however, is much more limited.

Gross and Notowidigdo (2011) estimate the effect of previous Medicaid expansions (1992-2004), mostly covering children and parents, on personal bankruptcy filings. The authors use aggregated state-level data on personal bankruptcy filings provided by the Administrative Office of the U.S. Courts, combined with other sources, and estimated a simulated-instrumental-variables model commonly used to study previous Medicaid expansions (Currie & Gruber, 1996). In essence, this approach exploits within-state variation across eligible groups over time to identify the effect of expansions on bankruptcy filings. The authors find that a 10-percentage-point increase in Medicaid eligibility resulted in an 8% reduction in personal bankruptcies.

Finkelstein et al. (2012) use the Oregon Health Insurance Experiment to study the effect of access to Medicaid on medical debt and medical out-of-pocket expenditures, in addition to health care utilization and health. This was a random experiment where, through a lottery, uninsured adults in Oregon with family income up to 100% of the federal poverty level (FPL)—slightly below the ACA's Medicaid income-eligibility threshold—randomly acquired the ability to enroll in Medicaid. About *1 year* after enrollment, using linked administrative data, the authors estimate that Medicaid enrollment reduced the probability of unpaid medical bills sent to collection by 6.4 percentage points, or an average reduction in the amount owed of $390 (see Table VII in Finkelstein et al., 2012). From survey data on lottery participants, they estimate that insurance reduced the probability of (see Table VIII in Finkelstein et al., 2012): out-of-pocket expenses (20.0 percentage points), owing money for medical expenses (18.0 percentage points), borrowing money or skipping bills to pay medical bills (15.4 percentage points), and being refused treatment because of medical debt (3.6 percentage points).

More recent work by Mazumder and Miller (2016) studied the effect of the Massachusetts health insurance expansion that began in April 2006, which was the template for the ACA, on multiple financial outcomes related to personal credit and debt. In addition to bankruptcy filings, this work investigated the effect on the total balance among all credit accounts, debt past due on all accounts, debt past due as a percentage of total debt, and the amount of third-party collections. The authors used the Federal Reserve Bank of New York Consumer Credit Panel covering years 1999 to 2012. This is a unique and nonpublicly available data source, produced by the credit agency Equifax, of consumer-level data available to researchers employed with the U.S. Federal Reserve Bank system. Their identification strategy—used previously by Miller (2012) as well as the present article—uses variation in exposure to the reform immediately prior to implementation in order to identify the effect of the reform. Specifically, they use the prereform rate of uninsured among nonelderly adults across counties in Massachusetts as their measure of exposure. The authors estimate that, across all individuals age 18 to 64, the reform decreased the total amount of debt past due ($182; 22%) and the fraction of past-due debt to total debt (0.6 percentage points; 10%), decreased total collections balances ($12; 20%), improved creditworthiness as measured by risk scores (2.4 points; 0.5%), and reduced the likelihood of personal bankruptcy (0.2 percentage points; 19%).

Finally, a recent working paper by Hu et al. (2016) studied the effect of the ACA Medicaid expansions on financial well-being. These researchers use quarterly data from the Federal Reserve Bank of New York Consumer Credit Panel, covering calendar years 2010 through 2015, and implement a differences-in-differences analysis using a synthetic control group of states that did not expand Medicaid. Specifically, these authors study total debt, debt past due, credit card debt, number of nonmedical bills in collections, and balance on nonmedical collections. They estimate that the balance on nonmedical collections decreased by approximately $600 to $1,000 per newly enrolled Medicaid beneficiary as a result of the expansions.

New Contribution

The present article contributes the growing literature in several ways. First, it extends the work of Gross and Notowidigdo (2011) by studying a much broader expansion of Medicaid. That is, their study covered previous Medicaid expansions focused on low-income children and parents, whereas the ACA Medicaid expansions also cover low-income childless adults. It builds on the work by Finkelstein et al. (2012) and Mazumder and Miller (2016) as the ACA Medicaid expansions cover a much broader geographic area (28 states and DC), compared with two states (Oregon or Massachusetts). This article also focuses on the low-income Medicaid population, like Finkelstein et al. (2012), but unlike Mazumder and Miller (2016), which includes all nonelderly adults in Massachusetts.

Importantly, this work goes beyond the recent paper by Hu et al. (2016) insofar as it studies both nonmedical and medical collection balances, in turn, compared with only nonmedical collections, as well as the flow of new medical collections and

derogatory debt. This is a significant contribution for several reasons. Most important, medical collections are directly related with medical out-of-pocket spending risk, which is the direct mechanism through which the expansions might influence consumers' personal finances. While nonmedical collections may also be influenced by the expansions, the mechanism is seemingly less direct. Furthermore, studying the incidence of new medical collections more closely addresses whether medical spending risk changed as a results of the expansions, compared with total balances on medical collections that may take time to adjust. Finally, the addition of new derogatory balances, which include new medical collections in addition to other unpaid debt, sheds some light on the magnitude of any decreased flow of unpaid bills. In short, this work contributes to a growing body of literature that is important for policy makers to consider when debating the costs and benefits of expanding their Medicaid programs.

The Affordable Care Act Medicaid Expansions

Medicaid expansions were the intended mechanism through which most uninsured low-income Americans in all states were to obtain health insurance coverage via the ACA. Those with income up to 138% of the FPL would be income eligible, unlike "categorical" eligibility requirements such as being disabled or a single parent, in large part expanding eligibility of existing Medicaid programs to low-income childless adults. States also had the option to expand their programs as early as 2010, prior to the intended country-wide expansion on January 1, 2014 (summarized below).[1] The 2012 Supreme Court ruling *National Federation of Independent Business v. Sebelius*, however, made the decision for states to expand their Medicaid programs optional. And as of March 2016, 30 states and the District of Columbia had implemented Medicaid expansions (The Henry J. Kaiser Family Foundation, 2016).[2]

Table 1 summarizes the timing of the ACA Medicaid expansions as they relate with the timing of the data used in this analysis, discussed in more detail below, covering years 2010 through 2015. Connecticut, the District of Columbia, Minnesota, and 48 California counties expanded prior to 2014.[3] Twenty-one states expanded January 1, 2014; Michigan and New Hampshire expanded mid-2014; and Pennsylvania and Indiana expanded early 2015. Finally, Alaska and Montana both expanded after August 2015.[4]

The fraction of individuals who were uninsured, among those with incomes up to 138% of the FPL, decreased more rapidly in states that expanded their Medicaid programs. Figure 1 reports statistics from the American Community Survey on the population targeted for Medicaid eligibility. It excludes states that expanded Medicaid before and after January 1, 2014, in order to make clear comparisons. The left panel of Figure 1 reports the percentage point change in the fraction who was uninsured among the population age 18 to 64 with incomes up to 138% of the FPL in expansion and nonexpansion states. Between 2013 and 2015, this fraction decreased by 15.5 percentage points in expansion states compared with 9.6 percentage points in nonexpansion states. The right panel reports the percentage point change in the key measure of exposure to expansion we use in this analysis: the fraction of the population that was *both* uninsured and had income up to 138% of the FPL among all individuals aged 18 to 64. This

Table 1. Timing of the Affordable Care Act Medicaid Expansions, 2010 to 2015.

	Pre-expansion period					Expansion year	Post-expansion period				
Time = *t* equals time with respect to expansion (calendar year − expansion year)	−5	−4	−3	−2	−1	0	1	2	3	4	5
Calendar year = *y* of expansion\states (month\day)											
2010: CT (4/1), DC (7/1)						2010	2011	2012	2013	2014	2015
2011: MN (3/1), CA (10 counties; 7/1)[a]					2010	2011	2012	2013	2014	2015	
2012: CA (38 counties; 1/1)[b]				2010	2011	2012	2013	2014	2015		
2014: 23 states[c], CA (10 counties; 1/1)[d]		2010	2011	2012	2013	2014	2015				
2015: PA (1/1), IN (2/1)	2010	2011	2012	2013	2014	2015					
Nonexpansion states											
2014: 22 states[e]		2010	2011	2012	2013	2014	2015				

Note. States identified in italics expanded Medicaid using an 1115 waiver.

Source. The Henry J. Kaiser Family Foundation (2016); Harbage and King (2012).

[a]CA counties (10): Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, Ventura. [b]CA counties (38): Riverside, San Bernardino, Santa Cruz, Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba. [c]Expanded January 1, 2014: AZ, *AR*, CO, DE, HI, IL, *IA*, KY, MD, MA, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, WV; Expanded mid-year: *MI* (April 1, 2014); *NH* (August 15, 2014). [d]CA counties (10): Fresno, Merced, Monterey, Placer, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara, Stanislaus, Tulare. [e]AL, FL, GA, ID, KS, ME, MS, MO, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI, WY; Expansion states treated as no expansion states (expansion after last year of credit bureau data): AK (September 1, 2015), *MT* (January 1, 2016), LA (to be determined).

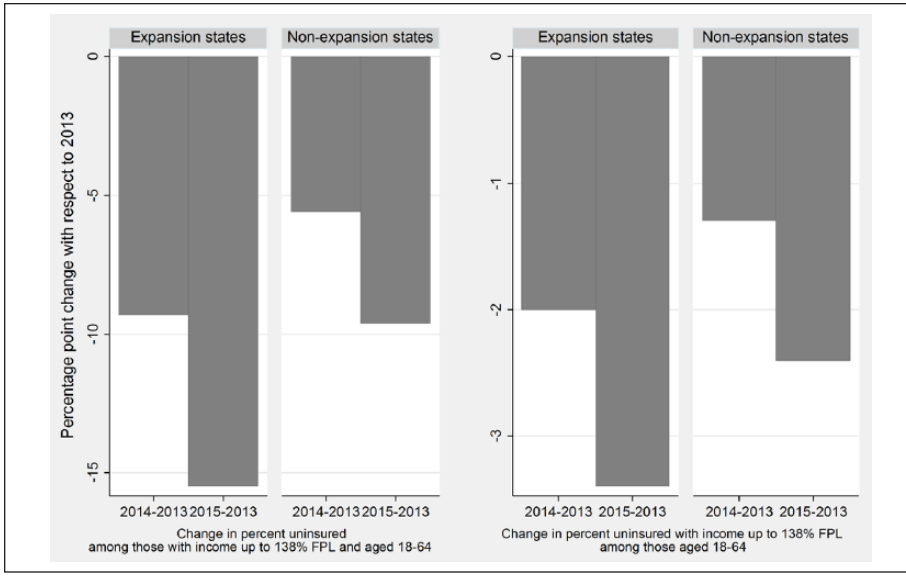

Figure 1. Percentage point change in the rate of uninsured among the targeted Medicaid eligible population, 2015 to 2013 and 2014 to 2013.
Note. Estimates exclude states that expanded Medicaid before or after January 1, 2014.
Source. Authors' calculations using the American Community Survey.

fraction decreased by 3.4 percentage points in expansion states between 2013 and 2015, compared with 2.4 percentage points in nonexpansion states. The reported changes between 2013 and 2015 are also larger compared with the changes between 2013 and 2014, highlighting that the first expansion year was indeed a year of transition.

Data

Credit Bureau Data

The unique and primary data of interest on financial outcomes is from one of the three major credit bureaus.[5] It is a nationally representative 2% sample of consumers from a universe of more than 250 million consumer records. This work uses six annual data archives covering years 2010 through 2015. Each archive represents the characteristics of consumers at the end of August for a given year. It is designed such that the same consumers appear in each year for which they have a record in the master file, while consumers newly entering the credit market enter in proportion to their representation relative to the consumer population for a given year. As a result, the sample is appropriate to use as a single-year cross-section, repeated cross-sections, as well as a longitudinal panel. The final subsample of consumers aged 18 to 64 in a given year consist of 23.5 million consumer-year observations, covering years 2010 through 2015, or approximately 3.9 million consumers per year.

Note that the population represented in data from the three nationwide credit reporting agencies differs from the civilian noninstitutionalized population typically analyzed using federal household surveys. In particular, to be included in these data, at a minimum it is necessary for an individual to interact with the formal credit market and/or have some public record information, for example, the former could include an application for credit (approved or disapproved), having an account with a utility company, or a visit to the hospital and subsequent nonpayment for medical services received, and the latter may include a civil judgement, tax lien, or bankruptcy. Recent research by the Consumer Financial Protection Bureau carefully documents how the population in credit bureau data differ with respect to the general population (Brevoort, Grimm, & Kambara, 2015; Consumer Financial Protection Bureau, 2014). In short, these authors report that approximately 11% of U.S. adults are not represented in the credit bureau data and that such individuals are more likely to reside in lower income areas, which is a limitation of this study.[6]

Outcomes

Using the credit bureau data we study several outcomes that reflect various degrees of financial stress, and a direct relationship with medical spending risk, that may be influenced by the Medicaid expansions, which we categorize into "stocks" and "flows." This distinction is important insofar as any effect of the Medicaid expansions may be more apparent on recent events (flows) compared with the cumulative summary of past events both recent and distant (stocks), especially during the early phase of the expansions.

In terms of stocks, we study Vantage credit score, which is a credit risk score with a range of 350 to 850 that has become an increasingly popular metric used to summarize consumers' overall creditworthiness. A higher score represents a lower predicted risk of delinquency. Credit scores are categorized here as a stock as they incorporate past and current information from consumers' credit history. We also study total balance on all credit accounts, which includes all accounts in good standing, as well as those that are not and could be on a consumer's record for many years. In addition, we study balances past due (90 to 180 days), and past due balance as a percentage of total balances. Overall, these are very general financial outcomes insofar as they reflect many types of debt combined (e.g., mortgages, auto loans, third-party collections, etc.), which may be influenced by the Medicaid expansions.

In addition to the general outcomes above we study medical and nonmedical collections balances, in turn. This addition is important as medical collections are directly related to medical out-of-pocket spending risk—the direct mechanism through which we hypothesize Medicaid coverage may improve personal finances. Nonmedical collections may be influenced by the expansions insofar as there is an income effect of Medicaid coverage, whereby the previously uninsured have more disposable income as their out-of-pocket spending for medical care decreases with Medicaid coverage. Furthermore, note that medical collections are defined here as only those that originated with a medical provider. They do not include balances initially paid via credit obtained from a source other than the provider, such as a credit card. Such debt will be included in "nonmedical" collections.

We also study a number of flow outcomes that occurred within the previous 6 months with respect to the date a given data archive was culled. Importantly, we study incidence of new medical collections that occurred in the last 6 months, a flow outcome directly relevant to medical spending risk. Relatedly, we study new derogatory debt balances, excluding mortgages, which occurred in the last 6 months. Derogatory is a term used by credit agencies for debt that is not in good standing where the creditor took significant action to retrieve any unpaid balance and includes categories such as collections, repossessions, and bankruptcy. New medical collection balances are included in new derogatory balances; however, we are not able to identify them separately in our data. We are only able to identify new derogatory mortgage balances, which we exclude as we consider them much less directly relevant to the Medicaid expansions. Finally, we study bankruptcy filings that occurred within the past 6 months, which are severe and low-probability events.[7]

Control Variables

In terms of more general information related to individuals, the credit bureau data include information on the age of each consumer as well as their zip code and county for each year.[8] It does not include other demographic information such as race and ethnicity or sex, nor does it include data on income, wealth, or health insurance status. Therefore, we rely on external information related to each consumer's county of residence.

Key to the estimation strategy, discussed in the following section, are data on the relative size of the potentially affected Medicaid expansion population in the calendar year immediately prior to expansion. Specifically, we use estimates on the percent of each county's population, aged 18 to 39 and 40 to 64, that was uninsured with family income up to 138% of the FPL—the income eligibility threshold in expansion states. These age categories were chosen because they are the most refined categories available. These data are produced by the Small Area Health Insurance Estimates (SAHIE) group at the U.S. Census Bureau. They are model-based estimates based on information from the American Community Survey, IRS federal tax returns, the 2010 decennial Census, population estimates from the Census Bureau's Population Estimates Program, County Business Patterns data from the Business Register, and administrative data on participation in Medicaid, CHIP, and the Supplemental Nutrition Assistance Program (Bauder, Luery, & Szelepka, 2015; U.S. Census Bureau, 2016).

For each Medicaid expansion state we merge the SAHIE statistics with the consumer data by age-groups (18-39 and 40-64) and county for each year of the consumer data. The SAHIE estimates correspond to the calendar year prior to a given state's Medicaid expansion, or county in the case of California. For nonexpansion states we merge the SAHIE statistics to consumers in the same way but use data corresponding to 2013, the year for most Medicaid expansion states.

We also incorporate data on the rate of unemployment from the Bureau of Labor Statistics, Local Area Unemployment Statistics program (Bureau of Labor Statistics, 2016b). County-level unemployment rates, corresponding to August of a given year, are merged with the consumer data by county and year.

Empirical Method

The empirical approach is similar to that used by Miller (2012) and Mazumder and Miller (2016), who studied the effects of the Massachusetts health insurance expansion. Like these authors' work, we exploit two sources of variation to estimate the effect of the ACA Medicaid expansions on outcomes observed in the credit-bureau data. The first source of variation is that across individuals, similarly exposed to the Medicaid expansions, who resided in states that expanded their Medicaid program compared with those in states that did not. The second source of variation is, within states that expanded Medicaid and those that did not, variation in the pre-expansion rate of exposure across county age-category groups. Exposure is measured as the percent of the county population that is both uninsured and with income up to 138% FPL for each age category, 18 to 39 and 40 to 64.[9]

Unlike the Massachusetts expansion, however, not all states or counties within states (i.e., California) expanded Medicaid via the ACA simultaneously. The timing of the expansions with respect to the timing of the six credit bureau data files (2010 to 2015) is summarized in Table 1. Each row includes states that expanded Medicaid during the same calendar year (e.g., the first row includes both CT and DC, which expanded in 2010). Effectively, three states and 48 California counties (of 58) expanded prior to January 1, 2014; 23 states and 10 California counties expanded on January 1, 2014; two states expanded mid-2014; and two states expanded in 2015.[10] Our preferred specification incorporates information from all 50 states and the District of Columbia from 2010 through 2015, where "event time" (indexed by subscript t) is defined as the difference between the reference year of data (indexed by y) and the calendar year in which a given state or county expanded Medicaid. Table 1 shows that the number of observed pre- and post-expansion time periods across geographies range between zero and five.

This empirical approach assumes that, in the absence of Medicaid expansion, trends in outcomes among individuals in similarly exposed county-age categories would have evolved similarly across expansion and nonexpansion geographies. As these assumptions are not directly testable, we examine differences in outcomes in Medicaid geographies relative to nonexpansion geographies before and after the reform, taking into account higher or lower rates of exposure to the expansions. Should the outcomes studied not exhibit a trend before the reform, yet exhibit a different trend after implementation, we have more confidence that the expansions caused any changes in the outcomes.

To test for differences in the pre- and post-expansion period trends, we estimate models that take the following form, which we refer to the "event-study approach":

$$Y_{icgy} = \sum_{t} \left\{ \begin{array}{l} \delta_{1t} 1\left(Time = t\right) \cdot E_c \cdot ULE138_{cg} + \delta_{2t} 1\left(Time = t\right) \cdot E_c \\ +\delta_{3t} 1\left(Time = t\right) \cdot ULE138_{cg} + \delta_{4t} 1\left(Time = t\right) \end{array} \right\} + \\ \beta_1 ULE138_{cg} \cdot E_c + \beta_2 ULE138_{cg} + \rho \mathrm{Age}_{iy} + \phi U_{cy} + \gamma_c + \eta_y + e_{icgy}, \quad (1)$$

where i represents a given individual, c is a given U.S. county, g indexes one of two age categories (18-39; 40-64), y represents calendar year (2010 to 2015, as available), and t equals calendar year, y, minus the Medicaid expansion calendar year for county c. Specifically, $t \in$ (−4 or more, −3, −2, −1, 0, 1 or more). The first Medicaid expansion year is indicated by $t = 0$, and $t = -1$ is the reference time period. The dependent variable Y_{icgy} equals a financial outcome of interest for individual i, in county c, in age-group g, during calendar year y. Counties within states that expanded Medicaid are identified by E_c, and $ULE138_{cg}$ equals the percentage of individuals in county c and age-group g that are uninsured and have income up to 138% of the FPL in the calendar year prior to Medicaid expansion. Finally, Age_{iy} is a dummy variable, indicating whether consumer i is age 40 to 64, and U_{cy} is the unemployment rate in county c during August of calendar year y, γ_c are time invariant county effects, η_y are calendar year time effects (2013 reference year), and e_{icgy} is the error term.

Coefficient estimates from the three-way interaction terms, $\hat{\delta}_{1t}$, represent the change in a given outcome Y in expansion states compared with nonexpansion states, per percentage point change in exposure, with respect to the year prior to expansion ($t = -1$). Coefficient estimates from the two-way interactions of the time period dummies with expansion counties, $\hat{\delta}_{2t}$, capture trends in the outcomes over time that are specific to the expansion counties. Likewise, coefficients from the two-way interactions between the time period dummies and the exposure proxy, $\hat{\delta}_{3t}$, account for possible trends in the exposure rate over time common to county-age group categories. Finally, estimates $\hat{\delta}_{4t}$ capture trends in event time common to both expansion and nonexpansion geographies.

Should trends in outcomes be similar prior to the expansions the corresponding three-way interaction coefficient estimates should equal zero ($t = -4$ or more, −3, −2). We formally estimate F tests where the null hypothesis is that all corresponding pre-expansion period coefficient estimates for a given outcome are jointly equal to zero $\left(\hat{\delta}_{1,-4\ or\ more} = \hat{\delta}_{1,-3} = \hat{\delta}_{1,-2} = 0\right)$, which we use as the basis for evaluating whether an outcome exhibits differential pre-period trends, or not. Should the expansions cause a change in a given outcome, a break in trend should be apparent and result in non-zero coefficient estimates during initial expansion year and the post-period ($t = 0$, 1 or more). We group estimates together for four or more pre-expansion periods, and more than one post-expansion period, as not all geographies have the same number of pre- and post-expansions periods (see Table 1).[11,12] Finally, all standard errors are clustered at the state level to address serial correlation in the outcomes studied. This is important insofar as many of the same consumers are included in the data for multiple time periods, and Medicaid expansion occurred at the state level (Bertrand, Duflo, & Mullainathan, 2004).

To estimate the effects of the Medicaid expansions on a given outcome we estimate models that take the following form, which we refer to as the "triple-difference design":

$$
\begin{aligned}
Y_{icgy} = {} & \delta_{11}\text{Post}_t \cdot E_c \cdot ULE138_{cg} + \delta_{21}\text{Post}_t \cdot E_c + \\
& \delta_{31}\text{Post}_t \cdot ULE138_{cg} + \delta_{12}\text{Expansion year}_t \\
& \cdot E_c \cdot ULE138_{cg} + \delta_{22}\text{Expansion year}_t \cdot E_c + \\
& \delta_{32}\text{Expansion year}_t \cdot ULE138_{cg} + \beta_1 ULE138_{cg} \\
& \cdot E_c + \beta_2 ULE138_{cg} + \theta_1\text{Post}_t + \theta_2\text{Expansion year}_t + \\
& \rho\text{Age}_{it} + \phi U_{cy} + \gamma_c + \eta_y + e_{icgy},
\end{aligned}
\tag{2}
$$

where Post_t is an indicator for one or more periods after the initial Medicaid expansion calendar year, and Expansion year_t is an indicator for the calendar year in which county c expanded Medicaid, the "transition" year.

This model is similar in structure to that of Equation (1), where the three- and two-way interactions for all pre-expansion years are omitted. The estimate of interest is $\hat{\delta}_{11}$, which is the reduced-form effect of the Medicaid expansions per unit of exposure on a given outcome Y. This model accounts for any effects that occurred during the initial expansion year ($t = 0$) separately, which may be considered a transition period and are captured by the coefficient estimates $\hat{\delta}_{12}$, $\hat{\delta}_{22}$, $\hat{\delta}_{32}$, and $\hat{\theta}_2$.

Limitations

A limitation of this study is that the postimplementation period observed in the data is most likely too short to reflect full implementation of the Medicaid expansions. The channel through which we postulate the Medicaid expansions affect financial outcomes is via decreased risk of out-of-pocket medical expenditures and debt for those who are newly eligible and take up Medicaid. This chain of events and the full-implementation effects will not be immediate. And given the credit bureau data reflects a maximum of 1.5 years after expansion for most states, results presented here are best interpreted as early impacts of the Medicaid expansions.

A second limitation to this study regarding the proxy used for pre-expansion exposure is that we are unable to distinguish rates above the poverty threshold and up to 138% of the FPL. This may be important insofar as individuals in nonexpansion states with income in this range have access to marketplace health insurance and tax subsidies to purchase insurance.

A third potential limitation is that the estimates will be reduced form and will consequently incorporate additional dimensions of the reform related with Medicaid expansion and take-up of coverage. For example, the reduced-form estimate may include any potential effects resulting from the additional provisions of the law such as Medicaid take-up as a result of the individual mandate, or substitution from less comprehensive private insurance to Medicaid (i.e., crowd out). While it would be desirable to obtain structural estimates, it is beyond what our data and methods can produce. Nonetheless, we believe that the reduced-form estimates are informative to policy makers considering whether to expand their Medicaid programs as the expansion decision is within the context of the additional ACA provisions.

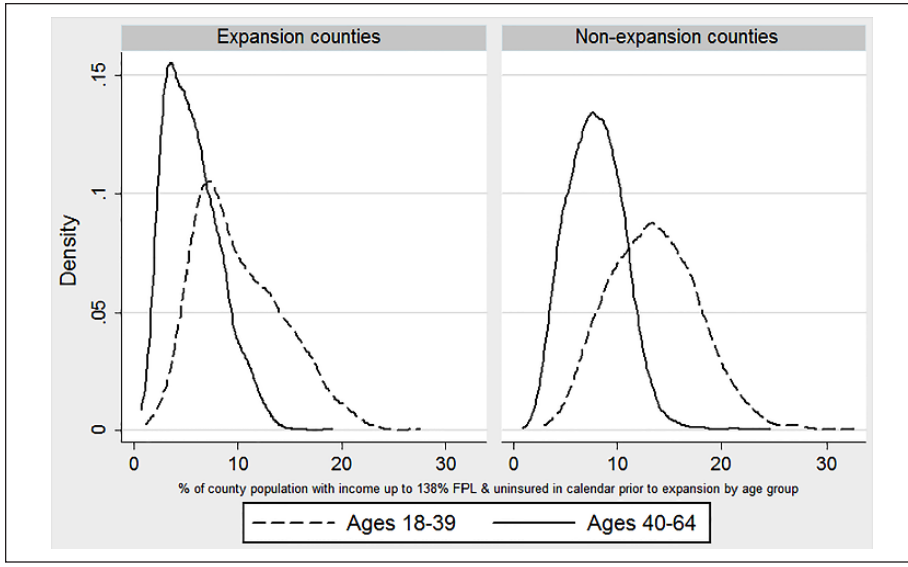

Figure 2. Distribution of county-level rate of exposure to Medicaid expansions by age-group and expansion status.
Note. Early, late, and 1115 waiver expansion states are included. AK and MT are defined as non expansion states. County-age groups are weighted equally. Kernel = epanechnikov, bandwidth (from left to right) = 0.5600, 0.9102, 0.5678, 0.8771.
Source. U.S. Census Bureau, Small Area Heath Insurance Estimates (SAHIE).

Results

Summary Statistics

Figure 2 demonstrates variation in estimates of the county-level rate of potential exposure to the Medicaid expansions by age category. All county-age categories are weighted equally. For each age-group exposure is defined as the percentage of the county population that was both uninsured and had family income up to 138% of the FPL in the calendar year prior to the expansions.[13] For nonexpansion states we report the rate corresponding to 2013. It is apparent that there is more variation in the rate of exposure among the 18 to 39 age-group compared with the 40 to 64 group, where the older population has less potential exposure to the expansions reflecting the fact that they are more likely to have higher income and less likely to be uninsured. The overall average pre-expansion rate of exposure for those 18 to 64 was 7.2% in expansion states and 10.2% in nonexpansion states.

Table 2 reports summary statistics from the credit-bureau data for the period prior to the Medicaid expansions by age-group (18-64, 18-39, 40-64). Note that all outcomes measured in dollars are top coded at the 99.9th percentile throughout this analysis, by year, due to extreme and influential outliers (see the appendix for more details).

Table 2. Summary Statistics on Financial Outcomes by Age and Medicaid Expansion Status Prior to the Medicaid Expansions[a].

	Ages 18-64		Ages 18-39		Ages 40-64	
	Expansion states	Nonexpansion states	Expansion states	Nonexpansion states	Expansion states	Nonexpansion states
Stocks						
Credit risk score (Vantage score 3.0; range 300-850)	665	651	636	622	688	674
Total balance	$82,843	$67,678	$54,009	$47,186	$106,264	$84,754
Balance past due (90-180 days)	$305	$273	$224	$229	$371	$309
Balance past due as a % of total	0.4%	0.5%	0.4%	0.6%	0.3%	0.4%
Balance on medical collections[b]	$414	$641	$479	$708	$362	$585
Medical collection balance >$0[b]	18.4%	25.9%	21.0%	28.5%	16.4%	23.8%
Medical collection balance ≥$1,000[b]	7.4%	11.7%	8.8%	13.3%	6.3%	10.3%
Balance on nonmedical collections[b]	$724	$895	$743	$889	$710	$900
Nonmedical collection balance >$0[b]	24.6%	28.9%	29.1%	33.0%	21.1%	25.6%
Nonmedical collection balance ≥$1,000[b]	13.0%	15.0%	15.4%	17.3%	11.1%	13.1%
Flows						
Medical collection last 6 months[b]	4.6%	7.7%	5.4%	8.9%	4.0%	6.6%
New derogatory balance last 6 months	13.8%	18.2%	16.7%	21.6%	11.4%	15.4%
New derogatory balance last 6 months ≥$1,000	6.0%	7.9%	7.2%	9.6%	5.0%	6.6%
Bankruptcy filed last 6 months	0.5%	0.4%	0.4%	0.3%	0.5%	0.5%

Note. Credit bureau data cover years 2010 to 2015 and reflect consumers' status at the end of August in each year. All monetary values are expressed in constant 2015 U.S. dollars and are top coded at the 99.9th percentile by year. New derogatory balances exclude those related with mortgages.
[a]The pre-expansion period varies by expansion state (or county for California) and equals 2010-2013 for nonexpansion states. See Table 1 for details on the timing of the expansions. [b]2010 data are unavailable for outcomes related to medical collections.

Among the Medicaid expansion states, the pre-expansion period varies by county (see Table 1), whereas the pre-expansion period for nonexpansion states span 2010 through 2013.[14] For those aged 18 to 64 there are approximately 8.2 million individual-year observations in the pre-expansion period within expansion states, and 6.2 million individual-year observations for nonexpansion states. All monetary values are expressed in constant 2015 dollars (Bureau of Labor Statistics, 2016a).

On average, compared with nonexpansion states, Table 2 shows that those age 18 to 64 in expansion states had slightly higher credit scores (665 and 651), held significantly higher total credit balances ($83,000 and $68,000) yet only slightly higher past due balances ($305 and $273). Table 2 also reports statistics on collection balances disaggregated by medical and nonmedical. Medical collections in this context are limited to unpaid balances providers (e.g., hospitals and individual medical practices) send to collections. Medical collections do not include balances initially paid via credit from a source other than the provider (e.g., credit card) ultimately sent to collections. This is an important distinction as some providers require (at least partial) payment at the time of service. Therefore, medical collection balances as defined here are a lower bound for all medical-related collection balances. Average medical and nonmedical collection balances are lower for those in Medicaid expansion states. For those 18 to 64 years old in expansion states the average medical collection balance was $414 per person, compared with $641 per person in nonexpansion states.

Given the importance of collections balances we also study whether consumers had any collections balance (greater than zero), or a "high" balance that we define as $1,000 or more. While the latter is somewhat arbitrary—in a given year, $1,000 is approximately the 91st percentile of the nonelderly adult medical collections distribution, and the 87th percentile of the nonmedical collections distribution—our main results are not sensitive to this definition. It is not uncommon that individuals had a collections balance at a given point in time. And adults age 18 to 64 in nonexpansion states were more likely to have a medical collection balance (25.9% compared with 18.4%), or a nonmedical collection balance (28.9% and 24.6%, respectively). Likewise, adults in nonexpansion states were more likely to have a medical collections balance of $1,000 or more (11.7% compared with 7.4%), or a high nonmedical collection balance (15.0% compared with 13.0%).[15]

The bottom of Table 2 reports statistics on the flow of new financial events that may be the most likely outcomes influenced by the early phase of the Medicaid expansions. In expansion states 4.6% of consumers aged 18 to 64 had one or more medical collections trades within the previous 6 months, compared with 7.7% in nonexpansion states. Similarly, consumers in nonexpansion states were more likely to experience a new derogatory balance, which is a broader metric including medical collections as one component (18.2% compared with 13.8%). And those in nonexpansion states were more likely to experience a new "high" derogatory balance equal to $1,000 or more (7.9% compared with 6.0%). Finally, consumers in expansion states were slightly more likely to have filed for bankruptcy in the past 6 months compared with nonexpansion states (0.5% and 0.4%, respectively).

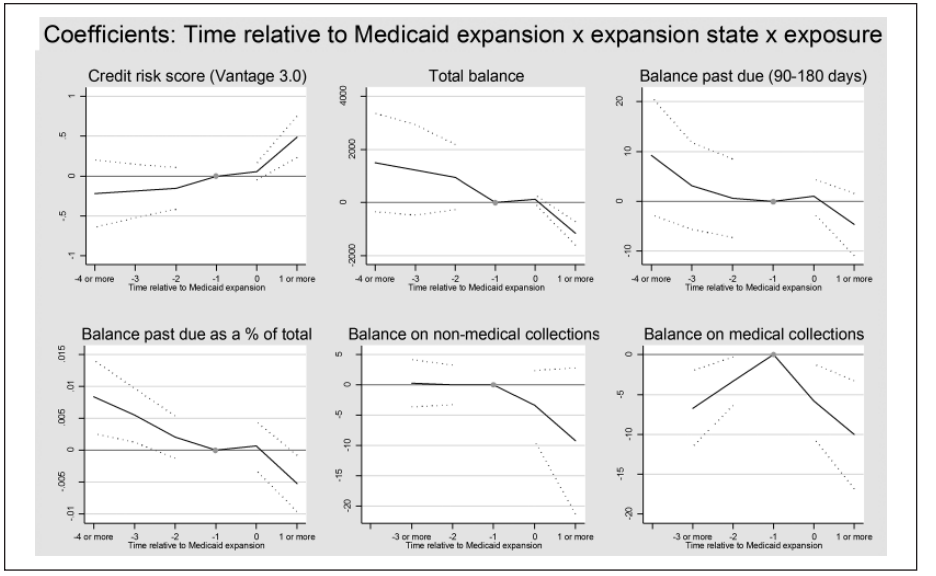

Figure 3. Event-study figures of financial outcomes and time until Medicaid expansion.
Note. Coefficient estimates from three-way interaction terms (Equation 1) and corresponding 90% confidence intervals that account for clustering at the state level are reported. Estimates incorporate early, late, and 1115 waiver expansion states. AK and MT are defined as non expansion states. Additional independent variables include: county fixed effects, time period fixed effects, calendar year fixed effects, county unemployment rate, rate of exposure, expansion state x years until expansion, expansion state x exposure, years until expansion x exposure. Omitted time period = −1 (calendar year prior to expansion) is marked with the black dot. Exposure is measured as the percent of the county population that is both uninsured and with income up to 138% FPL by age category, 18-39 and 40-64.

There are a few notable contrasts in these outcomes by age-group. Older individuals aged 40 to 64 had higher credit scores, higher total credit balances, and balances past due, yet lower past due balances as a fraction of total balances. Nonmedical collections balances were higher for younger individuals in expansion states, yet very similar across age-groups in nonexpansion states. However, average medical collection balances, the flow of medical collections and new derogatory balances, were higher for the younger age-group in both expansion and nonexpansion states, which may reflect higher rates of uninsured among younger individuals.

Event-Study Approach

Figure 3 presents results from the event-study approach for "stock" outcomes. It plots coefficient estimates, and 90% confidence intervals, corresponding to the triple-interaction terms from Equation (1) for a given outcome. Coefficient estimates measure the average change in a given outcome in expansion states relative to nonexpansion states, per percentage point in exposure relative to the year immediately prior to the expansions (marked with a gray dot at −1).

Using this methodology, outcomes consistent with a causal interpretation are those that do not exhibit a differential pre-expansion period trend and a break in the relative trend during the post-expansion period. Immediately clear from Figure 3 is that results for several outcomes are seemingly inconsistent with a causal interpretation. Indeed, *F* tests for the joint significance of the pre-expansion period coefficient estimates reject the null hypothesis (10% level) that the estimates jointly equal zero for total balance, balance past due, and balance on medical collections. That is, the direction of the relative trend for these outcomes during the post-expansion period is not inconsistent with our hypothesis. Rather, it is the apparent difference in the pre-expansion period trend that makes a causal interpretation for these outcomes less convincing. However, results for credit score appear generally consistent with a causal interpretation. And those for nonmedical collections are compelling, yet the coefficient estimates are not significantly different from zero in the post period. Finally, results for balance past due as a percent of total show that although the interaction terms for two of the three preperiod interactions are significant, the joint *F* test for the preperiod coefficients is insignificant ($p = .103$).

Figure 4 takes a closer look at medical and nonmedical collection balances. Specifically, it reports event study results for any balance greater than zero, and a balance of $1,000 or more for each type of collection balance. Results from *F* tests for the joint significance of the pre-expansion period coefficient estimates fail to reject the null hypothesis for all outcomes (10% level), suggesting no differential pre-expansion period trends. There is evidence that the expansions decreased medical collection balances of $1,000 or more, possibly nonmedical collection balances greater than $1,000, and medical collections balances greater than zero.

Figure 5 reports results for the flow outcomes. We cannot reject the null hypothesis from *F* tests of the joint significance of the pre-expansion period coefficient efficient estimates corresponding to any outcome, lending confidence to the hypothesis that the post-expansion period change is due to the expansions. Results for one or more new medical collections and derogatory balances (greater than $0 and $1,000 or more) that occurred during the previous 6 months are very compelling. Recall that new derogatory balances as defined here include medical collection balances, yet exclude those related with mortgages. That is, while we are not able to directly measure new medical collection balances separately, such balances are included in new derogatory balances, and the results are consistent across both outcomes. Finally, there is some evidence that the expansions may have decreased recent bankruptcy filings.

While not all outcomes presented in Figures 3 through 5 are consistent with a causal interpretation due to differential preperiod trends, it is reassuring that some results relevant to collections, especially the flow of new medical collections, are generally consistent. Should the Medicaid expansions affect the financial outcomes of individuals, it is anticipated that the most direct and immediate means through which that process occurs is via decreased probability of unpaid medical bills and, as observed here, decreased flow of new medical collections. It is also known that the most common type of collections are medical collections (Consumer Financial Protection

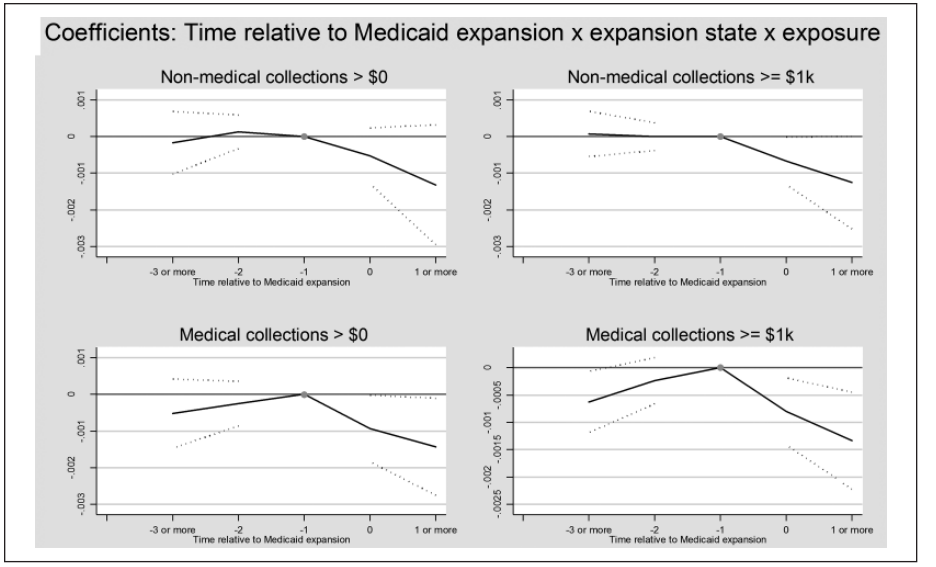

Figure 4. Event-study figures of medical and nonmedical collections and time until Medicaid expansion.

Note. Coefficient estimates from three-way interaction terms (Equation 1) and corresponding 90% confidence intervals that account for clustering at the state level are reported. Estimates incorporate early, late, and 1115 waiver expansion states. AK and MT are defined as non expansion states. Additional independent variables include: county fixed effects, time period fixed effects, calendar year fixed effects, county unemployment rate, rate of exposure, expansion state x years until expansion, expansion state x exposure, years until expansion x exposure. Omitted time period = −1 (calendar year prior to expansion) is marked with the black dot. Exposure is measured as the percent of the county population that is both uninsured and with income up to 138% FPL by age category, 18-39 and 40-64.

Bureau, 2014), thus lending credibility to the focus on collections. Also, while credit score incorporates historical information from consumers' credit history, it should be, to some degree, responsive to recent changes in consumers' creditworthiness.

That the remaining outcomes exhibit different trends in the pre-expansion period may reflect different experiences across expansion and nonexpansion states in the recovery to the great recession, unrelated to the ACA. For example, total balances include balances on mortgages or even derogatory unpaid balances related with foreclosures and bankruptcies that are maintained on consumers' records for up to 7 to 10 years. In short, while the Medicaid expansions may have influenced these outcomes, and the post-expansion period trends are consistent with our hypothesis, the differences in the pre-expansion period trends suggest that any changes in these outcomes due to the Medicaid expansions are overshadowed by factors unrelated with the expansions. This suggests that changes in measures that exhibit differential preperiod trends, including total balance, balance past due, and balance on medical collections, are best not interpreted as a result of the expansions.

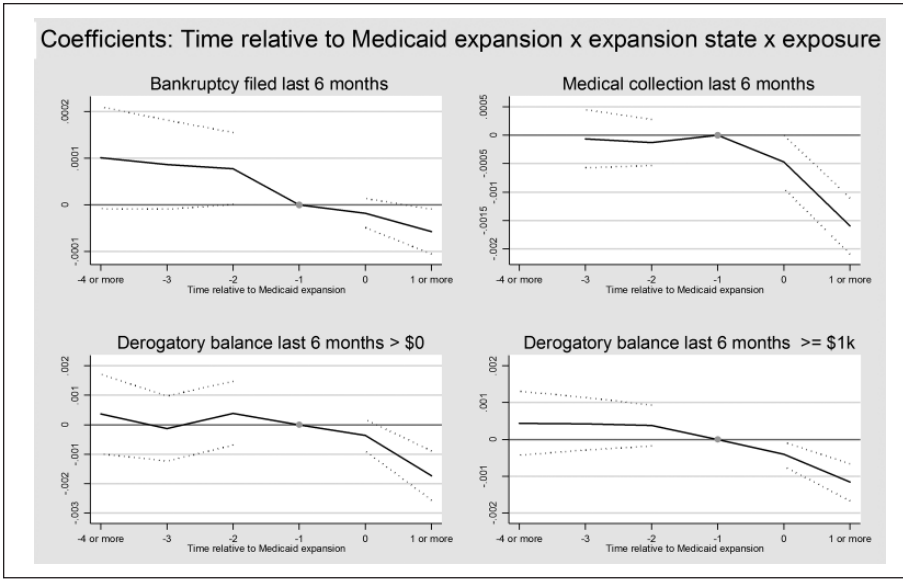

Figure 5. Event-study figures of recent financial outcomes and time until Medicaid expansion.

Note. Coefficient estimates from three-way interaction terms (Equation 1) and corresponding 90% confidence intervals that account for clustering at the state level are reported. Estimates incorporate early, late, and 1115 waiver expansion states. AK and MT are defined as non expansion states. Additional independent variables include: county fixed effects, time period fixed effects, calendar year fixed effects, county unemployment rate, rate of exposure, expansion state x years until expansion, expansion state x exposure, years until expansion x exposure. Omitted time period = −1 (calendar year prior to expansion) is marked with the black dot. Exposure is measured as the percent of the county population that is both uninsured and with income up to 138% FPL by age category, 18-39 and 40-64. Derogatory balances that occured in the last 6 months excludes mortgage balances.

Main Results: Triple-Difference Design

Table 3 reports results from the triple-difference design. It includes results for all 14 outcomes; however, we focus the discussion on results identified in the event study figures as consistent with a causal interpretation (i.e., those with no differential prepe-riod trends). Results presented in bold are the main results and are coefficient estimates corresponding to the triple-interaction term in Equation (2). These estimates represent the average change in a given outcome per percentage point in the pre-expansion rate of exposure among all individuals age 18 to 64.

Table 3 shows that credit scores increased by 0.61 points per percentage point in the pre-expansion rate of exposure (column 1). And balance past due as a percent of total decreased by 0.01 percentage points per percentage point in the exposure rate (column 4). Subsequent results reported in columns 5 and 7 through 9 take the expected sign yet are statistically insignificant: namely, balance on nonmedical collections (−$9.40;

Table 3. Regression Results of the Impact of the Medicaid Expansions on Financial Outcomes per Percentage Point Change in Exposure.

	(1) Credit risk score			(2) Total balance			(3) Balance past due (90 to 180 days)			(4) Balance past due as a percent of total			(5) Balance on nonmedical collections			(6) Balance on medical collections			(7) Nonmedical collections >$0		
Panel A	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*
Post-expansion * Expansion geography * Exposure	**0.6131**	**0.2782**	**.032**	**−2062.2**	**714.4**	**.006**	**−10.2**	**6.0**	**.094**	**−0.0001**	**0.0000**	**.029**	**−9.4**	**7.3**	**.203**	**−6.4**	**4.3**	**.142**	**−0.0012**	**0.0010**	**.233**
Post-expansion * Expansion state	−1.3596	1.8795	.473	12195.4	4841.2	.015	23.3	32.3	.474	0.0005	0.0002	.028	87.4	65.5	.188	4.9	28.6	.864	0.0045	0.0088	.609
Post-expansion * Exposure	0.4009	0.0926	.000	297.8	86.6	.001	2.5	3.4	.477	0.0000	0.0000	.128	−8.5	4.6	.070	−0.2	2.4	.923	−0.0025	0.0005	.000
Expansion * Expansion geography * Exposure	0.1917	0.1785	.288	−799.3	541.1	.146	−3.7	5.7	.519	0.0000	0.0000	.296	−3.4	3.7	.367	−2.5	3.5	.467	−0.0005	0.0005	.349
Expansion * Expansion geography	0.2032	1.3192	.878	4838.2	3606.5	.186	18.3	32.6	.576	0.0003	0.0003	.225	44.5	33.9	.195	−4.0	26.0	.879	0.0020	0.0040	.614
Expansion * Exposure	0.2718	0.0652	.000	251.5	65.5	.000	1.1	2.6	.670	0.0000	0.0000	.133	−3.1	2.5	.229	0.7	1.4	.599	−0.0011	0.0004	.005
Exposure * Expansion geography	−0.4162	0.4336	.342	−3161.2	2090.5	.137	−10.6	7.9	.184	−0.0002	0.0002	.303	5.8	8.9	.518	2.9	5.7	.612	0.0013	0.0015	.374
Post-expansion period	−4.5819	1.5176	.004	−3910.5	1893.3	.044	−69.7	29.7	.023	−0.0002	0.0003	.330	107.2	65.7	.109	27.4	24.0	.260	0.0270	0.0059	.000
Expansion period	−3.7730	0.9965	.000	−1723.3	1394.0	.222	−8.8	21.4	.683	−0.0001	0.0002	.720	45.7	35.4	.203	6.9	21.3	.746	0.0104	0.0038	.008
2015	2.9908	1.2672	.022	5635.1	1477.9	.000	50.3	21.0	.020	0.0001	0.0002	.745	−240.5	45.1	.000	−27.7	19.9	.171	−0.0261	0.0061	.000
2014	1.7754	0.7701	.025	1862.5	924.3	.049	1.3	16.4	.937	0.0000	0.0001	.666	−99.5	24.3	.000	5.2	11.8	.658	−0.0065	0.0035	0.067
2012	0.1376	0.2424	.573	2402.6	431.2	.000	19.7	12.5	.122	−0.0001	0.0001	.546	71.6	6.7	.000	−29.6	8.5	.001	0.0072	0.0012	.000
2011	1.3728	0.4688	.005	4442.9	837.7	.000	−20.9	20.2	.304	−0.0006	0.0001	.000	51.3	13.9	.001	−42.1	11.9	.001	0.0093	0.0018	.000
2010	0.4490	0.6028	.460	9140.0	1170.4	.000	−25.3	19.4	.199	−0.0008	0.0002	.000	——	——	——	——	——	——	——	——	——
Exposure	−1.5182	0.4632	.002	4025.0	893.6	.000	18.8	4.0	.000	0.0004	0.0002	.056	8.9	6.9	.203	14.5	4.5	.002	0.0058	0.0019	.004
County unemployment rate	−0.3266	0.2709	.234	1668.2	494.6	.001	41.5	14.5	.006	0.0002	0.0001	.009	19.3	4.4	.000	1.5	7.6	.840	0.0004	0.0014	.776
Age 40 to 64	42.0146	2.2470	.000	58465.7	4973.6	.000	170.5	26.0	.000	−0.0002	0.0003	.547	44.4	35.7	.220	−35.0	13.8	.014	−0.0452	0.0073	.000
Constant	653.2318	5.0508	.000	9913.6	12485.7	.431	−236.8	105.8	.030	0.0008	0.0012	.493	487.4	76.6	.000	389.1	66.0	.000	0.2267	0.0194	.000
F			1.048.993			321.627			50.198			13.750			255.797			22.959			197.962
Probability > *F*			0.000			0.000			0.000			0.000			0.000			0.000			0.000
Adjusted R^2			0.094			0.068			0.004			0.006			0.010			0.016			0.038
N		23,079,017			23,521,668			23,521,668			23,521,668			19,585,807			19,585,807			19,585,807	
DV mean: Expansion states, pre-expansion period			665.2			$82,842.8			$305.3			0.4%			$724.4			$414.4			0.2465

(continued)

Table 3. (continued)

	(8) Nonmedical collections ≥$1,000			(9) Medical collections >$0			(10) Medical collections ≥$1,000			(11) Medical collection last 6 months			(12) New derogatory balances last 6 months >$0			(13) New derogatory balances last 6 months ≥$1,000			(14) Bankruptcy filed last 6 months		
Panel B	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	*SE*	*p*	Coeff.	SE	*p*	Coeff.	*SE*	*p*	Coeff.	SE	*p*	Coeff.	SE	*p*
Post-expansion * Expansion geography * Exposure	**−0.0012**	**0.0007**	**.104**	**−0.0011**	**0.0008**	**.189**	**−0.0010**	**0.0005**	**.077**	**−0.0015**	**0.0004**	**.000**	**−0.0019**	**0.0006**	**.004**	**−0.0016**	**0.0004**	**.001**	**−0.0001**	**0.0000**	**.000**
Post-expansion * Expansion state	0.0061	0.0056	.278	−0.0022	0.0060	.718	0.0004	0.0039	.912	−0.0008	0.0026	.759	0.0050	0.0046	.284	0.0054	0.0025	.036	0.0007	0.0003	.017
Post-expansion * Exposure	−0.0013	0.0004	.001	−0.0013	0.0004	.001	0.0000	0.0003	.959	0.0003	0.0003	.245	−0.0003	0.0003	.293	0.0008	0.0002	.001	0.0001	0.0000	.000
Expansion * Expansion geography * Exposure	−0.0007	0.0004	.115	−0.0007	0.0006	.279	−0.0005	0.0004	.229	−0.0004	0.0003	.241	−0.0006	0.0006	.334	−0.0008	0.0005	.097	−0.0001	0.0000	.017
Expansion * Expansion geography	0.0044	0.0028	.126	−0.0009	0.0044	.848	−0.0004	0.0030	.885	−0.0002	0.0023	.947	0.0014	0.0042	.743	0.0023	0.0025	.361	0.0005	0.0003	.063
Expansion * Exposure	−0.0004	0.0003	.190	−0.0006	0.0002	.003	0.0001	0.0002	.541	0.0000	0.0001	.978	0.0000	0.0002	1.000	0.0008	0.0002	.000	0.0001	0.0000	.000
Exposure * Expansion geography	0.0007	0.0008	.397	0.0004	0.0014	.765	−0.0002	0.0009	.805	−0.0010	0.0006	.137	−0.0008	0.0013	.545	−0.0008	0.0008	.356	0.0000	0.0001	.922
Post-expansion period	0.0147	0.0044	.002	0.0135	0.0038	.001	0.0044	0.0024	.075	0.0064	0.0024	.010	0.0078	0.0037	.043	−0.0041	0.0021	.059	−0.0008	0.0003	.004
Expansion period	0.0043	0.0028	.128	0.0056	0.0028	.047	0.0016	0.0022	.487	0.0018	0.0019	.347	0.0036	0.0036	.313	−0.0031	0.0016	.064	−0.0005	0.0002	.054
2015	−0.0206	0.0044	.000	−0.0069	0.0036	.059	−0.0036	0.0021	.097	−0.0070	0.0016	.000	−0.0060	0.0028	.035	0.0029	0.0015	.059	0.0002	0.0002	.285
2014	−0.0067	0.0025	.011	−0.0005	0.0020	.819	−0.0002	0.0015	.920	−0.0033	0.0011	.007	−0.0028	0.0023	.233	0.0014	0.0011	.216	−0.0001	0.0001	.440
2012	0.0062	0.0007	.000	−0.0063	0.0016	.000	−0.0042	0.0012	.001	−0.0044	0.0011	.000	0.0053	0.0021	.016	0.0027	0.0008	.001	0.0001	0.0001	.276
2011	0.0085	0.0012	.000	−0.0099	0.0026	.000	−0.0055	0.0015	.001	−0.0061	0.0014	.000	0.0023	0.0020	.272	−0.0016	0.0011	.172	0.0003	0.0001	.011
2010	—	—	—	—	—	—	—	—	—	—	—	—	0.0012	0.0022	.601	0.0008	0.0010	.428	0.0009	0.0002	.000
Exposure	0.0034	0.0010	.001	0.0053	0.0015	.001	0.0038	0.0008	.000	0.0032	0.0005	.000	0.0048	0.0011	.000	0.0025	0.0006	.000	0.0000	0.0000	.649
County unemployment rate	0.0016	0.0006	.015	−0.0005	0.0011	.657	−0.0002	0.0008	.856	−0.0006	0.0006	.293	0.0003	0.0009	.693	0.0014	0.0006	.032	0.0005	0.0001	.000
Age 40 to 64	−0.0235	0.0046	.000	−0.0208	0.0050	.000	−0.0100	0.0029	.001	−0.0060	0.0021	.007	−0.0353	0.0045	.000	−0.0150	0.0027	.000	0.0015	0.0002	.000
Constant	0.1053	0.0104	.000	0.1801	0.0144	.000	0.0662	0.0092	.000	0.0448	0.0070	.000	0.1303	0.0120	.000	0.0445	0.0072	.000	−0.0005	0.0008	.531
F			195.353			39.566			39.133			30.905			167.516			87.756			85.175
Probability > *F*			0.000			0.000			0.000			0.000			0.000			0.000			0.000
Adjusted R^2			0.023			0.056			0.033			0.026			0.027			0.012			0.001
N			19,585,807			19,585,807			19,585,807			19,585,807			23,521,668			23,521,668			23,521,668
DV mean: expansion states, pre-expansion period			0.1301			0.1843			0.0739			0.0462			0.1381			0.0602			0.0046

Note. Coefficient estimates from the triple interaction terms (in bold) measure the change in a given outcome with respect to a percentage point change in exposure to the Medicaid expansions (Equation 2). All models include county fixed effects. Results incorporate early, late, and 1115 waiver expansion states. AK and MT are defined as nonexpansion states as these expansions occurred after the most recent credit bureau data file reference period. Exposure is measured as the percent of the county population that is both uninsured and with income up to 138% federal poverty level by age category, 18 to 39 and 40 to 64. *SE* = standard error; *SE* are clustered at the state level. "—" indicates "not available"; medical collections are not available for the 2010 data file. Monetary values are expressed in constant 2015 dollars.

$p = .203$), probability of nonmedical collections balance greater than zero (−0.12 percentage points; $p = .233$), probability of nonmedical collections balance greater $1,000 (−0.12 percentage points; $p = .104$), and probability of nonmedical collections balance greater than zero (−0.11 percentage points; $p = .189$).

The remaining results presented in columns 10 through 14 are statistically significant at conventional levels and take the hypothesized sign. The probability of having a medical collections balance of $1,000 or more decreased by 0.10 percentage points per percentage point in the exposure rate (column 10); the probability of experiencing one or more new medical collections decreased by 0.15 percentage points (column 11); the probability of having any new derogatory balance decreased by 0.19 percentage points (column 12); the likelihood of experiencing a new derogatory balance greater than $1,000 increased by 0.16 percentage points (column 13); and the probability of a new bankruptcy filing decreased by 0.01 percentage points (column 14).

Finally, the remaining outcomes are those where the event-study results exhibit differential preperiod trends, where we have less confidence that the reported changes are (solely) a result of the expansions: total balance (column 2), balance past due (column 3), and balance on medical collections (column 6).

To interpret results from Table 3 in terms of the average effect of the Medicaid expansions per person age 18 to 64, we assume that a percentage point change in the pre-expansion period exposure rate corresponds to a commensurate change in the share of the low-income, uninsured population as a result of the expansions. The estimates based on ACS data presented in Figure 1 suggest that the decrease in the share of uninsured, low-income adults between 2013 and 2015 equals −1.0 percentage points (or 13.9%) in expansion states relative to nonexpansion states; that is, −3.4 percentage points in expansion states compared with −2.4 percentage points nonexpansion states. In Table 4, we interpret our coefficient estimates as corresponding to this one-percentage point change in the fraction of uninsured, low-income adults to arrive at the average effect of the Medicaid expansions per person age 18 to 64. Results presented here are limited to those that did not exhibit differential preperiod trends and are statistically significant as reported in Table 3.

Results reported in Table 4 imply that, per person age 18 to 64: credit scores increased by 0.61 points (0.1%); debt past due as a percent of total decreased by 0.01 percentage points (2.9%); the probability of having a medical collections balance of $1,000 or more decreased by 0.10 percentage points (1.3%); the probability of having one or more medical bills sent to collections over a 6-month period decreased by 0.15 percentage points (3.3%); the probability of any new derogatory balance decreased by 0.19 percentage points (1.4%); the probability of a new derogatory balance greater than $1,000 decreased by 0.16 percentage points (2.6%); and the probability of a new bankruptcy filing decreased by 0.01 percentage points (2.8%).

Given that the reduced-form estimates above correspond to *all* individuals age 18 to 64, and those who gained Medicaid coverage due to the expansions represent a relatively small share of this group, these estimates imply *much* larger changes for those directly affected by the expansions. In our view these results do, however, demonstrate that the ACA Medicaid expansions significantly increased financial security of new

Table 4. Estimated Effects of the Medicaid Expansions on Financial Outcomes.

	(1) Change in credit score	(2) Change in balance past due as a % of total balance	(3) Change in probability of medical collections balance $1,000 or more	(4) Change in probability of medical collection during last 6 months	(5) Change in probability of new derogatory balance during last 6 months	(6) Change in probability of new derogatory balances $1,000 or more during last 6 months	(7) Change in probability of bankruptcy filing during last 6 months
1.0 percentage point (13.9%) decrease in low-income, uninsured							
Level change per person age 18-64	0.61	−0.0001	−0.0010	−0.0015	−0.0019	−0.0016	−0.0001
Percent change per person age 18-64	0.1%	−2.9%	−1.3%	−3.3%	−1.4%	−2.6%	−2.8%

Note. Estimates of the level change per person are based on coefficient estimates from Table 3 (in bold) multiplied by the stated percentage point change in the proportion of individuals who are low income and uninsured; estimates of percent change incorporate the pre-expansion period average of a given outcome in expansion states.

beneficiaries. And given that our data reflect consumers' experiences through August 2015, these effects are best interpreted as the initial effects of the expansions, where it will most likely take several years to reach a new equilibrium.

It is important to keep in mind that the price Medicaid pays providers for services is likely much lower than the prices the uninsured are charged for the same services. Consequently, any decrease in the amount of medical collections or new derogatory debt balances due to the expansions is likely larger than what Medicaid would have paid and would not translate into a dollar-for-dollar shift from collections to Medicaid spending. That said, some portion of the related dollar amount contributes to the large estimated transfer of $0.6 per dollar of public spending on Medicaid to providers for implicit insurance for the low-income uninsured (Finkelstein, Hendren, & Lutttmer, 2015). These effects also reflect inefficiencies relative to providing insurance to the low-income uninsured when taking into consideration resources employed to (partially) recover unpaid bills.

Robustness of Results

In the appendix, we present and discuss results from multiple alternative model specifications to assess the robustness and validity of the main results. These models generally support the main findings discussed above and presented in Table 4, with a few caveats. To summarize, we find that results regarding new medical collections and derogatory debt (any balance and balance $1,000 or more) that occurred in the previous 6 months are the most unaffected by choice of model specification in terms of statistical significance and magnitude of results. This is an important finding as the flow of new medical collections, and derogatory balances more generally, should arguably be the first and most likely outcome studied here, if any, influenced by the expansions.

Results for recent bankruptcy filings and balance past due as a percent of total were less sensitive to different model specifications, although these were the only outcomes that that failed placebo tests estimated among adults age 65 and older. The latter finding suggests that factors other than the expansions may be responsible for the observed changes in these outcomes. Results for credit score and medical collection balances $1,000 or more were more sensitive to alternative specifications, which may reflect the fact that they change more slowly over time and the relatively short post-expansion period observed in the data. However, results that include state- or county-level time trends are generally consistent with those reported in Table 4.

Summary and Discussion

Using data from one of the major credit bureaus, combined with information on the likelihood of exposure to the ACA Medicaid expansions, we estimate triple-difference models to evaluate the early effects of the expansions on multiple dimensions of personal finance. Overall, results demonstrate financial improvements in states that expanded their Medicaid programs.

In summary, our estimates of the effect of the Medicaid expansions per individual age 18 to 64 include improved credit scores (0.1%), reduced balances past due as a percent of total debt (2.9%), reduced probability of a medical collection balance of $1,000 or more (1.3%), a 3.3% reduction in the probability of having one or more medical bills go to collections in the previous 6 months, a 1.4% reduction in the probability of experiencing a new derogatory balance of any type, a 2.6% reduction in the probability of incurring a new derogatory balance equal to $1,000 or more, and a 2.8% reduction in the probability of a new bankruptcy filing. Given that the proportion of individuals affected by the Medicaid expansions is much smaller than the population adults age 18 to 64, these estimates reflect much larger effects per newly enrolled Medicaid beneficiary.

These results are broadly consistent with recent work by Hu et al. (2016), using data on *nonmedical* collection balances, that suggests that ACA Medicaid expansions reduced average balances by −$600 to −$1,000 per new beneficiary. We extend those findings to other measures of beneficiaries' financial well-being and more clearly illustrate the mechanism through which any improvements occurred. Indeed, this work demonstrates that the Medicaid expansions significantly reduced the likelihood of new medical collections and, more generally, the flow of new and large derogatory debt balances. This finding is consistent with the hypothesis that Medicaid coverage directly decreased the risk of medical out-of-pocket expenditures and ultimately unpaid medical bills.

These results are important for policy decisions. This work demonstrates how the ACA Medicaid expansions have improved economic well-being of low-income Americans, which at the same time has implications for providers and payers of medical services. From the consumer perspective our results show that increased access to Medicaid substantively decreases the risk of bills that go unpaid, which are at times nontrivial in magnitude especially for low-income families. Overall this suggests that the ACA Medicaid expansions provide meaningful financial protection to the low-income uninsured. From the provider perspective our results indirectly suggest that the Medicaid expansions have decreased reliance on third-party bill collectors, likely a very inefficient means of obtaining payment for services. Finally, from the payer prospective the results may suggest decreased need for funding of uncompensated care, such as disproportionate share hospital payments and upper payment limit supplemental payments, much of which is funded by Medicaid.

Appendix

Distribution of Financial Outcomes and Outliers

Table A1 reports statistics on the distribution of the monetary financial outcomes studied in this work by year among all adults age 18 to 64. These statistics reveal that these data contain extreme values. For example, in 2011, the 99th percentile of nonmedical collections was $15,362, the 99.9th percentile was $50,909, and the maximum value was $11.8 million. We also found that some regression results were sensitive to these

Table A1. Distribution of Financial Outcomes Among Adults Age 18 to 64 by Year.

	Year	% >$0	p25	p50	p75	p90	p95	p99	p99.9	Max	Mean	Mean top coded	*N*
Total balance	2010	87.0%	$1,211	$13,891	$105,155	$263,065	$388,813	$779,163	$1,839,429	$16,887,812	$87,398	$86,450	3,935,861
	2011	87.0%	1,110	12,684	97,928	249,442	368,000	730,187	1,698,078	24,155,798	82,001	81,115	3,929,095
	2012	87.8%	1,169	12,540	91,090	238,248	351,624	694,164	1,589,872	16,125,511	77,898	77,106	3,899,937
	2013	88.1%	1,205	12,287	82,843	228,861	338,245	659,839	1,491,321	20,586,920	73,954	73,230	3,900,323
	2014	88.3%	1,272	12,882	83,840	228,866	336,835	653,532	1,479,548	20,469,814	74,074	73,364	3,920,110
	2015	88.4%	1,283	13,312	82,260	229,090	337,248	652,366	1,481,639	13,134,628	74,026	73,302	3,936,347
Balance past due (90-180 days)	2010	4.6%	0	0	0	0	0	9,421	62,189	2,183,048	384	339	3,935,861
	2011	4.2%	0	0	0	0	0	7,596	67,539	7,745,325	376	322	3,929,095
	2012	4.3%	0	0	0	0	0	6,622	70,744	1,680,166	373	316	3,899,937
	2013	3.8%	0	0	0	0	0	4,027	67,645	6,423,262	324	259	3,900,323
	2014	3.8%	0	0	0	0	0	2,979	61,876	4,374,896	285	213	3,920,110
	2015	3.6%	0	0	0	0	0	2,252	48,462	2,087,500	225	162	3,936,347
Nonmedical collections balance	2011	26.8%	0	0	105	1,927	4,332	15,362	50,909	11,863,371	879	841	3,929,095
	2012	26.6%	0	0	96	1,831	4,187	15,776	56,370	11,660,385	889	846	3,899,937
	2013	25.8%	0	0	63	1,651	3,764	13,940	52,811	11,490,424	801	759	3,900,323
	2014	25.2%	0	0	32	1,485	3,336	11,849	47,260	5,888,934	703	664	3,920,110
	2015	23.5%	0	0	0	1,214	2,751	9,315	33,805	3,133,482	550	521	3,936,347

(continued)

Table A1. (continued)

	Year	% >$0	p25	p50	p75	p90	p95	p99	p99.9	Max	Mean	Mean top coded	*N*
Medical collections balance	2011	20.0%	0	0	0	736	2,108	9,829	43,677	1,345,653	512	473	3,929,095
	2012	20.3%	0	0	0	753	2,145	9,986	44,774	1,415,268	522	483	3,899,937
	2013	21.0%	0	0	0	824	2,295	10,425	46,565	914,065	551	511	3,900,323
	2014	20.8%	0	0	0	828	2,308	10,578	47,390	898,881	558	516	3,920,110
	2015	20.2%	0	0	0	780	2,193	9,913	43,961	789,278	522	484	3,936,347
New derogatory balances excluding mortgage	2010	15.2%	0	0	0	435	1,721	15,630	63,122	2,205,600	636	597	3,935,861
	2011	15.3%	0	0	0	417	1,504	13,093	59,285	2,790,000	558	518	3,929,095
	2012	15.5%	0	0	0	448	1,631	14,231	64,461	2,440,990	606	566	3,899,937
	2013	14.9%	0	0	0	393	1,420	12,065	59,955	1,576,115	531	491	3,900,323
	2014	14.8%	0	0	0	421	1,482	12,248	60,859	2,355,213	542	501	3,920,110
	2015	14.3%	0	0	0	387	1,418	11,956	59,906	5,369,786	525	484	3,936,347

Note. Monetary values are expressed in constant 2015 dollars. Top coded mean estimates are based on data that were top coded at the 99.9th percentile by year. Data on medical collections are not available for 2010.

values, mostly for nonmedical collection balances. While it is not clear that these extreme cases are misreported values, it is reasonable to hypothesize that the Medicaid expansions did not reduce (or cause) balances in nonmedical collections, or changes thereof, in the millions of dollars. The fact that the maximum values for medical collections do not exceed $1.4 million in a given year supports this proposition.

To address this issue throughout this analysis we top-coded the data at the 99.9th percentile by year. We prefer this strategy for two reasons. First, this method addresses the issue in such a way that does impose judgment on whether particular values are misreported, which we cannot discern with confidence from the data. Second, by top coding only 0.1% of the data by year we affect a very small proportion of the data while gaining confidence that our main results are not influenced by extreme values. Note that due to computing constrains using this very large data set we are not able to implement more formal diagnostics such as "robust regression" (e.g., Stata's command "rreg").

Alternative Specifications and Placebo Tests

To test the robustness and validity of our main results we estimate several alternative model specifications reported in Table A2, some of which are also used in the work by Mazumder and Miller (2016) who studied the Massachusetts health insurance expansion. Results from Specification 1 include county fixed effects, and correspond to those reported in Table 3. Table A2 reports only the main coefficient estimate of interest for each model, the corresponding standard error in parenthesis and *p* value in brackets. Specification 2 allows outcomes in each state to follow state-specific trends in the most flexible way possible by including state-year fixed effects. This could be important, for example, if states recovered uniquely from the great recession, which could threaten the assumptions of our identification strategy. Outcomes not robust to the inclusion of state-specific time trends include medical collections balance $1,000 or more and new bankruptcy filings, which are no longer significant, and balance past due as a percentage of total, which is significant but changes sign. Results for credit score and new derogatory balances increase in magnitude (absolute value).

Similarly, Specification 3 accounts for county-specific trends in outcomes with the inclusion of county-year fixed effects. All results are robust to county-specific time trends except balance past due as a percent of total and recent bankruptcy filings, and coefficient estimates for the remaining outcomes are greater in magnitude with respect to Specification 1. These results are reassuring as these models also effectively control for unobserved state- or county-level factors, which change over time that we have not explicitly accounted for.

To account for unobservable time-invariant characteristics specific to age categories (18 to 39, 40 to 64) within each county, Specification 4 includes county age category fixed effects. Therefore, this model relies on variation within each county age category over time. Results for medical collections in the previous 6 months, total balance as a percent of total, new derogatory balance $1,000 or more, and bankruptcy filing in the previous 6 months are robust to this specification; results for any new

Table A2. Alternative Model Specifications.

Specification (Description identifies difference with respect to Specification 1)	Credit risk score	Balance past due as a % of total	Medical collections ≥$1,000	Medical collection last 6 months	Derogatory balance last 6 months >$0	Derogatory balance last 6 months ≥$1,000	Bankruptcy filed last 6 months
(1) Base specification: All states and county fixed effects	0.6 (0.3) [.032]	−0.0001 (0.0000) [.029]	−0.0010 (0.0005) [.077]	−0.0015 (0.0004) [.000]	−0.0019 (0.0006) [.004]	−0.0016 (0.0004) [.001]	−0.0001 (0.0000) [.000]
(2) State-year fixed effects	1.4 (0.3) [.000]	0.0001 (0.0000) [.027]	−0.0011 (0.0008) [.158]	−0.0013 (0.0005) [.017]	−0.0035 (0.0007) [.000]	−0.0022 (0.0004) [.000]	0.0000 (0.0000) [.132]
(3) County-year fixed effects	1.2 (0.3) [.001]	0.0000 (0.0001) [.887]	−0.0026 (0.0005) [.000]	−0.0020 (0.0004) [.000]	−0.0036 (0.0007) [.000]	−0.0025 (0.0004) [.000]	0.0000 (0.0000) [.958]
(4) County-age group fixed effects	0.2 (0.2) [.175]	−0.0001 (0.0000) [.005]	0.0000 (0.0004) [.914]	−0.0009 (0.0004) [.016]	−0.0007 (0.0004) [.101]	−0.0008 (0.0003) [.019]	−0.0001 (0.0000) [.017]
(5) Excluding early, late, and 1115 waiver states	0.1 (0.2) [.481]	−0.0001 (0.0001) [.126]	−0.0003 (0.0006) [.663]	−0.0011 (0.0004) [.016]	−0.0007 (0.0006) [.249]	−0.0008 (0.0004) [.054]	−0.0001 (0.0000) [.053]
(6) High exposure subsample (DD)	2.3 (1.6) [.163]	−0.0011 (0.0005) [.036]	−0.0025 (0.0033) [.448]	−0.0134 (0.0027) [.000]	−0.0110 (0.0038) [.006]	−0.0112 (0.0040) [.008]	−0.0015 (0.0004) [.001]
(7) Low exposure subsample (DD)	0.9 (0.7) [.196]	0.0001 (0.0002) [.772]	−0.0055 (0.0024) [.027]	−0.0115 (0.0024) [.000]	−0.0060 (0.0022) [.010]	−0.0056 (0.0016) [.001]	0.0002 (0.0002) [.301]
(8) Low credit score subsample	0.2 (0.1) [.149]	−0.0002 (0.0001) [.002]	−0.0001 (0.0007) [.909]	−0.0011 (0.0005) [.034]	−0.0018 (0.0008) [.019]	−0.0017 (0.0005) [.001]	−0.0001 (0.0001) [.054]
(9) High credit score subsample	0.3 (0.1) [.006]	0.0000 (0.0000) [.010]	0.0000 (0.0001) [.719]	0.0000 (0.0001) [.728]	0.0000 (0.0001) [.904]	0.0000 (0.0000) [.676]	0.0000 (0.0000) [.000]
(10) Medical debt in collections at some point prior to expansions	0.4 (0.3) [.173]	−0.0002 (0.0001) [.009]	−0.0007 (0.0012) [.598]	−0.0034 (0.0010) [.001]	−0.0038 (0.0014) [.011]	−0.0031 (0.0009) [.002]	−0.0001 (0.0001) [.246]
(11) No medical debt in collections at some point prior to expansions	0.6 (0.2) [.014]	−0.0001 (0.0000) [.116]	0.0005 (0.0002) [.006]	0.0004 (0.0001) [.000]	0.0001 (0.0003) [.723]	0.0000 (0.0002) [.877]	−0.0001 (0.0000) [.000]
(12) Ages 65+	0.1 (0.1) [.398]	0.0000 (0.0000) [.052]	0.0001 (0.0002) [.530]	−0.0001 (0.0002) [.539]	−0.0002 (0.0002) [.363]	−0.0002 (0.0002) [.177]	−0.0002 (0.0000) [.000]

Note. Coefficient estimates from the triple interaction terms are reported—unless indicated by "DD," which indicates differences-in-differences, which measure the change in a given outcome with respect to a percentage point change in exposure to the Medicaid expansions. See Table 3 for additional covariates included but not reported. Standard errors are reported in parentheses and are clustered at the state level. *P* values are reported in brackets. Data on medical collections are not available for the 2010 data.

derogatory balance is marginally insignificant, whereas results for credit score and medical collection balance $1,000 or more is insignificant. The latter result could indicate that there were divergent trends by age category for credit score. Alternatively it could be that the number of post-expansion time periods we observe is too few to measure the effect of the expansions given the significant loss of variation. While the coefficients are closer to zero with respect to Specification 1, the standard errors are comparable with Specification 1.

Specification 5 excludes early expansion states, late expansion states, and 1115 waiver states. Consequently, there is no variation in the length of the pre- or post-expansion time periods among expansion states in this specification, and event time equals calendar time. By August 2015, the last reference period of the data, 18 months passed since the Medicaid expansion implementation date (January 1, 2014). Results for the probability of a medical collection during the previous 6 months, new derogatory balance $1,000 or more, and bankruptcy filings in the last 6 months are robust to this exclusion, while the remaining results are insignificant. Should 18 months be an insufficient amount of time for the full effects of the expansions to materialize it could be expected that the coefficient estimates in this model be smaller in magnitude, or insignificant, compared with Specification 1 that includes early expansion states.

The following two Specifications (6 and 7) are estimated on high and low pre-expansion exposure subsamples, where differences-in-differences coefficient estimates (expansion state times expansion time period) are reported. Here we may expect that results for the high exposure group to be more pronounced. High and low exposure is defined, for each county age-group weighted equally, as a pre-expansion exposure rate above or below the median. The median was 11.9% for ages 18 to 39, and 6.8% for ages 40 to 64. Results for medical collections in the last 6 months are significant for both models, and slightly in absolute value for the high exposure group. Estimates from either model suggest that the Medicaid expansions decreased the probability of a medical collection by approximately one percentage point (or approximately 20%) among all individuals age 18 to 64. Results for medical collections balance $1,000 or more is only significant for the low-exposure sample, which is unexpected, and both credit score results are insignificant for both specifications. However, results for balance past due as a percent of total, new derogatory balance (any and $1,000 or higher) and recent bankruptcy filings are more consistent are either larger or only significant for the high exposure group, which is generally consistent with our hypothesis.

Should individuals with lower credit scores also be more likely uninsured and have lower incomes, the measured effects of the Medicaid expansions should be stronger among the low credit score group. Specifications 8 and 9 stratify the sample into low and high credit score groups respectively based on the median vantage credit score in 2011 across all consumers age 18 to 64, which was 666. Results for the low credit score group are generally greater (in absolute value) or significant compared with the high credit score group. Two exceptions are results for medical collection balance $1,000 or more, which is insignificant for both Specifications, 8 and 9, and credit score that is significant only for the high score sample.

The following specifications, 10 and 11, split the sample by whether individuals had any medical collections up to three years prior to the Medicaid expansion. Should those with medical collections at one point in time be more likely to have future medical collections, and the Medicaid expansions reduce the probability financial distress, we may expect a larger impact among those who had medical collections prior to the expansions. Twenty-nine percent of overall person-year observations correspond to the group with prior medical collections. Most results are consistent with the hypothesis in that they are either larger in magnitude (absolute value) or significant for Specification 10 compared with Specification 11. There are three exceptions. Results for credit score, recent bankruptcy filings, and medical collections balance $1,000 or more are only significant among those with no prior medical collections balance. Also the significant result for large medical collection balance is positive, albeit small in magnitude.

Specification 12 includes only individuals age 65 and older, where we use the county-level exposure rate for those aged 18 to 64. These models serve as a placebo test as this age-group is not directly affected by the Medicaid expansions. Results are insignificant for all outcomes except balance past due as a percent of total and recent bankruptcy filings.

Finally, results from a regression model corresponding to Equation (2), where the county-level unemployment rate equals the dependent variable (instead of an explanatory variable), reveal statistically insignificant results for the triple interaction term of interest (−0.0348; $p = .288$). This is a falsification test used in previous studies and is valid insofar the ACA Medicaid expansions did not cause a change in the unemployment rate. That said there may be concern about the validity using the unemployment rate as a placebo test given recent work on the "job lock" hypothesis (Dague, DeLeire, & Leininger, 2014; Garthwaite, Gross, & Notowidigdo, 2014). Should individuals no longer work with increased access to health insurance outside the workplace, unemployment may change insofar as the Medicaid expansions influence the labor market overall.

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Notes

1. See Sommers, Arntson, Kenney, and Epstein (2013) and Sommers, Kenney, and Epstein (2014) for more details on the Medicaid expansions prior to 2014, as well as Harbage and King (2012) for details on the California expansions.
2. As of March 2016, Louisiana had yet to implement their expansion.
3. New Jersey and Washington were technically early expansion states. However, in these states existing enrollees were transferred to new programs, and no new beneficiaries were enrolled prior to 2014 (Sommers et al., 2013).
4. As discussed in more detail in the following section, August 2015 corresponds to the reference period of the most recent data used in this analysis. Consequently, Alaska and Montana are considered nonexpansion states throughout this work.
5. The legal agreement with the credit bureau states that we cannot use the bureau's name unless given permission. Consequently, we use the generic language "credit bureau" throughout this article. The data obtained from the credit bureau are confidential and proprietary to the credit bureau. These data may be used for research but they cannot be transferred to third parties.
6. The work by Brevoort et al. (2015) studies consumers with limited credit histories in two groups. The first are "unscoreable" consumers who have a credit record that is sufficiently limited such that it is not possible to estimate a credit score for the consumer. "Credit invisibles" are consumers that do not have any credit record. The data in this study include the "unscorable" but not "credit invisibles."
7. New medical collections and bankruptcy filings were derived from information on the number of months since a given consumer's most recent medical collection or bankruptcy filing (if any). Results are very similar when we used the definition: one or more medical collections or bankruptcy filing in the previous 12 months. Note that we do not have similar information on the number of months since the most recent nonmedical collection in our data, and consequently are not able to similarly study the flow of nonmedical collections. Finally, we do not have information on new derogatory debt balances other than those which occurred in the previous 6 months.
8. It is possible that related individuals are included in these data. However, we are not able to identify relationships between consumers in the data.
9. This approach is similar to a traditional difference-in-differences model, with the modification of an additional interaction term with the difference-in-differences estimator that is continuous.
10. Two states, Alaska and Montana, expanded after August 2015, the reference period of our last year of credit bureau data. These states are included throughout the analysis and are classified as nonexpansion states.
11. IN and PA have five periods of pre-expansion data; DC, CT, MN, and 48 counties in CA have three or more post-expansions periods.
12. Medical collections data are not available for 2010. Consequently, we modify these models slightly for these outcomes accordingly; that is, $t = (-3 \text{ or more}, -2, -1, 0, 1, \text{or more})$.
13. For Pennsylvania and Indiana, who expanded in 2015, we use 2013 data which is the most recent SAHIE data available.
14. Medical collections data are not available for 2010.
15. A recent report, using a similar sample of data from a credit bureau, reported that 19.4% of all consumer credit reports (all ages and all states) include one or more medical collection trade lines (Consumer Financial Protection Bureau, 2014). The estimated prevalence of medical collections using our data is comparable.

References

Bauder, M., Luery, D., & Szelepka, S. (2015). *Small area estimation of health insurance coverage in 2010-2013*. Washington, DC: U.S. Census Bureau. Retrieved from http://www.census.gov/did/www/sahie/methods/files/sahie_tech_2010_to_2013.pdf

Bertrand, M., Duflo, E., & Mullainathan, S. (2004). How much should we trust differences-in-differences estimates? *Quarterly Journal of Economics*, *119*, 249-275. doi:10.1162/003355304772839588

Blumberg, L. J, Waidmann, T. A., Blavin, F., & Roth, J. (2014). Trends in health care financial burdens, 2001 to 2009. *Milbank Quarterly*, *92*, 88-113. doi:10.1111/1468-0009.12042

Brevoort, K. P., Grimm, P., & Kambara, M. (2015). *Data point: Credit invisibles*. Washington, DC: Consumer Financial Protection Bureau. Retrieved from http://www.consumerfinance.gov/reports/data-point-credit-invisibles/

Bureau of Labor Statistics. (2016a). *Consumer price index: All urban consumers. U.S. All Items, 1967=100-CUUR0000AA0*. Retrieved from http://data.bls.gov/cgi-bin/surveymost?cu.

Bureau of Labor Statistics. (2016b). *Local area unemployment statistics: County data*. Retrieved from http://www.bls.gov/lau/#tables

Carman, K. G., Eibner, C., & Paddock, S. M. (2015). Trends in health insurance enrollment, 2013-15. *Health Affairs*, *34*, 1044-1048. doi:10.1377/hlthaff.2015.0266

Caswell, K. J., Waidmann, T. A., & Blumberg, L. J. (2012). *The financial burden of medical spending among the non-elderly, 2010* (ACA Implementation–Monitoring and Tracking Report). Washington, DC: Robert Wood Johnson Foundation. Retrieved from http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412696-The-Financial-Burden-of-Medical-Spending-Among-the-Non-Elderly-.PDF

Caswell, K. J., Waidmann, T. A., & Blumberg, L. A. (2014). Financial burden of medical out-of-pocket spending by state and the implications of the 2014 Medicaid expansions. *Inquiry*, *50*, 177-201. doi:10.1177/0046958013516590

Consumer Financial Protection Bureau. (2014). *Consumer credit reports: A study of medical and non-medical collections*. Washington, DC: Author. Retrieved from http://www.consumerfinance.gov/reports/consumer-credit-reports-a-study-of-medical-and-non-medical-collections/

Currie, J., & Gruber, J. (1996). Saving babies: The efficacy and cost of recent changes in the Medicaid eligibility of pregnant women. *Journal of Political Economy*, *104*, 1263-1296.

Dague, L., DeLeire, T., & Leininger, L. (2014). *The effect of public insurance coverage for childless adults on labor supply* (NBER Working Paper No. 20111). Cambridge, MA: National Bureau of Economic Research. Retrieved from http://www.nber.org/papers/w20111.pdf

Finkelstein, A., Hendren, N., & Lutttmer, E. F. P. (2015). *The value of Medicaid: Interpreting results from the Oregon Health Insurance Experiment* (NBER Working Paper No. 21308). Cambridge, MA: National Bureau of Economic Research. Retrieved from http://www.nber.org/papers/w21308.pdf

Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J. P., . . . Oregon Health Study Group. (2012). The Oregon Health Insurance Experiment: Evidence from the first year. *Quarterly Journal of Economics*, *127*, 1057-1106. doi:10.1093/qje/qjs020

Garthwaite, C., Gross, T., & Notowidigdo, M. J. (2014). Public health insurance, labor supply, and employment lock. *Quarterly Journal of Economics*, *129*, 653-696. doi:10.1093/qje/qju005

Gross, T., & Notowidigdo, M. J. (2011). Health insurance and the consumer bankruptcy decision: Evidence from expansions of Medicaid. *Journal of Public Economics*, *95*, 767-778. doi:10.1016/j.jpubeco.2011.01.012

Harbage, P., & King, M. (2012). *A bridge to reform: California's Medicaid Section 1115 Waiver*. Oakland, CA: California Healthcare Foundation. Retrieved from http://www.chcf.org/publications/2012/10/bridge-to-reform

The Henry J. Kaiser Family Foundation. (2016). *Status of state action on the Medicaid expansion decision*. Retrieved from http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Hill, S. C. (2015). Medicaid expansion in opt-out states would produce consumer savings and less financial burden than exchange coverage. *Health Affairs*, *34*, 340-349. doi:10.1377/hlthaff.2014.1058

Hu, L., Kaestner, R., Mazumder, B., Miller, S., & Wong, A. (2016). *The effect of the Patient Protection and Affordable Care Act Medicaid expansions on financial well-being* (NBER Working Paper No. 22170). Cambridge, MA: National Bureau of Economic Research. Retrieved from http://www.nber.org/papers/w22170

Mazumder, B., & Miller, S. (2016). The effects of the Massachusetts health reform on financial distress. *American Economic Journal*, *8*, 284-313.

Miller, S. (2012). The effect of insurance on emergency room visits: An analysis of the 2006 Massachusetts health reform. *Journal of Public Economics*, *96*, 893-908. doi:10.1016/j.jpubeco.2012.07.004

Sommers, B. D., Arntson, E., Kenney, G. M., & Epstein, A. M. (2013). Lessons from early Medicaid expansions under health reform: Interviews with Medicaid officials. *Medicare & Medicaid Research Review*, *3*, E1-E19. doi:10.5600/mmrr.003.04.a02

Sommers, B. D., Kenney, G. M., & Epstein, A. M. (2014). New evidence on the Affordable Care Act: Coverage impacts of early Medicaid expansions. *Health Affairs*, *33*, 78-87. doi:10.1377/hlthaff.2013.1087

U.S. Census Bureau. (2016). *Small Area Health Insurance Estimates (SAHIE): Data inputs*. Retrieved from http://www.census.gov/did/www/sahie/methods/inputs/index.html.

Wherry, L. R., & Miller, S. (2016). Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansions: A quasi-experimental study. *Annals of Internal Medicine*, *164*, 795. doi:10.7326/M15-2234

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How Would Coverage, Federal Spending, and Private Premiums Change if the Federal Government Stopped Reimbursing Insurers for the ACA's Cost-Sharing Reductions?

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Timely Analysis of Immediate Health Policy Issues

SEPTEMBER 2017

In-Brief

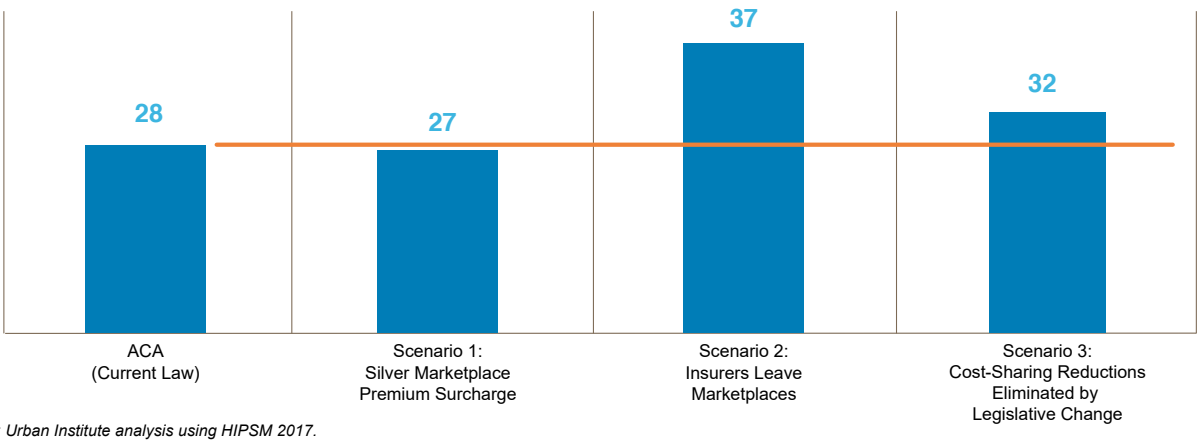
The Affordable Care Act (ACA) requires insurers to provide cost-sharing reductions (CSRs) that lower deductibles, co-payments, co-insurance, and out-of-pocket maximums for people eligible for nongroup market premium tax credits with incomes below 250 percent of the federal poverty level (FPL). But there is tremendous uncertainty about whether insurers will continue to be reimbursed by the federal government for these CSRs. We analyze three 2018 scenarios that could occur if federal CSR payments stop. Our main findings are as follows:

Scenario 1. If insurers have enough time before the start of the plan year to incorporate their anticipated CSR costs into a surcharge placed on silver marketplace premiums and are willing to remain in the marketplaces, then the surcharge would increase silver premiums by 23 percent in 2018. About 600,000 more people would enroll in marketplace coverage, reducing the number of uninsured. However, the federal government would spend 18 percent more on premium tax credits than it would have spent on tax credits and CSRs combined under current law, an additional $7.2 billion in 2018.

Scenario 2. If insurers exit the marketplaces in response to the loss of CSRs and other policy uncertainties and changes (e.g., lack of clarity on intended enforcement of the individual mandate and the administration's substantially reduced commitment to outreach and enrollment assistance), then the number of uninsured people would increase by 9.4 million, enrollment in the private nongroup market would decrease by 57 percent, and nongroup premiums would rise by 37 percent. Eliminating the tax credits and CSRs would reduce federal spending on this assistance by $40.7 billion in 2018.

Scenario 3. If lawmakers alter the ACA in response to the elimination of CSRs such that insurers are no longer required to pay CSRs to eligible enrollees, 4.0 million more people would be uninsured, and nongroup premiums would rise by 12 percent.

Number of Uninsured Nonelderly People Under The ACA and Three Scenarios with No Cost-Sharing Reductions (Millions) (Figure 1, Page 5)



Source: Urban Institute analysis using HIPSM 2017.

Introduction

There is tremendous uncertainty about whether insurers will be reimbursed by the federal government for future cost-sharing reductions (CSRs) paid to their low-income private nongroup marketplace enrollees. The Affordable Care Act (ACA) requires insurers to provide these subsidies, which lower deductibles, co-payments, co-insurance, and out-of-pocket maximums for people eligible for nongroup market premium tax credits who have incomes below 250 percent of FPL and purchase silver-level (70 percent actuarial value) marketplace coverage.[1] In December 2016, the U.S. House of Representatives sued the Obama administration over CSRs, arguing that the Treasury could not reimburse insurers for these subsidies because the funds had not been explicitly appropriated by Congress.[2] Hearings on the lawsuit have been delayed at the request of the Trump administration and the House, and the federal government is now paying the insurer reimbursements one month at a time with no commitment to continue. Congress could appropriate funds to make the payments and end the uncertainty, but so far it has not exercised this power.

The parties to the lawsuit agree on at least one issue: Marketplace insurers are required to provide eligible enrollees with the CSRs, regardless of whether the federal government reimburses the insurers for those incurred expenses. The CSRs bring the actuarial value of silver coverage up from 70 percent to 94 percent for people with incomes between 100 and 150 percent of FPL, to 87 percent for people with incomes between 150 and 200 percent of FPL, and to 73 percent for people with incomes between 200 and 250 percent of FPL.[3]

Uncertainty over whether reimbursements will continue has discouraged some insurers from selling coverage in the nongroup marketplaces for plan year 2018 and has led others to request substantially larger premium increases than they otherwise would have.[4–11] This brief analyzes the implications of ending federal CSR reimbursements to insurers under three response scenarios (Box 1). The first scenario, an update of our earlier work on this topic,[12] assumes that insurers have enough time before the start of the plan year to incorporate their anticipated CSR costs into a surcharge placed on silver marketplace premiums and that insurers are willing to remain in the marketplaces. At least one state, California,[13] required insurers to submit premiums computed under these assumptions. The second scenario assumes that insurers leave the nongroup marketplaces entirely, leaving eligible people no opportunity to use their premium tax credits, but unsubsidized coverage is still offered in the nonmarketplace nongroup market. Insurers may leave the marketplaces in response to uncertainty about and changes in other important policies in addition to the loss of CSRs, such as the federal government's lack of clarity on the intent to enforce the individual mandate and its substantially reduced commitment to marketplace outreach and enrollment assistance. In practice, Scenario 1 may occur in some states or substate areas while Scenario 2 occurs in others. The third scenario assumes that lawmakers alter the ACA in response to the elimination of CSRs such that insurers are no longer required to pay CSRs to eligible enrollees. In this scenario, eligible individuals would still have marketplace insurance options and could still use their premium tax credits, but people with incomes below 250 percent of FPL would face the full out-of-pocket requirements of their chosen plan.

Box 1. Modeling Scenarios for Nongroup Marketplaces, Assuming No Federal Funding of Cost-Sharing Reductions

	Premium tax credits available?	Cost sharing reductions available to low income people?	Insurers leave market places?	Legislation required?
Scenario 1: Insurers incorporate their anticipated CSR costs into a surcharge placed on silver marketplace premiums only, and insurers stay in the marketplaces	Yes	Yes	No	No
Scenario 2: Insurers leave the nongroup marketplaces entirely	No	No	Yes	No
Scenario 3: Insurers are no longer required to pay CSRs	Yes	No	No	Yes

CSR = cost-sharing reduction

Methodology

We simulate these three scenarios using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[14] We start with a simulation of the ACA in 2018, assuming no change to current law or CSR payments. The model takes into account actual 2017 marketplace and Medicaid/CHIP enrollment data by state, as well as 2017 marketplace premiums, and it reproduces the reported national distribution of marketplace enrollment with premium tax credits and CSRs by income and age. We compare our simulation of the ACA in 2018 with three alternative scenarios that could occur if the federal government declines to reimburse insurers for CSRs (Box 1). All estimates assume that the changes have their full effect starting in the first year. In reality, these changes may take more than one premium rating cycle to reach equilibrium, unless insurers accurately anticipate the resulting adverse selection; we do not model that time path here.

We estimate the coverage implications of each scenario by income group as well as changes in the number of uninsured people by state. We also estimate the changes in federal spending that would result from each scenario and any associated changes in unsubsidized premiums.

This analysis builds on our January 2016 analysis of *House v. Burwell*.[12] The earlier analysis focused exclusively on the first of the three scenarios simulated here and used an earlier version of HIPSM that did not have the current enrollment data under the ACA and was built upon the Current Population Survey, limiting its ability to simulate state insurance markets. The current version of HIPSM uses two merged years of American Community Survey data and has been updated to take into account actual premium and enrollment data for plan year 2017. Other analyses of the implications of eliminating CSRs conducted by the Kaiser Family Foundation[15,16] and the Congressional Budget Offic [17] focused exclusively on what we refer to as Scenario 1. The Kaiser Family Foundation provided 2016 premium effect estimates nationally and for 38 states but did not provide federal spending effects by state, and the Congressional Budget Office did not provide any state-specific estimates.

Box 2. Rationale for Scenario 1 Assumptions

In Scenario 1, insurers recoup their full expenditures on CSRs by building those costs into all their silver plan premiums in the marketplaces. Consistent with other analyses,[17] and our previous work,[12] we do not think that insurers would spread these costs beyond their silver plan premiums or load them only into premiums for CSR plans, for several reasons. First, the ACA does not permit insurers to charge different premiums for enrollees in CSR silver plans and enrollees in standard silver plans. Second, if insurers spread the CSR costs across other plan premiums, they would be charging those enrollees for a higher actuarial value of coverage than would be provided. This would discourage people from enrolling in these options through the marketplaces, and insurers would not want to create such disincentives. Spreading the costs across all tiers would mean increasing the prices of all products, and any insurer that did so would place itself at a disadvantage compared with lower-priced competitors that did not. Third, the federal government, state-based marketplace management, and state departments of insurance do not generally seem interested in actively managing insurers' pricing policies. Where the law allows, they have usually allowed insurers to determine their own policies and are reluctant to interfere unless required to enforce specific provisions of the ACA. A few states, such as California, have actively negotiated marketplace premiums with insurers, but other states have no clear incentive for requiring that CSR costs be spread across all marketplace products. Thus, we believe the most likely scenario is that the marketplace and regulators would allow insurers to build CSR expenses into their silver plan premiums only.

In addition, we do not expect insurers to spread the costs of CSRs to coverage for silver plans sold outside the marketplaces. Although section 1301(a)(1)(C)(iii) of the ACA requires that qualified health plans offer the same premiums inside and outside the marketplaces, we assume that elimination of federal CSR funding would create a strong incentive for insurers to offer ACA-compliant but non–Qualified Health Plan options outside the marketplaces, allowing insurers to charge different premiums for them. Many insurers already offer different plans inside and outside the marketplaces, so this should not be viewed as a significant burden on insurers. If insurers spread the costs associated with CSRs to their nonmarketplace plans, they would place themselves at a competitive disadvantage with insurers only selling nonmarketplace coverage because the latter have no such costs to cover. Thus, in our simulations and consistent with federal law, the health care risk of the nongroup market inside and outside the marketplaces is shared broadly, although the additional premium cost associated with CSRs is included in the marketplace silver plan premiums alone, effectively as a premium surcharge. HIPSM computes the costs associated with providing CSRs, calculates the premium "add-on" necessary to cover those costs, and increases the marketplace silver plan premiums accordingly. Premium tax credits are recomputed because they are tied to the now higher second-lowest-cost marketplace silver plan premium, individual and household decisions are made, the costs associated with the CSRs are recomputed, and the process iterates until it reaches equilibrium (i.e., until there are few or no additional changes under additional iterations of the model).

Results

Insurance Coverage Distribution Under the ACA and Three No-CSR Response Scenarios

Table 1 shows the 2018 national health insurance coverage distribution for the nonelderly population (under age 65) under current law and under the three simulated response scenarios. If Congress decides to explicitly appropriate CSRs, the outcome would be the same as the current law (ACA) results. Scenario 1, where insurers increase silver marketplace premiums to compensate for their costs associated with providing CSRs, would increase insurance coverage modestly, with 600,000 fewer people uninsured (Figure 1). This would occur because the surcharge added to silver marketplace coverage would increase the premium tax credit benchmark premiums, increasing the dollar value of the tax credits for eligible people with incomes up to 400 percent of FPL. The increased tax credits would allow people with incomes between 200 and 400 percent of FPL to purchase higher actuarial value (gold) plans at the same premium contribution that they are currently paying for silver coverage (or, for those with incomes between 200 and 250 percent of FPL, for 73 percent actuarial value plans). Nongroup enrollment would increase among people eligible for tax credits because the larger tax credit would allow them to purchase richer coverage for the same share of income (Figure 2).

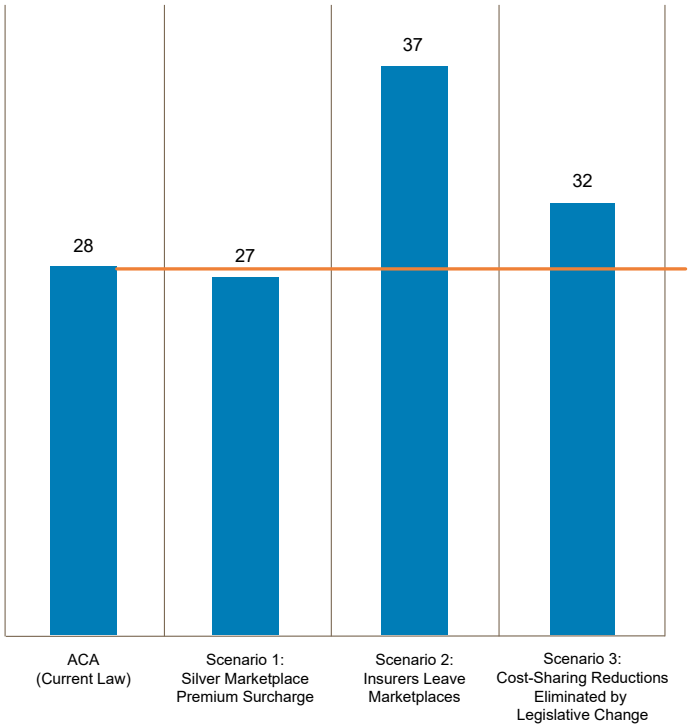
Under Scenario 2, where insurers refuse to sell coverage in the marketplaces because the federal government would no longer reimburse them for their CSR expenses, the number of uninsured people would increase by 9.4 million in 2018 (Figure 1 and Table 1). In this scenario, insurers would sell nongroup coverage in the *non*marketplace segment of the market, but people eligible for premium tax credits would have nowhere to use them. Nongroup insurance enrollment among people eligible for tax credits would fall by 7.1 million people, or 73 percent, and the resulting increase in premiums from the exit of this largely healthy population would lead to an additional coverage loss of 4.0 million people (41 percent) who have nongroup insurance but are ineligible for tax credits. Thus, total nongroup enrollment would fall by 57 percent, from 19.4 million under current law to 8.3 million people (Figure 2 and Table 1). About 1.6 million people, mostly children, would lose Medicaid or CHIP coverage, because parents would not seek marketplace coverage and thus would not learn that their children are eligible for a public program. About 3.3 million people losing their source of coverage would enroll in employer-based insurance, with the bulk of this group purchasing employer coverage deemed unaffordable for them under federal law.

Table 1. Health Insurance Coverage Distribution of the Nonelderly Under the ACA and Three Scenarios With No Cost-Sharing Reductions, 2018 (Millions of people)

	ACA		Scenario 1		Difference	Scenario 2		Difference	Scenario 3		Difference
	(Current Law)		Silver Marketplace Premium Surcharge			Insurers Leave Marketplaces			Cost Sharing Reductions Eliminated		
Insured	**245.8**	**90%**	**246.4**	**90%**	**0.6**	**236.4**	**86%**	**-9.4**	**241.7**	**88%**	**-4.0**
Employer	148.8	54%	148.8	54%	0.0	152.1	56%	3.3	151.8	55%	2.9
Nongroup—eligible for tax credit	9.7	4%	10.2	4%	0.5	2.6	1%	-7.1	6.4	2%	-3.3
Nongroup—other	9.7	4%	9.7	4%	0.0	5.7	2%	-4.0	6.9	3%	-2.8
Medicaid/CHIP	69.0	25%	69.0	25%	0.0	67.4	25%	-1.6	68.1	25%	-0.9
Other (including Medicare)	8.5	3%	8.5	3%	0.0	8.5	3%	0.0	8.5	3%	0.0
Uninsured	**27.7**	**10%**	**27.1**	**10%**	**-0.6**	**37.1**	**14%**	**9.4**	**31.8**	**12%**	**4.0**
Total	**273.5**	**100%**	**273.5**	**100%**	**0.0**	**273.5**	**100%**	**0.0**	**273.5**	**100%**	**0.0**

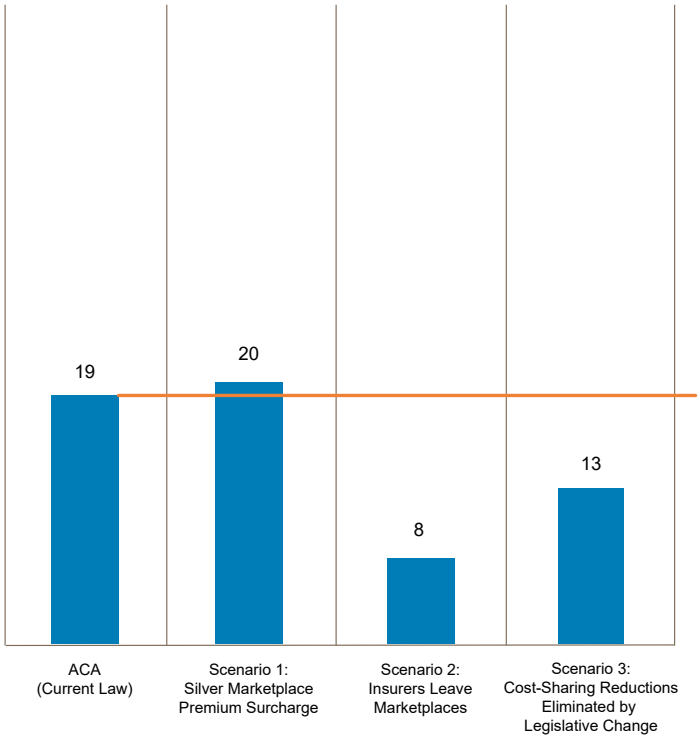
Source: Urban Institute analysis using HIPSM 2017.

Figure 1. Number of Uninsured Nonelderly People Under The ACA and Three Scenarios with No Cost-Sharing Reductions (Millions)



Source: Urban Institute analysis using HIPSM 2017.

Figure 2. Number of Nonelderly People with Private Nongroup Insurance Under the ACA and Three Scenarios with No Cost-Sharing Reductions (Millions)



Source: Urban Institute analysis using HIPSM 2017.

Scenario 3 assumes that a legislative change would allow insurers to sell marketplace coverage without requiring that CSRs be paid to eligible enrollees; thus, premium tax credits could still be used. In this scenario, 3.3 million people enrolled in nongroup coverage using their premium tax credits and CSRs would drop coverage because of the higher out-of-pocket requirements. The loss of these covered lives would raise nongroup premiums, decreasing the number enrolled in unsubsidized nongroup coverage by 2.8 million people. Total nongroup enrollment would fall by 32 percent to 13.3 million people (Figure 2 and Table 1). A smaller number of children would lose their Medicaid/CHIP coverage under this scenario (compared to scenario 2), and 2.9 million people would newly enroll in employer coverage. But again, most of these people would be opting into employer coverage deemed unaffordable under federal law. On net, the number of people uninsured would increase by 4.0 million (Figure 1 and Table 1).

Insurance Coverage by Income Group Under the ACA and Three No-CSR Response Scenarios

Table 2 shows how changes in coverage under each scenario would be distributed across people in different income groups. The top panel of the table provides the total number of people in each coverage type and income group under the ACA; this is the scenario if CSR payments are made. The next three panels show the percent change in coverage of each type within each income group under scenarios 1, 2, and 3.

Under Scenario 1, decreases in the number of uninsured people are concentrated among those with incomes between 200 and 400 percent of FPL. These decreases come from 9 to 18 percent increases in nongroup coverage using tax credits, depending upon the income group. Tax credits for people in each income group increase in value under this scenario because of the increase in the silver benchmark premium. This benchmark increase yields larger tax credits and thus allows eligible people to purchase higher-

Table 2. Percent Change in Health Insurance Coverage Under Three No-Cost-Sharing Reduction Scenarios Relative to the ACA, by Income, 2018

	< 100% of FPL	100–150% of FPL	150–200% of FPL	200–250% of FPL	250–300% of FPL	300–400% of FPL	> 400% of FPL	Total
ACA (current law)								
Millions of people								
Insured	**50.0**	**23.7**	**21.8**	**18.6**	**17.5**	**30.6**	**83.6**	**245.8**
Employer	7.4	7.3	10.7	12.3	13.1	25.0	73.0	148.8
Nongroup—eligible for tax credit	0.1	2.5	2.8	1.3	1.1	1.8	0.0	9.7
Nongroup—other	0.6	0.4	0.4	0.5	0.5	0.9	6.4	9.7
Medicaid/CHIP	40.1	12.4	6.8	3.6	2.1	1.9	2.2	69.0
Other (including Medicare)	1.8	1.2	1.0	0.8	0.7	1.1	1.9	8.5
Uninsured	**8.4**	**2.1**	**2.4**	**2.2**	**1.5**	**1.7**	**9.4**	**27.7**
Total	**58.5**	**25.8**	**24.1**	**20.8**	**19.0**	**32.3**	**93.0**	**273.5**
Scenario 1: Silver Marketplace Premium Surcharge								
Percent change relative to the ACA								
Insured	**0%**	**0%**	**0%**	**1%**	**1%**	**1%**	**0%**	**0%**
Employer	0%	0%	0%	0%	0%	0%	0%	0%
Nongroup—eligible for tax credit	0%	0%	0%	18%	13%	9%	0%	6%
Nongroup—other	0%	0%	1%	2%	1%	1%	0%	0%
Medicaid/CHIP	0%	0%	0%	0%	0%	0%	0%	0%
Other (including Medicare)	0%	0%	0%	0%	0%	0%	0%	0%
Uninsured	**0%**	**0%**	**0%**	**-11%**	**-10%**	**-9%**	**0%**	**-2%**
Total	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Scenario 2: Insurers Leave Marketplaces								
Percent change relative to the ACA								
Insured	**-1%**	**-8%**	**-10%**	**-5%**	**-5%**	**-4%**	**-2%**	**-4%**
Employer	1%	9%	6%	2%	2%	2%	1%	2%
Nongroup—eligible for tax credit	-63%	-85%	-76%	-67%	-64%	-63%	0%	-73%
Nongroup—other	-41%	-25%	-36%	-40%	-46%	-50%	-41%	-41%
Medicaid/CHIP	-1%	-3%	-7%	-5%	-6%	-6%	-4%	-2%
Other (including Medicare)	0%	0%	0%	0%	0%	0%	0%	0%
Uninsured	**6%**	**95%**	**88%**	**45%**	**53%**	**70%**	**20%**	**34%**
Total	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
Scenario 3: Cost Sharing Reductions Eliminated by Legislative Change								
Percent change relative to the ACA								
Insured	**-1%**	**-5%**	**-5%**	**-2%**	**0%**	**0%**	**-1%**	**-2%**
Employer	1%	9%	6%	2%	1%	1%	1%	2%
Nongroup—eligible for tax credit	-36%	-57%	-50%	-29%	0%	0%	0%	-34%
Nongroup—other	-25%	-17%	-26%	-31%	-39%	-43%	-27%	-29%
Medicaid/CHIP	0%	-2%	-5%	-2%	-1%	-2%	-3%	-1%
Other (including Medicare)	0%	0%	0%	0%	0%	0%	0%	0%
Uninsured	**3%**	**53%**	**48%**	**19%**	**5%**	**8%**	**10%**	**15%**
Total	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**

Source: Urban Institute analysis using HIPSM 2017.

Note: FPL = federal poverty level.

value coverage for the same share of income they now spend under the ACA. As a result, the number of uninsured decreases by about 11 percent among people with incomes between 200 and 250 percent of FPL, by 10 percent among those with incomes between 250 and 300 percent of FPL, and by 9 percent among those with incomes between 300 and 400 percent of FPL.

As nongroup coverage increases among tax credit-eligible people under Scenario 1, the nongroup insurance risk pool becomes slightly healthier, leading to slight decreases in premiums for bronze, gold, and platinum coverage and small additional increases in nongroup coverage for the unsubsidized population. The uninsured share of the total nonelderly population would fall by 2 percent.

Under Scenario 2, where insurers exit the marketplaces, the number of uninsured people would increase by 34 percent. Increases in the uninsured are highest among those with incomes between 100 and 400 percent of FPL because people in this income group could no longer use their premium tax credits. People with incomes between 100 and 250 percent of FPL also would lose their CSRs.[18] The number of tax credit-eligible people enrolled in nongroup coverage would fall by 85 percent among those with incomes between 100 to 150 percent of FPL, by 76 percent among those with incomes between 150 and 200 percent of FPL; by 67 percent among people with incomes between 200 and 250 percent of FPL; and by about 63 percent among people with incomes between 250 and 400 percent of FPL. Nongroup market coverage for people ineligible for tax credits under current law would fall by about 41 percent because of worsening average health care risk in the market and related premium increases; these declines would be spread broadly across the income distribution.

Under Scenario 3, where tax credits can still be used but CSRs are eliminated, the number of uninsured people would increase by 15 percent. The highest increases in the uninsured would occur among those currently eligible for CSRs: people with incomes below 250 percent of FPL. Nongroup enrollment would fall by 36 percent among eligible people with incomes below 100 percent of FPL; by 57 percent among those with incomes between 100 and 150 percent of FPL; by 50 percent among those with incomes between 150 and 200 percent of FPL; and by 29 percent among those with incomes between 200 and 250 percent of FPL. The loss of these CSR enrollees would increase average health care risk, raising premiums. Thus, the number of people enrolled in nongroup coverage without tax credits would decline by 29 percent across all income groups.

State-by-State Changes in the Uninsured Under Three No-CSR Response Scenarios, Compared with the ACA

Table 3 shows the change in the number of people uninsured under each scenario by state. Under Scenario 1, the number of people uninsured would decrease modestly in almost every state. States with the largest percent decreases include Rhode Island (8 percent), Arkansas (6 percent), and West Virginia (6 percent). States with little percent change in their uninsured populations include Florida and Wisconsin (less than 1 percent). All these changes are relatively small, but larger changes tend to be found in states with more uninsured people in the income range of 200–400 percent of FPL. This group would be most likely to newly enroll in coverage because higher silver benchmark premiums would allow them to use their premium tax credits to purchase more comprehensive gold coverage at no additional cost.

New York and Minnesota are unique in that they have implemented Basic Health Programs (BHPs) under the ACA. BHPs cover people with incomes up to 200 percent of FPL, so CSRs are only paid for marketplace enrollees with incomes between 200 and 250 percent of FPL. Federal BHP payments were not challenged in *House v. Burwell*, so BHP enrollment likely would not be affected by the lawsuit. As a result, the elimination of CSRs would have a smaller impact in New York and Minnesota under all three scenarios. While other states could adopt BHPs as a strategy to ensure federal funding for CSRs for eligible residents with incomes below 200 percent of FPL, doing so generally requires state legislation and the development of administrative structures to implement a program, and, as a consequence, creating a BHP takes time.

Scenario 2 leads to an increase in the number of uninsured people in every state, affecting those currently enrolled in coverage with premium tax credits as well as those ineligible for the credits; the latter are affected by the worsening insurance pool as the former lose coverage. For example, Florida has had notably higher marketplace participation than average and Texas relatively low marketplace participation under current law. In Scenario 2, Florida would see a 61 percent increase in the uninsured and Texas would only see an 18 percent increase. The percent increase in the uninsured in Massachusetts would be higher than in any other state because its uninsurance rate is extremely low under current law.

Percent changes in the uninsured under Scenario 3 would vary across states based on the current enrollment rates of people eligible for CSRs, but all states would experience some increase in uninsurance. States with low enrollment rates, such as South Dakota and Wyoming, would see smaller percent increases in their uninsured under this scenario. States with high enrollment rates, such as Florida and Vermont, would experience larger percent increases in their uninsured populations. With the effects of Scenario 3 concentrated among marketplace enrollees with incomes up to 250 percent of FPL, the overall impact on the uninsured would be smaller than under Scenario 2.

Changes in Federal Funding Under Three No-CSR Response Scenarios, Compared with the ACA

Figure 3 shows the dollar and percent change in federal funding for marketplace financial assistance nationally under the three scenarios in 2018, compared with that under current law. We estimate that under current law, $40.7 billion would be

Table 3. Uninsured Under the ACA and Three No-Cost-Sharing Reduction Scenarios, by State, 2018 (Thousands of People)

State	ACA	Scenario 1			Scenario 2			Scenario 3		
	(Current Law)	Silver Marketplace Premium Surcharge			Insurers Leave Marketplaces			Cost Sharing Reductions Eliminated		
	Number of Uninsured	Number of Uninsured	Difference from ACA	Percent Change from ACA	Number of Uninsured	Difference from ACA	Percent Change from ACA	Number of Uninsured	Difference from ACA	Percent Change from ACA
Alabama	507	496	-11	-2%	632	125	25%	583	77	15%
Alaska	95	89	-5	-6%	120	25	27%	101	6	6%
Arizona	701	675	-26	-4%	821	120	17%	807	106	15%
Arkansas	159	149	-10	-6%	227	68	42%	182	23	14%
California	2,952	2,921	-31	-1%	4,334	1,382	47%	3,474	523	18%
Colorado	388	385	-3	-1%	476	88	23%	427	38	10%
Connecticut	157	153	-5	-3%	247	90	57%	201	44	28%
Delaware	60	58	-1	-2%	81	22	36%	69	9	15%
District of Columbia	26	26	0	0%	30	4	15%	28	2	8%
Florida	2,210	2,205	-4	0%	3,564	1,354	61%	2,817	608	28%
Georgia	1,598	1,562	-36	-2%	1,928	330	21%	1,725	127	8%
Hawaii	92	90	-2	-2%	104	12	13%	98	6	7%
Idaho	175	169	-6	-4%	258	83	47%	213	37	21%
Illinois	957	935	-23	-2%	1,219	261	27%	1,096	139	15%
Indiana	481	467	-14	-3%	629	148	31%	528	47	10%
Iowa	150	147	-3	-2%	182	32	21%	163	12	8%
Kansas	312	306	-7	-2%	376	64	20%	347	34	11%
Kentucky	199	193	-6	-3%	260	62	31%	219	21	10%
Lousiana	327	316	-11	-3%	461	134	41%	382	55	17%
Maine	79	75	-3	-4%	132	54	68%	101	23	29%
Maryland	350	343	-7	-2%	458	108	31%	397	47	13%
Massachusetts	97	96	-1	-1%	213	116	120%	146	50	52%
Michigan	504	489	-15	-3%	754	250	50%	609	105	21%
Minnesota*	321	321	0	0%	396	75	23%	379	57	18%
Mississippi	384	383	-1	0%	443	59	15%	412	28	7%
Missouri	558	540	-18	-3%	718	160	29%	632	74	13%
Montana	74	72	-2	-3%	121	47	63%	95	21	28%
Nebraska	157	155	-3	-2%	216	59	38%	196	38	24%
Nevada	340	331	-9	-3%	436	95	28%	375	35	10%
New Hampshire	58	55	-3	-6%	93	35	60%	69	12	20%
New Jersey	589	576	-13	-2%	851	262	45%	694	106	18%
New Mexico	168	161	-7	-4%	208	40	24%	182	13	8%
New York*	1,219	1,217	-1	0%	1,648	429	35%	1,311	92	8%
North Carolina	1,125	1,101	-24	-2%	1,555	430	38%	1,348	223	20%
North Dakota	43	41	-1	-3%	65	22	52%	50	7	17%
Ohio	579	549	-30	-5%	775	196	34%	655	76	13%
Oklahoma	557	543	-14	-2%	656	99	18%	608	52	9%
Oregon	240	235	-6	-2%	357	117	49%	294	54	22%
Pennsylvania	543	522	-20	-4%	842	299	55%	703	160	29%

Table 3. Continued

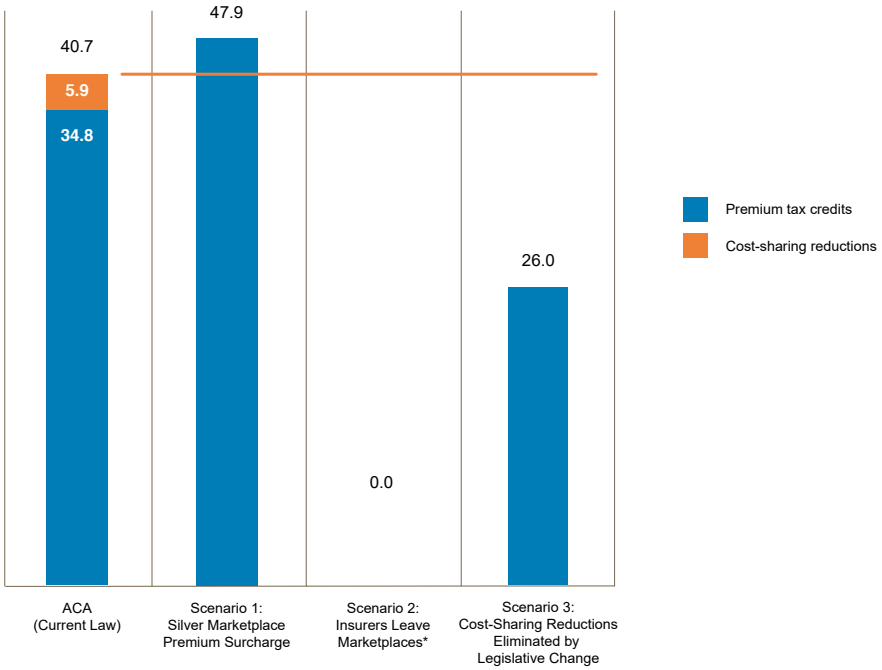
State	ACA (Current Law)	Scenario 1 Silver Marketplace Premium Surcharge			Scenario 2 Insurers Leave Marketplaces			Scenario 3 Cost Sharing Reductions Eliminated		
	Number of Uninsured	Number of Uninsured	Difference from ACA	Percent Change from ACA	Number of Uninsured	Difference from ACA	Percent Change from ACA	Number of Uninsured	Difference from ACA	Percent Change from ACA
Rhode Island	48	44	-4	-8%	75	26	55%	59	11	23%
South Carolina	547	533	-14	-3%	722	174	32%	628	81	15%
South Dakota	84	84	0	0%	108	24	29%	100	16	20%
Tennessee	650	637	-13	-2%	805	155	24%	745	95	15%
Texas	4,686	4,569	-117	-2%	5,531	845	18%	4,980	295	6%
Utah	294	293	-1	0%	425	131	45%	355	61	21%
Vermont	24	24	0	-1%	40	16	66%	31	7	29%
Virginia	904	885	-18	-2%	1,177	273	30%	1,023	119	13%
Washington	468	449	-19	-4%	625	157	33%	519	50	11%
West Virginia	73	69	-5	-6%	113	40	54%	91	18	25%
Wisconsin	348	347	-1	0%	520	172	49%	434	86	25%
Wyoming	62	58	-4	-6%	87	25	41%	72	10	16%
Total	**27,719**	**27,141**	**-578**	**-2%**	**37,114**	**9,394**	**34%**	**31,753**	**4,034**	**15%**

Source: Urban Institute analysis using HIPSM 2017.

Note: FPL = federal poverty level.

** Minnesota and New York established Basic Health Plan programs to provide coverage for low-income residents (those with incomes between 133 and 200 percent of the federal poverty level) who would otherwise be eligible to purchase coverage through the health insurance marketplaces. In Scenario 1, the elimination of cost-sharing reductions in these two states is simulated to result in the allocation of premium surcharges to nongroup enrollees with incomes between 200 and 250 percent of the federal poverty level.*

Figure 3. Federal Spending on Marketplace Financial Assistance Under the ACA and Three Scenarios with No Cost-Sharing Reductions (Billions)



Source: Urban Institute analysis using HIPSM 2017.

** Scenario 2 excludes federal funding of the Basic Health Programs in New York and Minnesota.*

spent on tax credits and CSRs in 2018—$34.8 billion on premium tax credits and $5.9 billion on CSRs. Under Scenario 1, federal funding would increase to $47.9 billion, an 18 percent increase over current law; that entire amount would go to premium tax credits, with no funding for CSRs. Federal spending would be higher in this scenario because loading the CSR costs into silver marketplace premiums would yield larger premium tax credits. The increase in premium tax credits would exceed the federal savings from eliminating CSRs because the increase in the tax credits would benefit all tax credit–eligible enrollees, not only those eligible for CSRs. The higher tax credits would increase nongroup enrollment by about 600,000 (Figure 2), further adding to federal costs.

Under Scenario 2, all premium tax credit and CSR payments (except those for Basic Health Plans in New York and Minnesota, not shown) would simply be eliminated. Under Scenario 3, federal

financial assistance flowing to the marketplaces would fall by 36 percent nationally, not only because of the savings from eliminating CSR payments, but also because of the associated decrease in enrollment among the low-income population, which would reduce federal payments for premium tax credits. Because tax credits for lower-income enrollees are larger than those for higher-income enrollees, significant decreases in enrollment among those with incomes below 250 percent of FPL would yield substantial decreases in federal tax credit spending overall. As we describe in the following section, this decrease in enrollment would lead to premium increases as relatively healthy people decline to enroll. These increased premiums would increase tax credits per person enrolled, but not enough to offset the effect of fewer people receiving tax credits.

Table 4 shows differences in federal spending on marketplace enrollees by state. The table does not include federal BHP payments to New York and Minnesota. The lawsuit does not challenge the legality of federal BHP payments, and we did not attempt to predict how the administration would interpret the BHP payment formula in the absence of CSR payments.[19]

Under Scenario 1, Alaska would see significant increases in federal spending, largely because the state already has very high premiums and health care costs. The two BHP states, Minnesota and New York, would see very small increases because only residents with incomes between 200 and 250 percent of FPL receive cost-sharing reductions under current law.

Under Scenario 3, the change in federal spending is determined by the balance of two opposing forces: Reduced marketplace enrollment lowers federal spending, while the resulting premium increases caused by adverse selection increase federal spending. Alaska, for example, would see large premium increases in Scenario 3 on top of already high premiums, so the premium increase offsets more of the effect of reduced enrollment. The resulting decrease in federal spending is less than in many other states. The two BHP states would see very little change in marketplace enrollment, so they would also see little change in premiums. Federal spending on tax credits would be essentially unchanged. Washington, D.C., shows a similar result because of its Medicaid waiver that enrolls some adults with incomes up to 200 percent of FPL.

Changes in Premiums Under Three No-CSR Scenarios, Compared with the ACA

Figure 4 shows the effect that each scenario would have on private nongroup insurance premiums. Under Scenario 1, the surcharge placed on silver marketplace coverage would increase those premiums by 23 percent. Other plans would be unaffected. Scenario 2 would lead to a 37 percent increase in all private nongroup premiums (with only nonmarketplace coverage available). The effect would vary across states depending upon two factors: (1) the health care risk of the population eligible for tax credits compared with the health care risk of higher-income nongroup enrollees under current law; and (2) the share of nongroup enrollees eligible for tax credits. The effect on premiums under Scenario 3 (a 12 percent increase) would be smaller than under Scenario 2 because fewer enrollees exit the market, limiting the adverse selection effect.

Discussion

Scenario 1 represents the highest level of insurance coverage and the highest federal costs if the federal government decides not to compensate insurers for the cost-sharing reductions they must pay to eligible low-income enrollees under current law. In this scenario, insurers stay in all marketplaces and have enough time and flexibility to incorporate their expected CSR costs into their silver marketplace premiums. As those premiums increase, federal government costs increase, but affordability is protected and, for some consumers, even enhanced. These effects are unlikely to occur in every area of the country, however.

The policy uncertainty facing nongroup insurers goes well beyond the payment of CSRs. The lack of clarity on enforcement of the individual mandate, the shorter open-enrollment periods, and the reduction in federal support for outreach and enrollment assistance all have the potential to reduce coverage and worsen the nongroup insurance risk pool.

States can require insurers to use assumptions like those in Scenario 1 when computing premiums without CSRs; California has already directed insurers to do so. But no state can guarantee continued insurer participation without CSRs, particularly when the policy uncertainty facing nongroup insurers goes well beyond the payment of CSRs. The lack of clarity on enforcement of the individual mandate, the shorter open-enrollment periods, and the reduction in federal support for outreach and enrollment assistance all have the potential to reduce coverage and worsen the nongroup insurance risk pool. Insurers are left guessing how these changes will affect the entire risk pool and the average risk of their enrollees. Uncertainty likely will discourage some insurers from selling coverage in the marketplaces, and some areas may wind up with no insurers at all. Many counties may become “bare” if CSRs are not paid on top of all the other changes being made. It is extremely difficult to operate any business effectively, let alone a business as sensitive as insurance, when the market equilibrium is constantly disrupted by changing rules. Without CSRs, some areas of the country may experience coverage losses and premium increases like those in Scenario 2.

Scenario 3, where insurers are no longer required to pay CSRs if the federal government does not agree to reimburse for them, is possible but unlikely, given the contentiousness of the current political environment. However, that scenario would lead to large relative increases in the number of low-income uninsured people.

Table 4. Federal Spending on Marketplace Financial Assistance Under the ACA and Two No-Cost-Sharing Reduction Scenarios, by State, 2018 (Millions)

State	ACA (Current Law)			Scenario 1: Silver Marketplace Premium Surcharge		Scenario 3: Cost Sharing Reductions Eliminated	
	Premium Tax Credits	Cost Sharing Reductions	Total	Premium Tax Credits	Percent Change from ACA	Premium Tax Credits	Percent Change from ACA
Alabama	$832.4	$121.0	$953.4	$1,147.0	20%	$632.5	-34%
Alaska	$98.1	$10.2	$108.3	$184.6	70%	$88.8	-18%
Arizona	$787.0	$44.9	$831.9	$1,202.7	45%	$696.7	-16%
Arkansas	$154.0	$33.3	$187.4	$246.4	32%	$131.5	-30%
California	$4,342.5	$642.7	$4,985.2	$5,762.4	16%	$3,375.6	-32%
Colorado	$157.2	$26.2	$183.5	$241.3	31%	$171.5	-7%
Connecticut	$346.2	$37.6	$383.9	$472.7	23%	$324.4	-15%
Delaware	$74.7	$9.0	$83.7	$102.3	22%	$55.2	-34%
District of Columbia	$7.1	$0.2	$7.3	$8.7	19%	$7.3	0%
Florida	$5,478.9	$1,013.0	$6,491.9	$7,222.1	11%	$3,874.7	-40%
Georgia	$1,252.3	$316.3	$1,568.6	$1,792.8	14%	$830.9	-47%
Hawaii	$58.0	$8.6	$66.5	$89.2	34%	$57.8	-13%
Idaho	$286.2	$55.4	$341.6	$407.6	19%	$216.7	-37%
Illinois	$963.3	$110.7	$1,073.9	$1,333.8	24%	$793.8	-26%
Indiana	$429.9	$78.8	$508.7	$617.0	21%	$353.3	-31%
Iowa	$139.9	$18.4	$158.3	$208.3	32%	$139.1	-12%
Kansas	$311.6	$50.8	$362.4	$455.6	26%	$241.9	-33%
Kentucky	$164.5	$31.6	$196.1	$263.8	35%	$129.7	-34%
Lousiana	$490.8	$65.2	$556.0	$675.4	21%	$371.7	-33%
Maine	$293.5	$47.3	$340.8	$393.3	15%	$238.8	-30%
Maryland	$279.4	$42.2	$321.6	$395.2	23%	$201.8	-37%
Massachusetts	$613.3	$97.1	$710.4	$814.8	15%	$348.4	-51%
Michigan	$645.7	$116.3	$762.0	$902.1	18%	$500.2	-34%
Minnesota*	$211.6	$1.8	$213.4	$228.3	7%	$213.4	0%
Mississippi	$308.1	$62.8	$370.9	$405.3	9%	$214.8	-42%
Missouri	$825.6	$179.2	$1,004.8	$1,164.4	16%	$551.6	-45%
Montana	$154.4	$17.9	$172.3	$204.3	19%	$120.0	-30%
Nebraska	$341.0	$51.8	$392.8	$454.6	16%	$234.7	-40%
Nevada	$289.6	$46.5	$336.1	$431.0	28%	$223.8	-33%
New Hampshire	$76.1	$13.4	$89.5	$106.7	19%	$57.8	-35%
New Jersey	$538.1	$93.4	$631.6	$744.6	18%	$357.4	-43%
New Mexico	$77.6	$14.0	$91.6	$121.2	32%	$47.2	-49%
New York*	$594.5	$15.7	$610.1	$654.2	7%	$610.1	0%
North Carolina	$2,716.5	$421.9	$3,138.4	$3,642.2	16%	$2,079.0	-34%
North Dakota	$47.4	$7.5	$54.9	$70.3	28%	$39.8	-27%
Ohio	$464.2	$91.9	$556.1	$717.6	29%	$393.2	-29%
Oklahoma	$623.0	$86.7	$709.8	$902.1	27%	$445.3	-37%
Oregon	$244.1	$37.2	$281.2	$329.6	17%	$193.2	-31%
Pennsylvania	$1,239.7	$129.3	$1,369.0	$1,638.0	20%	$966.2	-29%

Table 4. Continued

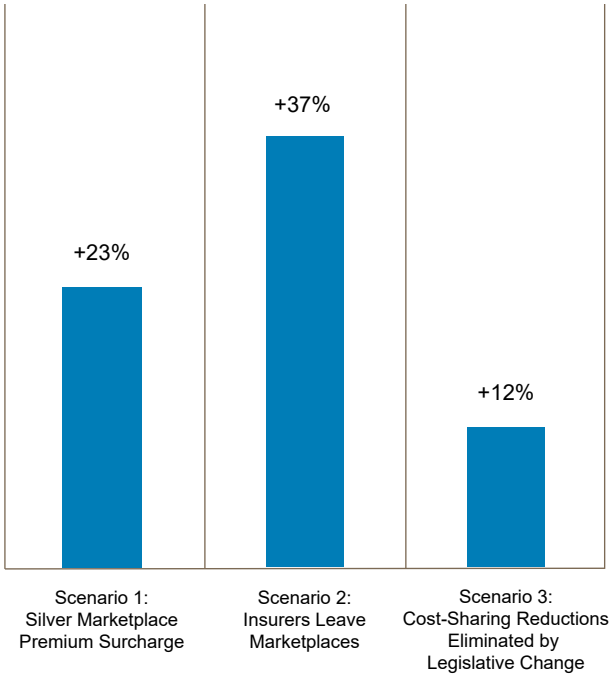
State	ACA (Current Law)			Scenario 1: Silver Marketplace Premium Surcharge		Scenario 3: Cost Sharing Reductions Eliminated	
	Premium Tax Credits	Cost Sharing Reductions	Total	Premium Tax Credits	Percent Change from ACA	Premium Tax Credits	Percent Change from ACA
Rhode Island	$45.8	$9.6	$55.4	$67.1	21%	$34.2	-38%
South Carolina	$861.8	$161.0	$1,022.7	$1,187.3	16%	$600.6	-41%
South Dakota	$114.5	$19.5	$134.0	$154.0	15%	$111.5	-17%
Tennessee	$860.6	$130.3	$990.9	$1,191.3	20%	$619.0	-38%
Texas	$3,026.7	$737.0	$3,763.6	$4,469.4	19%	$2,017.8	-46%
Utah	$437.4	$74.1	$511.5	$589.2	15%	$290.3	-43%
Vermont	$69.4	$7.7	$77.1	$91.4	19%	$40.4	-48%
Virginia	$1,110.8	$237.8	$1,348.6	$1,526.4	13%	$748.3	-45%
Washington	$306.0	$59.4	$365.3	$457.3	25%	$230.8	-37%
West Virginia	$130.6	$18.0	$148.6	$189.5	28%	$91.5	-38%
Wisconsin	$776.2	$126.3	$902.6	$1,015.9	13%	$610.0	-32%
Wyoming	$124.5	$23.0	$147.5	$182.7	24%	$118.8	-19%
Total	**$34,822.5**	**$5,851.4**	**$40,673.9**	**$47,875.0**	**18%**	**$26,043.4**	**-36%**

Source: Urban Institute analysis using HIPSM 2017.

Note: FPL = federal poverty level.

** Minnesota and New York established Basic Health Plan programs to provide coverage for low-income residents (those with incomes between 133 and 200 percent of the federal poverty level) who would otherwise be eligible to purchase coverage through the health insurance marketplaces. In Scenario 1, the elimination of cost-sharing reductions in these two states is simulated to result in the allocation of premium surcharges to nongroup enrollees with incomes between 200 and 250 percent of the federal poverty level. Spending estimates in these two states are only shown for individuals not covered under a Basic Health Plan.*

Figure 4. Percent Increase in Private Nongroup Insurance Premiums Under Three Scenarios with No Cost-Sharing Reductions, Relative to the ACA



Source: Urban Institute analysis using HIPSM 2017.

Notes: Scenario 1 estimate applies to silver marketplace premiums only. Scenario 2 and Scenario 3 estimates apply to the entire private nongroup insurance market selling ACA-compliant coverage.

NOTES

1 Silver coverage is intended to have an actuarial value of 70 percent, meaning that for an average population, the insurer reimburses 70 percent of covered health care benefits, and the average enrollee is responsible for the remaining 30 percent of claims costs.

2 Jost T. Rapid developments in *House v. Burwell*. Health Affairs Blog. Posted December 29, 2016. http://healthaffairs.org/blog/2016/12/29/rapid-developments-in-house-v-burwell/.

3 For reference, the 2017 benchmark silver plan in Cleveland has a $5,500 deductible for single coverage and a $6,500 out-of-pocket maximum. The associated 94 percent actuarial value plan has a $0 deductible and a $700 out-of-pocket maximum; the 87 percent actuarial value plan has a $450 deductible and a $2,250 out-of-pocket maximum; and the 74 percent actuarial value plan has a $3,500 deductible and a $5,450 out-of-pocket maximum.

4 Corlette S, Lucia K, Giovannelli J, Palanker D. *Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices*. Washington: Urban Institute; 2017. http://www.urban.org/research/publication/uncertain-future-affordable-care-act-leads-insurers-rethink-participation-prices.

5 Pennsylvania's five marketplace insurers asked for an aggregate statewide rate increase of 8.8 percent for individual plans. The insurers plan to seek a 23.3 percent statewide rate increase if the individual mandate is repealed, and a 20.3 percent increase if CSRs are not paid. Insurance commissioner announces single-digit aggregate 2018 individual and small group market rate requests, confirming move toward stability unless Congress or the Trump administration act to disrupt individual market [news release]. Harrisburg, PA: Commonwealth of Pennsylvania; June 1, 2017. http://www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=248.

6 Florida state regulators asked insurers to submit backup plans for premium increases because of CSR uncertainty, and Florida Blue will increase rates by 20 percent if CSRs are not paid. Chang D. Florida insurers want to hike Obamacare rates, and they may go even higher. *Miami Herald*. August 3, 2017. http://www.miamiherald.com/news/health-care/article165197907.html.

7 In North Dakota, Medica will refile to ask for a 20 percent rate increase if subsidies are discontinued. Hageman J. Discontinuing health insurer subsidies would rais premiums, ND insurance commissioner warns. *Bismarck Tribune*. August 3, 2017. http://bismarcktribune.com/news/state-and-regional/discontinuing-health-insurer-subsidies-would-raise-premiums-nd-insurance-commissioner/article_27616974-8b9b-5da9-a083-eec50c557b68.html.

8 In Idaho, CSR concerns are reportedly responsible for 23.2 percent of PacificSource Health Plans of Idaho s anticipated 45.6 percent rate increase, 20 percent of SelectHealth's 45 percent increase, and 17 percent of Mountain Health Co-op's 25 percent increase. Young D. Trump healthcare policy uncertainty is expected to drive ACA premiums higher. S&P Global Market Intelligence News. https://marketintelligence.spglobal.com/our-thinking/news/trump-healthcare-policy-uncertainty-is-expected-to-drive-aca-premiums-higher.

9 In Michigan, Meridian has requested an 8.3 percent rate increase with CSRs intact, or a 59.4 percent increase without CSRs; HAP has requested a 16.1 percent increase with CSRs or a 24 percent increase without CSRs; and Priority Health has requested a 17.7 percent increase with CSRs or a 19 percent increase without CSRs. Greene J. Michigan health insurers file record-high Obamacare rate increases for 2018. *Crain's Detroit Business*. June 14, 2017. http://www.crainsdetroit.com/article/20170614/news/631446/michigan-health-insurers-file-record-high-obamacare-rate-increases-fo .

10 Blue Cross Blue Shield North Carolina requested a 22.9 percent rate increase because of CSR uncertainty; the company said it otherwise would have asked for an 8.8 percent increase. Bryan B. Insurance companies have made it crystal clear how Trump could send Americans' healthcare costs soaring. *Business Insider*. June 4, 2017. http://www.businessinsider.com/north-carolina-pennsylvania-insurance-premiums-increase-trump-2017-6.

11 BlueCross BlueShield of Tennessee would have offered a nominal increase in 2018, but instead proposed another double-digit increase because of CSR uncertainty. Colorado Health Institute. *Federal Uncertainty Drives Another Year of Insurance Price Increases: 2018 Preliminary Insurance Rates Analysis*. Denver: Colorado Health Institute; 2017. http://www.coloradohealthinstitute.org/research/insurance-prices/2018-preliminary.

12 Blumberg LJ, Buettgens M. The Implications of a Finding for the Plaintiffs in House v. Burwell. Washington: Urban Institute; 2016. http://www.urban.org/research/publication/implications-finding-plainti fs-house-v-burwell.

13 Covered California. Supplemental guidance on rate filing instructions related to the cost-sharing reduction program. Sacramento, CA: Covered California; 2017. http://hbex.coveredca.com/stakeholders/plan-management/PDFs/Covered-CA-CSR_Supplemental_Rate_Filing_Instructions_6-6-17.pdf.

14 At the time of our earlier analysis of the implications of a finding for the plainti fs in *House v. Burwell*, HIPSM was based on Current Population Survey data. Since then, HIPSM has been updated, with its core now based on the much larger American Community Survey (ACS).

15 Estimates: average ACA marketplace premiums for silver plans would need to increase by 19% to compensate for lack of funding for cost-sharing subsidies [news release]. Menlo Park, CA: Kaiser Family Foundation; April 6, 2017. http://www.kff.org/health-reform/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/.

16 Levitt L, Cox C, Claxton G. *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments*. Menlo Park, CA: Kaiser Family Foundation; 2017. http://files.k f.org/attachment/Issue-Brief-The-Effects-of-Ending-the-Affordable-Care-Acts-Cost-Sharing-Reduction-Payments.

17 Congressional Budget Office. *The Effects of Terminating Payments for Cost-Sharing Reductions*. Washington: Congressional Budget Office; 2017. https://www.cbo.gov/system/files/ 15th-congress-2017-2018/reports/53009-costsharingreductions.pdf.

18 A small number of people with incomes below the poverty level are eligible for tax credits and cost-sharing reductions. These people are legal immigrants to the US who would otherwise be eligible for Medicaid except that they arrived within the preceding five years.

19 The Congressional Budget Office acknowledges this uncertaint , estimating that the impact could be either positive or negative.

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Regulated Medicare Advantage And Marketplace Individual Health Insurance Markets Rely On Insurer Competition

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ABSTRACT Two important individual health insurance markets—Medicare Advantage and the Marketplaces—are tightly regulated but rely on competition among insurers to supply and price health insurance products. Many local health insurance markets have little competition, which increases prices to consumers. Furthermore, both markets are highly subsidized in ways that can exacerbate the impact of market power—that is, the ability to set price above cost—on health insurance prices. Policy makers need to foster robust competition in both sectors and avoid designing subsidies that make the market-power problem worse.

Managed competition in health insurance was proposed more than thirty years ago by Alain Enthoven.[1] *Managed* (or, sometimes, *regulated*) refers to public regulators' specifying the health insurance product and its pricing (including any subsidies). *Competition* refers to the other main ingredient for success: a supply side offering a range of choices at prices reflecting their costs. Three public individual health insurance markets in the United States rely on managed competition: Medicare Advantage, the Marketplaces created by the Affordable Care Act (ACA), and Medicaid managed care. Although these markets differ in many ways, buyers' prices are highly subsidized and regulated in all three.

Regulation of health insurance in Medicare Advantage and the Marketplaces pursues multiple policy goals simultaneously, such as providing adequate health coverage, offering low premiums, ensuring affordable insurance for lower-income groups, promoting and guiding consumer choice, sharing efficiency gains with taxpayers, and stabilizing the market. Adding to the complexity of the task is the fact that market stabilization itself has two components: avoiding excessive plan turnover so that consumers aren't shuffled among health plans, and preventing the dreaded "death spiral"—a dynamic in which higher prices and a worsening risk pool feed on each other to destroy the market entirely. These multiple goals guide the design of payment to insurers and the structure of subsidies to consumers.

This article discusses one important way in which regulation and competition interact in two of these markets: Medicare Advantage and the Marketplaces. The form of their subsidies and price regulation rely on competition and can produce unintended new efficiency problems in the absence of robust competition.

The State Of Competition In Health Insurance

Competition benefits consumers in health insurance markets as it does in other markets. In a comprehensive review, Martin Gaynor and coauthors found that the evidence shows that markets with more insurance carriers have lower premiums—a finding that is robust across markets and over time.[2] The presence of relatively few competitors also limits consumer choice.

Health insurance markets have been consolidating since the 1990s, with over four hundred

health insurance mergers since 1996.[3] Recent data show that five insurers—Aetna, Cigna, UnitedHealthcare, Anthem, and Humana—together account for 83 percent of private insurance in the United States.[4] However, much health insurance is regional and sector-specific (for example, Centene sells plans in only certain states and concentrates on Medicaid managed care). Thus, statistics for the entire country that treat the different sectors of health insurance as one market overstate the degree of competition because all firms do not participate in all markets.

In economic terms, a seller has market power if it is able to raise its prices above its costs. As we note below, market power may extend into the political process and thus affect regulation as well. A monopoly firm has a high level of market power, but firms in markets with a few sellers may have market power as well. Typically, the state of competition is assessed by measures related to the number of competitors, such as the market share of the top three firms. Markets with fewer sellers are referred to as concentrated. The Herfindahl-Hirschman Index (HHI) is a commonly used metric for competition.[5] The *Horizontal Merger Guidelines* of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) define markets as "highly concentrated" if the HHI exceeds 2,500.[6]

In probably the most competitive sector of health insurance, commercial health insurance purchased by large employers, the HHI in 2015 averaged 2,973 in US metropolitan areas—a substantial increase from an average of 1,716 in 2001.[3,4] To get an idea of how concentrated this is, a market with four sellers of equal size has an HHI of 2,500, which is the threshold of the FTC and DOJ. Within geographic markets and sectors, health insurance markets are more concentrated than the national figures suggest.

Medicare Advantage and the Marketplaces are special sectors whose markets are defined locally. The average HHI across counties in the Medicare Advantage program was 5,392 in 2016 (corresponding to one firm with a 60 percent market share and a second firm with a 40 percent share).[7] Brian Biles and colleagues report that in 2012, 97 percent of county markets in Medicare Advantage were highly concentrated according to the definition of the FTC and DOJ.[8] While the typical Medicare Advantage enrollee has a choice of eighteen plans, this is a misleading indicator of competition when only two or three insurers are offering the plans.

In the Marketplaces in 2016, 57 percent of enrollees had a choice of three or more insurers in their local market, 22 percent had a choice of two insurers, and 21 percent had only one option.[9] In 2016 this translated into an average HHI across market areas of 4,907, corresponding to a highly concentrated market. To get an idea of what an HHI of 4,907 means, a market with two insurers of equal size has an HHI of 5,000. Effective competition in the Marketplaces emanates largely from Blue Cross plans and regional insurers that have primarily served Medicaid.[10]

Statistics on supply in geographically limited and sector-specific markets understate the degree of competition, as they capture only actual and not potential competitors. If entry by potential competitors is easy, competition can be effective even with only a few sellers. In our view, entry into either of the highly regulated Medicare Advantage or Marketplace sectors is not easy enough to ensure that potential competitors can introduce sufficient competition to these markets.

Medicare Advantage: Bidding And Competition

Medicare Advantage participation is at historic highs, claiming 33 percent of all Medicare beneficiaries (19.0 million enrollees).[11] In Part A (which covers primarily hospital services) and Part B (primarily physician services), Medicare sets prices that are paid to providers administratively. Part C (Medicare Advantage) works differently. Medicare fixes its payments to plans in the form of a per person per month (or capitation) payment, but plans can set their own premiums. A risk-adjustment system alters the payments Medicare makes to plans for beneficiaries according to past indicators of health status and some other elements. However, the level of payments and the premiums that beneficiaries pay are determined by a bidding system that was designed to provide incentives to keep costs and bids low. Its success in doing so depends on effective competition among plans. Low plan bids translate into lower costs to beneficiaries, but in a quirky way—the effect of which is to exacerbate the exercise of market power by plans in Medicare Advantage.

BIDDING AND BENEFICIARY PREMIUMS To understand how market power plays out in Medicare Advantage, it is necessary to understand the bidding and pricing system. Plans make bids that are supposed to equal the plan's average cost for services covered by Parts A and B for a beneficiary of average health status. A plan's bid is compared to an administratively set geographic benchmark spending level that is based, in a complicated way, on historical spending from traditional Medicare in that county and a plan's quality score.[12] The benchmark specifies the maximum amount that Medicare can pay to the plan per person before risk adjustment.[13]

Plans' bids can be above or below the benchmark. For bids that are above the benchmark, Medicare pays the benchmark instead. Plans must charge beneficiaries a supplemental premium equal to the difference between the bid and the benchmark. All beneficiaries, whether they join a Medicare Advantage plan or stay in traditional Medicare, pay a Part B premium directly to Medicare, usually in the form of a deduction in the beneficiary's monthly Social Security payment. So a Medicare Advantage plan with a bid that is above the benchmark charges a positive premium.

For bids that are below the benchmark, Medicare pays the plan the bid amount plus a percentage of the difference between the benchmark and the bid (50 percent or 70 percent, depending on the plan's quality rating)—an amount known as the rebate. Since the rebate is less than 100 percent of the difference, Medicare shares in the plan's savings. Plans must use the rebate to provide beneficiaries with reduced cost sharing, lower premiums, or additional benefits (such as vision care coverage). If a plan reduces its premiums, it is said to "buy down" the Part B premium—in effect, reducing what would otherwise be deducted from the beneficiary's Social Security payment. Plans can also offer additional benefits and charge premiums for them even if they do not receive a rebate from Medicare.

These rules mean that two things happen differently when a bid is above the benchmark instead of below it. Both differences play a part in how competition affects market premiums. First, if a bid is above the benchmark, beneficiaries must pay the full positive premium, while if a bid is below the benchmark, it lowers the deduction from the beneficiaries' Social Security payments. Consumers see and feel both positive prices and negative ones, but the latter have a much smaller impact. Second, if the bid is above the benchmark, the consumer pays the full amount, while if the bid is below the benchmark, the consumer gets only a share of the price reduction because of Medicare's shared savings. These two forces imply that plans lose enrollment when premiums are positive but gain little enrollment when supplemental premiums are below zero.

AN UNINTENDED CONSEQUENCE We assume for purposes of discussion that consumer benefits from any rebates take the form of reduced premiums. When the bid is reduced by $1 above the benchmark, the premium to the beneficiary is reduced by exactly $1, and the consumer sees this in the form of a lower supplemental premium paid. When the bid is reduced by $1 below the benchmark, the premium is reduced by only $0.50 to $0.70, and this change is bundled with the Social Security payment.

Medicare Advantage and the Marketplaces are special sectors whose markets are defined locally.

The effect of these regulations depends on the degree of competition in insurance markets. Robust competition among health plans will drive a health plan to make a bid equal to its costs (as regulations require), a result that has been supported empirically.[14–16] Since price is determined by cost in a competitive market, demand conditions—that is, beneficiaries' responses to premiums—have no effect on market prices. One implication of robust competition is that an increase in the benchmark when plans bid their costs is fully passed through to beneficiaries in the form of lower premiums or additional benefits.

Market power, which permits plans to set their prices above their costs, changes this result. With market power, demand conditions also influence price determination. The bidding and premium regulations make beneficiaries less responsive to negative supplemental premium levels. This lowered demand response gives a Medicare Advantage plan added power to mark premiums up over costs. Of course, even without the asymmetric sharing rules, a plan with market power would mark up its price. The asymmetry in the way that bidding and pricing work around the zero supplemental premium implies that the exacerbation of market power occurs in the range of negative supplemental premiums, not in the range of positive ones.

Pushing prices up when they would otherwise be negative but not when they would be positive implies that there would be a bunching of prices at zero (that is, prices are pushed up, but only to a certain level). In our view, the most compelling evidence supporting our interpretation of the pricing distortions caused by regulations comes from the observed Medicare Advantage supplemental premiums. Our analysis implies that bids will be bunched at the value where the supplemental premium equals zero, and that is just what happens. About half of plan bids are associated with a supplemental premium of exactly zero.[17]

Publicly regulated markets are vulnerable to market power via its connection to political power.

SELLER MARKET POWER The evidence on seller market concentration in Medicare Advantage presented above is one indication that sellers have market power. Another form of evidence is how Medicare Advantage plans respond to changes in the level of the subsidy (the benchmark payment) they receive from Medicare. If markets are competitive and plans bid their costs, a benchmark should not affect a bid, and any benchmark increase should be fully passed through to beneficiaries via lower premiums or expanded benefits. This might not happen if a plan with market power faces demand with asymmetric responses above and below the zero premium. If the premium to the consumer is stuck at zero before and after the benchmark change, none of the benchmark increase would be passed through.

Marika Cabral and colleagues found that increases were not fully passed through to beneficiaries:[18] On average across all markets, about half of an increase was passed through in the form of lower premiums or better benefits. Notably, in accord with our view of demand, where market power mattered, the amount that was passed through differed. The authors found that 75 percent was passed through in the more competitive markets, compared to only 13 percent in markets in the bottom third of measured competition.

Zirui Song and colleagues studied Medicare Advantage plan bids and benchmarks for the period 2006–10.[19] They found that on average, only about fifty cents of every one-dollar increase in the benchmark payment was passed through to beneficiaries, and they interpreted this as evidence that Medicare Advantage plans had market power. They also provided evidence indicating that with other factors equal, increasing the number of insurers in a market results in lower bids. Other studies also found that higher HHIs resulted in higher bids.[20]

Premium Setting In Marketplaces

Subsidies for premiums and cost sharing are essential to the Marketplaces. The goals of promoting price competition, ensuring the availability of affordable health insurance for low-income people, and preventing death spirals underpins the design of the subsidies. With robust competition, subsidies can help achieve those goals. With market power, some part of the subsidies is diverted to sellers, which undermines subsidies' intended effects.

Marketplace premium subsidies are the main instrument for ensuring the affordability of and access to health insurance. In March 2016 the Congressional Budget Office estimated the size of the nongroup health insurance market (for Marketplace and off-Marketplace plans) to be twenty-one million people, about twelve million of whom receive insurance through the Marketplaces.[21]

PREMIUM SUBSIDIES, PLAN PAYMENTS, AND COMPETITION Premium subsidies, available on a sliding scale for consumers with incomes of 100–400 percent of the federal poverty level, are distributed as advance premium tax credits—a refundable tax credit. The impact of the credit is significant: In 2016 the average unsubsidized premium in the Marketplaces was $386, whereas the average subsidized premium paid by Marketplace participants eligible for the subsidy (85 percent of participants in the same year) was $102.[22]

Marketplace consumers respond to premium differences. In 2016, 43 percent of renewing Marketplace consumers switched plans.[23] Most switching occurs within the same metal tier, which indicates that people are shopping on the basis of price, not coverage. A consumer's advance premium tax credit is based on income and on the premium for the second-lowest-cost silver plan in the Marketplace for that consumer. This is referred to as a "price-linked subsidy" because the value of the subsidy depends on the market price. Its economic characteristics are important for understanding the role of competition in Marketplaces.[24] Price-linked subsidies aim to protect low-income consumers from the full consequences of premium increases. In comparison to a subsidy with a fixed level, price-linked subsidies also protect taxpayers from windfall profits being paid to insurers in the event of a sudden premium decline because the subsidy falls with the premium. Furthermore, the subsidies protect the market from death spirals by insulating consumers from the consequences of premium increases. However, linking the subsidy to a particular plan's premium—that of the second-lowest-cost silver plan—means that the plan used to determine the subsidy amount can vary from year to year. When

there are few plans, the likelihood that any one plan is the second-lowest-cost silver plan is not small.

For a Marketplace health plan, an insurer's decisions about price will depend on the likelihood that the plan will be the lowest- or second-lowest-cost silver plan. In a market with a large number of plans, the likelihood is low, and the insurer will ignore any effect of its pricing decisions on the subsidy. With few competitors, however, the plan could have a meaningful chance of being the second-lowest-cost silver plan, and the insurer would rationally take this into account. If a plan is sure to be the second-lowest-cost silver plan and the insurer raises the premium $1, subsidies also go up by $1, and the net price to consumers is unaffected. The insurer in this case would rationally raise the premium at least until the point at which the probability of being the second-lowest-cost silver plan declines markedly.[25]

The unintended effect of price-linked subsidies' distorting premiums upward happens when there is market power, not when there is competition. The cost of higher subsidies is borne by taxpayers. Unsubsidized Marketplace consumers or those with off-Marketplace plans must pay the full amount of any premium increase that stems from the distortions resulting from imperfect competition.

Other market design choices made by state-based Marketplaces affect competition. There are seventeen such Marketplaces, ten of which have the authority to implement active purchasing approaches to Marketplace design. Five of these ten states have established Marketplaces that engage in some form of selective contracting with insurers. Active purchasing in the form of selective contracting creates a second tier of competition that precedes the types of competition for consumers discussed thus far: Some state-based Marketplaces create competition to gain access to the market or segments of the market. We term this "competition for contracts." It typically involves a state authority's evaluating both the premiums and the quality of plans offered. Selective contracting is most successful when there are multiple issuers in a state that compete for the opportunity to sell plans in its Marketplace. Thus, active purchasing can be used to inject competition even into markets that are sparsely populated, if numerous plans are prepared to bid for the right to serve those markets.

EVIDENCE ON MARKET STRUCTURE In an analysis of the Marketplaces' performance in their first year, the Department of Health and Human Services showed that an increase in the number of carriers in a local rating area reduced premiums for the second-lowest-cost silver plan by 4 percent.[26] In 2014 the average number of health insurance carriers in a rating area was five. Similar results were obtained by other researchers using somewhat different methods. Leemore Dafny and colleagues[27] show that for Marketplaces in which UnitedHealthcare might have participated based on its historical market activities, premiums would have been an estimated 5.4 percent lower had that one issuer entered the Marketplace. Unsurprisingly, in this as in other markets, empirical evidence supports the proposition that premium levels in the Marketplaces depend on the number of carriers competing in the market.

There are a variety of tools that regulators could use to make these markets more attractive to new insurers.

Final Observations

At first blush, it may appear that imperfect competition and market power would be less problematic in publicly regulated insurance markets. Prices and quality are subject to regulation by public and private payers. Governments at various levels also regulate the rules governing market entry and the conduct of competition. And finally, the health sector makes use of intermediaries that can structure the form of competition, including employers that structure competition among employees' choices.

The first two factors seem to imply that market power is less of a problem in publicly regulated markets: If the government or another payer can take pricing and quality decisions out of plans' decision making, thereby attenuating the ability to raise prices (including profit regulation), that might limit the scope of the problem created by market power. However, that is not the way the United States has designed the forms of regulated competition in Medicare Advantage and the Marketplaces.

Regulating price does not, of course, fully solve the market-power problem. Insurers can determine elements of a plan's quality—for ex-

ample, the breadth of its network—that are important to consumers, involve costs to the insurer, and are much more difficult to regulate than price.

Publicly regulated markets are vulnerable to market power via another channel: its connection to political power. The recent experience with two large mergers (between Aetna and Humana and between Anthem and Cigna) highlighted this connection. Since the administration of President Ronald Reagan, the dominant view has been that the focus of competition policy should be on consumer welfare or allocative efficiency. Previous concerns with political power and distributional issues were largely removed from consideration in the crafting of competition policy.[28] The recent merger cases raised the possibility that concentrated market power could be used to gain political influence over regulatory processes, thereby reducing consumer welfare. The trial judge in the Aetna merger case opined that "Aetna tried to leverage its participation in the exchanges for favorable treatment from DOJ regarding the proposed merger."[29] While the old view that big is bad is too simplistic, it may be worth revisiting the political economy of the full consequences of market concentration in a context with regulated competition.

In this article we have highlighted the fact that regulated competition American-style has many complicated features. We focused specifically on the design of subsidies related to health plan payments. We have shown how the payment arrangements for both Medicare Advantage and the Marketplaces rely on robust competition to achieve their goals. In the absence of such competition, the inefficiencies stemming from market power found in health insurance markets generally are likely to be worse in these market segments.

We see four general approaches that policy makers might use to contend with this market power, with the specifics differing between Medicare Advantage and the Marketplaces. One approach would promote market entry in the context of existing payment designs. There are a variety of tools that regulators could use to make markets in Medicare Advantage and the Marketplaces more attractive to new insurers. For example, retaining the reinsurance feature of payment in the Marketplaces could enable entry by smaller local carriers.

A second approach would recognize that some markets will never attract many entrants and instead need to rely on active purchasing arrangements, such as those used by some employers and state-based Marketplaces.

The third approach would redesign payment systems to make them less vulnerable to the exercise of market power. Premium subsidies in the Marketplaces could be linked to a wider basket of health insurance premiums, such as a regional average. This, of course, would come at the cost of weaker protection against a death spiral.

Finally, in Medicare Advantage, ironing out the kink in demand by presenting prices to beneficiaries without subtracting the mandatory Part B premium would go some way toward enhancing price competition. ■

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NOTES

1 Enthoven AC. Health plan: the only practical solution to the soaring cost of medical care. Reading (MA): Addison-Wesley; 1980.
2 Gaynor M, Ho K, Town RJ. The industrial organization of health-care markets. J Econ Lit. 2015;53(2):235–84.
3 Dafny L. Consolidation in healthcare markets: challenges for researchers and enforcers. Paper presented at: FTC Microeconomics Conference; 2014 Oct 17; Washington, DC.
4 Dafny LS. Health insurance industry consolidation: what do we know from the past, is it relevant in light of the ACA, and what should we ask? [Internet]. Washington (DC): Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights; 2015 Sep 22 [cited 2017 Jul 25]. Available from: http://www.hbs.edu/faculty/Profile%20Files/Testimony%20to%20Senate%20in%20re%20Insurance%20Industry%20Mergers%20-%209.2015_050cdb4e-db12-4a9d-9d50-48d917d39e2a.pdf
5 For example, if a given market contains five firms—one with a 30 percent share, one with a 10 percent share, and the other three with a 20 percent share each—the HHI is $30^2 + (3 \times 20^2) + 10^2$ (or $900 + 1{,}200 + 100) = 2{,}200$—which would not be classified as highly concentrated.
6 Department of Justice, Federal Trade Commission. Horizontal merger guidelines [Internet]. Washington (DC): FTC; 2010 Aug 19 [cited 2017 Jul 21]. Available from: https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf
7 Based on authors' tabulation of data in the Medicare Advantage Landscape Files of the Centers for Medicare and Medicaid Services.
8 Biles B, Casillas G, Guterman S. Competition among Medicare's private health plans: does it really exist? [Internet]. New York (NY): Com-

monwealth Fund; 2015 Aug [cited 2017 Jul 25]. (Issue Brief). Available from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf
9 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health plan choice and premiums in the 2017 health insurance marketplace [Internet]. Washington (DC): ASPE; 2016 Oct 24 [cited 2017 Jul 25]. (ASPE Research Brief). Available from: https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf
10 For a more complete discussion of these points, see Blumberg LJ, Holahan J, Wengle E. Marketplace price competition in 2014 and 2015: does insurer type matter in early performance? [Internet]. Washington (DC): Urban Institute; 2015 Jun [cited 2017 Jul 25]. Available from: http://www.urban.org/sites/default/files/publication/57191/2000277-Marketplace-Price-Competition-in%202014-and-2015-Does-Insurer-Type-Matter-in%20Early%20Performance.pdf
11 Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2017 spotlight: enrollment market update [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2017 Jun 6 [cited 2017 Jul 25]. Available from: http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/
12 For a fuller discussion of the economics of benchmarks and bidding, see Glazer J, McGuire TG. Paying Medicare Advantage plans: to level or tilt the playing field. J Health Econ. 2016 Dec 29. [Epub ahead of print].
13 There is a separate bidding process for the prescription drug (Part D) component of plan payments.
14 Gaynor M, Town RJ. Competition in health care markets. In: Pauly MV, McGuire TG, Barros PP, editors. Handbook of health economics. Amsterdam: North Holland; 2012. Vol. 2, p. 499–638.
15 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.
16 Song Z, Landrum MB, Chernew ME. Competitive bidding in Medicare: who benefits from competition? Am J Manag Care. 2012;18(9):546–52.
17 Newhouse JP, McGuire TG. How successful is Medicare Advantage? Milbank Q. 2014;92(2):351–94.
18 Cabral M, Geruso M, Mahoney N. Do larger health insurance subsidies benefit patients or producers? Evidence from Medicare Advantage [Internet]. Cambridge (MA): National Bureau of Economic Research; 2014 Sep [cited 2017 Jul 26]. (NBER Working Paper No. 20470). Available for download (fee required) from: http://www.nber.org/papers/w20470
19 Song Z, Landrum MB, Chernew ME. Competitive bidding in Medicare Advantage: effect of benchmark changes on plan bids. J Health Econ. 2013;32(6):1301–12.
20 Duggan M, Starc A, Vabson B. Who benefits when the government pays more? Pass-through in the Medicare Advantage program. J Public Econ. 2016;141:50–67.
21 Kilroe D, Kalicki A. CBO launches new page featuring baseline projections for selected programs. Congressional Budget Office Blog [blog on the Internet]. 2016 Mar 24 [cited 2017 Aug 4]. Available from: https://www.cbo.gov/publication/51420
22 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. The effect of shopping and premium tax credits on the affordability of Marketplace coverage [Internet]. Washington (DC): ASPE; 2016 Aug 24 [cited 2017 Jul 26]. (ASPE Issue Brief). Available from: https://aspe.hhs.gov/system/files/pdf/206741/APTCMarketplace.pdf
23 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance Marketplace premiums after shopping, switching, and premium tax credits, 2015–2016 [Internet]. Washington (DC): ASPE; 2016 Apr 12 [cited 2017 Jul 26]. (ASPE Issue Brief). Available from: https://aspe.hhs.gov/system/files/pdf/198636/MarketplaceRate.pdf
24 A formal economic analysis of price-linked subsidies can be found in Jaffe SP, Shepherd M. Price-linked subsidies and health insurance markups [Internet]. Cambridge (MA): National Bureau of Economic Research; [revised 2017 Jul; cited 2017 Jul 25]. (NBER Working Paper No. 23104). Available from: http://www.nber.org/papers/w23104.pdf
25 We recognize that issuers can offer multiple plans within a metal tier. Nevertheless, the basic incentive described here applies.
26 Burke A, Misra A, Sheingold S. Premium affordability, competition, and choice in the health insurance Marketplace, 2014 [Internet]. Washington (DC): Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; 2014 Jun 18 [cited 2017 Jul 26]. (ASPE Research Brief). Available from: https://aspe.hhs.gov/system/files/pdf/76896/2014MktPlacePremBrf.pdf
27 Dafny L, Gruber J, Ody C. More insurers lower premiums: evidence from initial pricing in Health Insurance Marketplaces. Am J Health Econ. 2015;1(1):53–81.
28 Bork RH. Legislative intent and the policy of the Sherman Act. J Law Econ. 1966;9:7–48.
29 United States of America, et al., v. Aetna Inc., et al. Memorandum opinion [Internet]. 2017 Jan 23 [cited 2017 Jul 26]. p. 125. Available from: https://cases.justia.com/federal/district-courts/district-of-columbia/dcdce/1:2016cv01494/180544/306/0.pdf?ts=1485247829

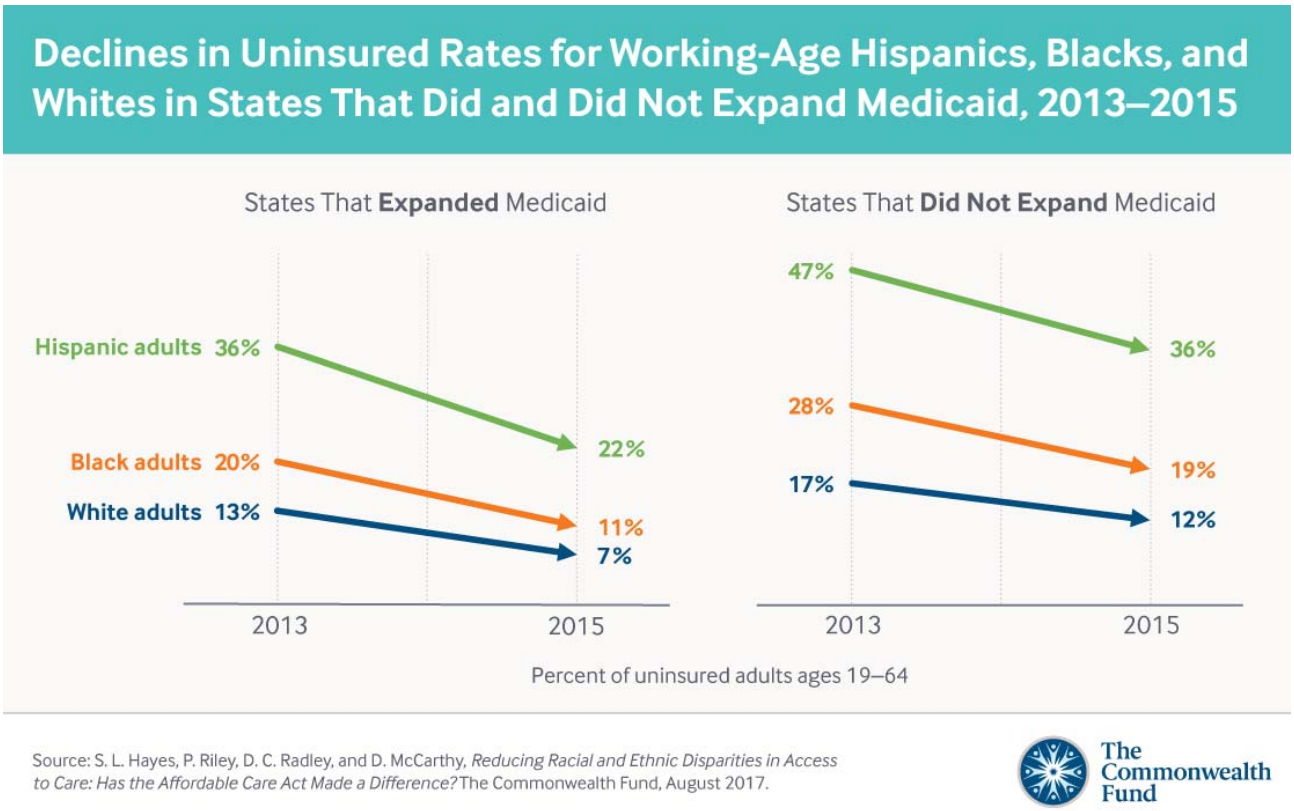
New Report: Affordable Care Act Narrowed Gaps in Access to Health Care Between Whites, and Blacks and Hispanics

Analysis Finds States That Expanded Medicaid Were More Likely to See Improvements

August 24, 2017

New York, NY, August 24 — The disparities in health care access that blacks and Hispanics face compared to whites narrowed between 2013 and 2015, following implementation of the Affordable Care Act's (ACA) major coverage provisions, according to a new Commonwealth Fund report.

While black and Hispanic adults still experience greater difficulty getting needed health care relative to whites, the historically wide gulf began to shrink after the ACA's coverage expansions took effect. As a group, states that expanded Medicaid saw, on average, greater declines in racial and ethnic disparities on health care access measures than nonexpansion states did.



The report, *Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference? (/publications/issue-briefs/2017/aug/racial-ethnic-disparities-care),* looks at three key measures of access through the lens of race and ethnicity: not having a regular source of care, not having insurance coverage, and going without needed health care because of cost. The analysis finds that between 2013 and 2015:

- **Regular health care provider:** The black–white disparity in the share of adults without a usual source of care has shrunken by nearly half, from eight percentage points to five points. The Hispanic–white disparity narrowed from 24 points to 21 points.
- **Health insurance coverage:** Among working-age adults who were uninsured, the black–white disparity narrowed by four percentage points, and the Hispanic –white disparity narrowed by seven points.

- **Skipping needed health care:** In terms of going without health care because of cost, the black–white disparity narrowed by two percentage points and the Hispanic–white disparity by three points.

"This analysis shows that the Affordable Care Act's health insurance coverage provisions have helped the U.S. make progress toward ensuring that everyone, regardless of race or ethnicity, has access to the health care they need," said Pamela Riley, M.D., The Commonwealth Fund's Vice President for Delivery System Reform and a coauthor of the report. "However, blacks and Hispanics are still much more likely than whites to be unable to get the health care they need. If we are going to reduce these disparities, we must continue to focus on policies like expanding eligibility for Medicaid that will address our health care system's historic inequities."

Overall, disparities shrank more between 2013 and 2015 in states that expanded Medicaid than in states that did not expand, especially for Hispanics:

- **Regular provider:** In Medicaid expansion states, the gap between Hispanics and whites narrowed by three percentage points, versus one point in nonexpansion states.
- **Health insurance coverage:** In expansion states, the gap between Hispanics and whites who were uninsured narrowed by eight percentage points, compared to six points in nonexpansion states.
- **Skipping needed health care:** In expansion states, the gap between blacks and whites in being able to afford needed health care narrowed by two percentage points, compared to one point in nonexpansion states.

ACA Improved Access to Health Care for Black and Hispanic Adults; Whites Still Do Better

According to the Commonwealth Fund report, blacks and Hispanics across the country made historic gains in their ability to access health care following the Affordable Care Act's full implementation. Even states that did not expand Medicaid saw improvements, as people gained coverage through the health insurance marketplaces. Between 2013 and 2015, an estimated:

- 2 million more black adults and 3.5 million more Hispanic adults had health insurance;
- 2.4 million fewer black and Hispanic adults reported that cost prevented them from visiting a doctor when they needed to; and
- 3.8 million more black adults and Hispanic adults had a usual source of health care.

"It's encouraging to see racial and ethnic disparities in access to health care narrowing," said Commonwealth Fund President David Blumenthal, M.D. "Improving upon the Affordable Care Act, and expanding Medicaid in all states, will be critical if we are going to see disparities continue to shrink and ensure that everyone can get affordable, high-quality health care."

Moving Forward

Despite the gains blacks and Hispanics have made, they still have a harder time than whites getting the health care they need and are more likely to be uninsured, skip needed health care because of cost, and go without a regular source of care. As Congress debates how to move forward with the Affordable Care Act and its health insurance marketplaces, the report's authors say that it is important to keep in mind the millions of black and Hispanics for whom access to care improved as a result of the law.

Methodology

Indicators and Data Sources:

Percent of uninsured adults ages 19–64. Source: Authors' analysis of U.S. Census Bureau, 2013, and 2015 1-Year American Community Surveys, Public Use Microdata Sample (ACS PUMS).

Percent of adults age 18 and older who went without care because of cost during past year and percent *of adults age 18 and older who did not have a usual source of care*. Source: Authors' analysis of 2013 and 2015 Behavioral Risk Factor Surveillance System (BRFSS).

For this analysis, survey respondents were stratified by their self-reported race or ethnicity: white (non-Hispanic), black (non-Hispanic) or Hispanic (any race). National averages were calculated for each of the indicators listed above, stratified by race/ethnicity. In addition, average rates were calculated for white, black, and Hispanic individuals in 2013 and in 2015 across two categories of states: The Medicaid expansion group included the 27 states that, along with the District of Columbia, expanded their Medicaid programs under the ACA between January 1, 2014, and January 1, 2015; the nonexpansion group comprised the 23 states that had not expanded Medicaid as of that time. Reported values are averages across survey respondents, not state averages. Subpopulation rates were suppressed if unweighted cell counts were less than 50.

ISSUE BRIEF
AUGUST 2017

How Medicaid Expansion Affected Out-of-Pocket Health Care Spending for Low-Income Families

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ABSTRACT

ISSUE: Prior research shows that low-income residents of states that expanded Medicaid under the Affordable Care Act are less likely to experience financial barriers to health care access, but the impact on out-of-pocket spending has not yet been measured.

GOAL: Assess how the Medicaid expansion affected out-of-pocket health care spending for low-income families compared to those in states that did not expand and consider whether effects differed in states that expanded under conventional Medicaid rules vs. waiver programs.

METHODS: Analysis of the Consumer Expenditure Survey 2010–2015.

KEY FINDINGS AND CONCLUSIONS: Compared to families in nonexpansion states, low-income families in states that did expand Medicaid saved an average of $382 in annual spending on health care. In these states, low-income families were less like to report any out-of-pocket spending on insurance premiums or medical care than were similar families in nonexpansion states. For families that did have some out-of-pocket spending, spending levels were lower in states that expanded Medicaid. Low-income families in Medicaid expansion states were also much less likely to have catastrophically high spending levels. The form of coverage expansion — conventional Medicaid or waiver rules — did not have a statistically significant effect on these outcomes.

KEY TAKEAWAYS

- Low-income families in states that expanded Medicaid are less likely to have any out-of-pocket health care costs than are low-income families in nonexpansion states.
- Among low-income families that have out-of-pocket premium or cost-sharing expenses, those in expansion states spend much less than those in nonexpansion states.
- There is little difference in spending between states that expanded Medicaid by conventional means and states that expanded under waiver rules.

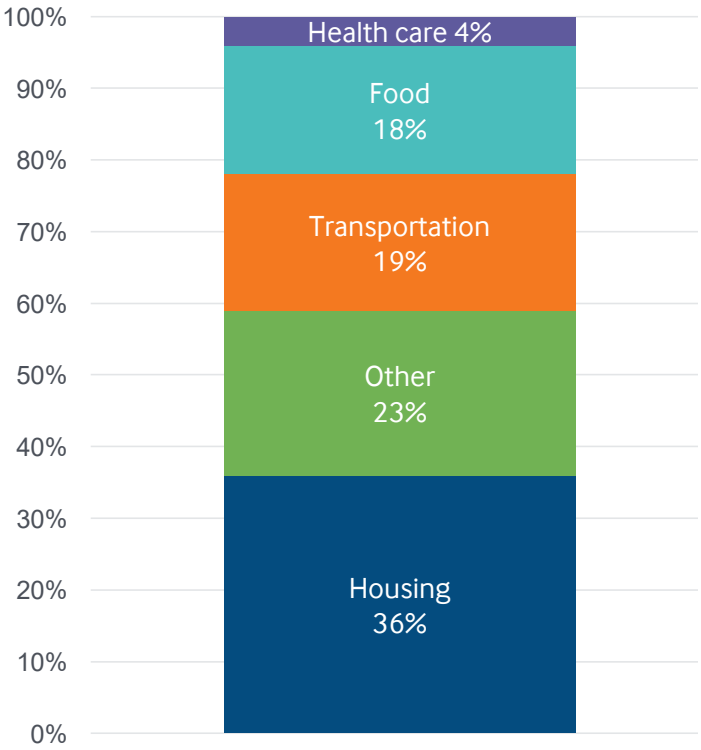
The Commonwealth Fund

BACKGROUND

Providing people with health insurance improves access to care by reducing financial barriers, which are most evident at the point of care — that is, when people try to get health care services.[1] In addition, expanding insurance coverage reduces the cost of care; previous research has shown that expanding eligibility for Medicaid reduces bankruptcy and debt.[2] This is particularly important for low-income families with little flexibility in their budgets to accommodate unexpected medical spending. For families with incomes under 138 percent of the federal poverty level (i.e., less than $33,600 for a family of four), housing, food, and transportation spending make up 73 percent of their total monthly budget (Exhibit 1).

To ease this economic burden and enhance access to care for low-income families, the Affordable Care Act expanded Medicaid coverage to adults with incomes up to 138 percent of the poverty level, although a later Supreme Court decision made this optional for states. In 2014, 30 states and the District of Columbia participated in the Medicaid expansion, 20 states did not. (Louisiana has since chosen to participate.) This variation offers a natural experiment to study the effects of the expansion. Recent studies have examined the effect of the expansion on the uninsured rate, access to care, and satisfaction.[3] One found that after the first two years, the expansion was associated with a 12.1 percentage-point increase in the likelihood of having a personal doctor, a 11.6 percentage-point decrease in skipping medications because of cost, and a 16.1 percentage-point increase in the likelihood of having a checkup in the past year.[4]

Exhibit 1. Health Care and Other Basic Needs as a Share of Total Expenditures for Low-Income Families



Data: Consumer Expenditure Survey 2010–2015, Families Under 138% of Federal Poverty Guideline.

In this study, we use data from the federal Consumer Expenditure Survey to examine how states' participation in the Medicaid expansion affected families' health care spending. Prior estimates suggest that the rate of Medicaid coverage increased by between 8 percent and 13.1 percent more in expansion states compared to nonexpansion states.[5] Our data show similar effects. Based on the estimate that enrollment in Medicaid increased by 13 percent more in expansion states, we use our estimates of average savings across the entire eligible population (whether or not newly enrolled) to provide estimates for those who were newly enrolled.

Seven states that participated in the expansion — Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and New Hampshire — did so under federally approved Section 1115 waivers.[6] Waiver requirements vary from state to state: Arkansas uses Medicaid funds to subsidize private insurance options, others include personal responsibility requirements,[7] such as premiums and cost-sharing, incentives for healthy behavior, and health savings account (HSA) contributions.[8]

Previous analyses comparing the experience of beneficiaries in waiver and nonwaiver states found few significant differences in coverage, access, or utilization. For instance, both Kentucky, a nonwaiver state, and Arkansas, a waiver state, after one year, had significant declines in the uninsured rate and significant

improvements in affordability, access to prescriptions, and care for chronic conditions. However, Arkansas did not see a significant reduction in the number of people with trouble paying medical bills.[9] Another analysis found similar results, including notably higher annual out-of-pocket medical spending in Arkansas than in Kentucky.[10] We repeat our analyses separately for waiver and nonwaiver states to assess these differences.

Medicaid coverage in most states requires low or no premiums, deductibles, or copayments. In expansion states that have adopted traditional Medicaid, as well as in most waiver states, premiums and cost-sharing may total to no more than 5 percent of income.[11] Consequently, enrollment in Medicaid might be expected to reduce beneficiaries' out-of-pocket spending to nearly zero. We evaluate how Medicaid affected the probability that a family had no out-of-pocket spending on premiums or cost-sharing. Some families may have incurred health care expenditures prior to enrolling in Medicaid. Indeed, poor health may be the factor that reduces incomes and makes families eligible for the program. We therefore separately examine the effects of Medicaid on reducing spending for people who had any level of expenditures. Finally, we look at how the Medicaid expansion affected catastrophic spending — that is, people whose spending placed them in the 90th percentile.

FINDINGS

Overall Effects of the Medicaid Expansion on Out-of-Pocket Spending

Low-income families living in states that expanded Medicaid had odds of having any out-of-pocket total health care spending that were 79 percent as high as those families living in nonexpansion states; this implies that they were about 11 percent less likely to have any spending. They were also less likely to have spent any money out-of-pocket on each major category of spending (total health care spending includes insurance premiums; medical services, which includes hospital services, physician services, and other medical costs; and prescription drugs).

Among families that did have expenditures, those who lived in expansion states spent much less. Families in expansion states who had any amount of out-of-pocket spending spent, on average, $754 less on total health care spending annually than did similar families in nonexpansion states. Those with any spending on health insurance premiums (about two-thirds of those with any spending had premium expenditures) spent about $379 less on premiums in expansion states compared to those in nonexpansion states. Those with any out-of-pocket expenses for medical services spent about $972 less in expansion states compared to those in nonexpansion states (Exhibit 2). Lower hospital spending among the very small number with any spending accounted for the largest share of savings in this category.

Medicaid reduces the likelihood of having any spending, and it reduces the level of spending among those who do have out-of-pocket expenses. When we combine those effects — the likelihood of having any spending with the amount spent among those who do have health care expenses — the average low-income family in an expansion state saved about $382 annually relative to a comparable family in a nonexpansion state. This lower spending is attributable to statistically significantly lower spending on insurance premiums, medical services, hospital services, prescription drugs, and lab tests (not shown).

If we assume that the overall reduction in medical spending observed in Medicaid expansion states was driven by families newly enrolled in Medicaid, and then conservatively assume that Medicaid enrollment increased by 13 percentage points more in expansion than nonexpansion states, the average newly enrolled Medicaid family saved at least $3,000 annually compared to what they would have spent without Medicaid.

Effects of the Medicaid Expansion on Those with Higher and Lower Out-of-Pocket Spending Levels

We next focus only on those with any spending and assess the effects of Medicaid expansion on people with higher and lower levels of spending (Exhibit 3). We find that the expansion had modest effects on out-of-pocket spending among those with low expenditure levels. At the median,

Exhibit 2. Spending on Premiums and Services Among Low-Income Families in States That Expanded Medicaid Compared to States That Did Not Expand Medicaid

Category of spending	Any spending in this category, 2010	Odds ratio: effect of expansion on probability of any spending	Effect of expansion on level of out of pocket spending among those with any spending	Combined effect of expansion (i.e., the likelihood of having any spending and reduced amount spent among those with health care expenses)
Total health care spending	50%	0.79***	–$754**	–$382***
Insurance premiums	34%	0.87	–$379***	–$133*
Prescription drugs	22%	0.85	–$111	$33*
Medical services	21%	0.68***	–$972**	–$249***
Hospital services	3%	0.72	–$5,862	–$297*
Physician services	11%	0.85	$201	–$5

Significance: * p<0.1, ** p<0.05, *** p<0.01.

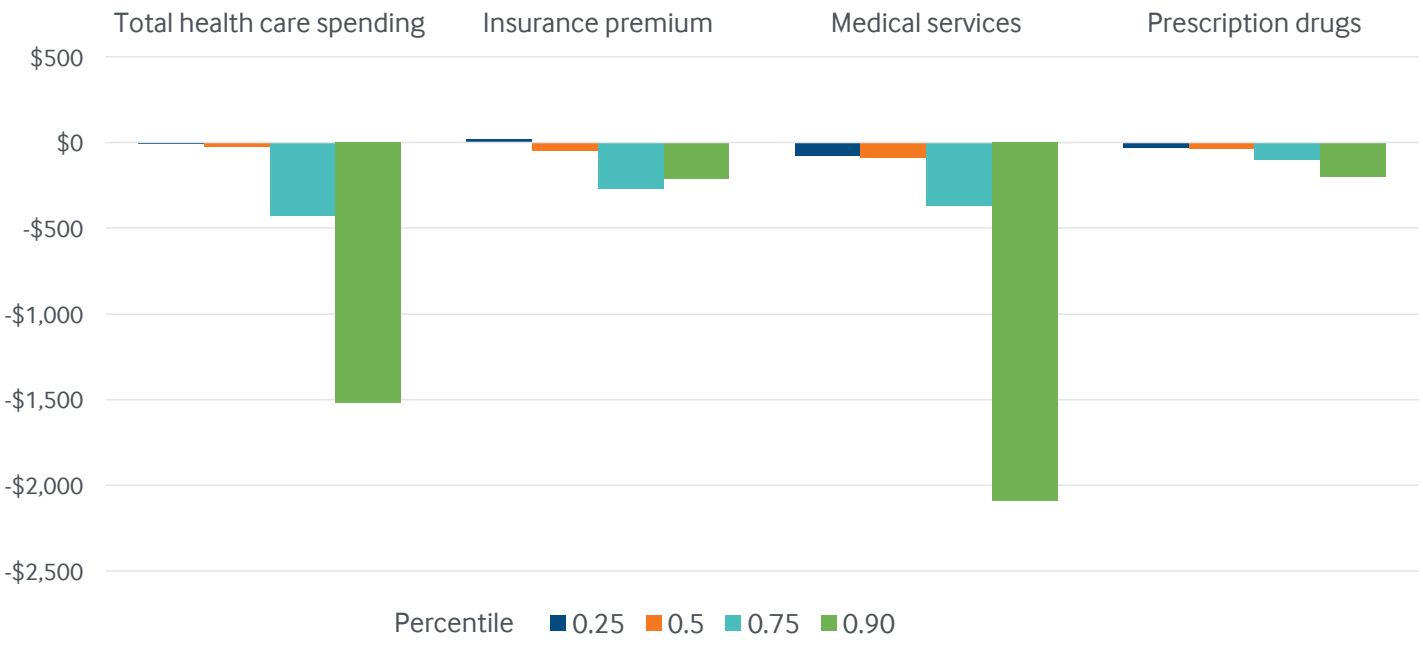
Regressions control for year, state as well as education, age, gender, race, family size, family type, and salary income. Combined effect incorporates both odds of any spending and level of spending among spenders using a two-part model. The two-part model uses a GLM-Log-Link specification.

* Total health care spending includes insurance premiums, prescription drugs, medical services, and medical supplies (not shown).

** Medical services include hospital services and physician services, as well as (not shown) dental care, eye care, lab tests, service by professionals other than physician, medical care in retirement community, care in convalescent or nursing home, repair of medical equipment, and other medical care services.

Data: Consumer Expenditure Survey 2010–2015, Families Under 138% of Federal Poverty Guideline.

Exhibit 3. Effects of Medicaid Expansion on Out-of-Pocket Spending Among Low-Income Families, by Spending Level



Bars represent changes in spending at the 25th percentile, 50th percentile, 75th percentile, and 90th percentile of the expenditure distribution.

Data: Consumer Expenditure Survey 2010–2015, Families Under 138% of Federal Poverty Guideline.

low-income families in Medicaid expansion states saw total health care spending fall by just $27. But the effects were much larger among those with very high levels of spending. Families in expansion states were much less likely to incur extremely high levels of spending. The highest level of spending among low-income families — those at in the top 10 percent of all spenders — fell very substantially; on average, by more than $1,500. This implies that in addition to providing access to preventive and routine care, as prior research has shown, expanding Medicaid substantially reduced the risk that low-income families incurred catastrophic expenses.

Differences Between Waiver and Nonwaiver States

The overall effects were comparable in states that expanded using traditional Medicaid or waivers, but the patterns were slightly different (Exhibit 4). Because waiver states have higher use of premiums, copayments, and other cost-sharing, families in these states were less likely to report they had zero out-of-pocket health spending. But overall changes in spending (including the effects of Medicaid on the level of spending among those who did incur expenses), were comparable across the two groups of states.

Exhibit 4. Spending on Premiums and Services Among Low-Income Families in States That Expanded Medicaid Compared to States That Did Not Expand Medicaid, by Waiver Status

Category of spending	Any spending in this category, 2010	Odds ratio: effect of expansion on probability of any spending		Effect of expansion on level of spending among those with any spending		Combined effect of expansion (i.e., the likelihood of having any spending and reduced amount spent among those with health care expenses)	
		Expansion without waiver	Expansion with waiver	Expansion without waiver	Expansion with waiver	Expansion without waiver	Expansion with waiver
Total health care spending	50%	0.799*	0.72	–$757***	–$729	–$382*	–$387
Insurance premiums	34%	0.863	0.99	–$389	–$300	–$142	–$64
Prescription drugs	22%	0.85	0.9	–$116	–$78	–$34	–$19
Medical services	21%	0.67***	0.89	–$906**	–$1,719	–$241***	–$382**
Hospital services	3%	0.67	1.38	–$6,391	–$2,145	–$336*	–$3
Physician services	11%	0.81	1.28	$171	$407	–$10	$33

Significance: * p<0.1, ** p<0.05, *** p<0.01.

* Total health care spending includes insurance premiums, prescription drugs, medical services, and medical supplies (not shown).

** Medical services include hospital services and physician services, as well as (not shown) dental care, eye care, lab tests, service by professionals other than physician, medical care in retirement community, care in convalescent or nursing home, repair of medical equipment, and other medical care services.

Data: Consumer Expenditure Survey 2010–2015, Families Under 138% of Federal Poverty Guideline.

DISCUSSION

Prior research has shown that after 2014, insurance coverage increased much more for people in states that expanded their Medicaid programs compared to those living in states that did not expand. These expansions led to improved access to services and less financial hardship. Consistent with these prior findings, our analyses suggest that the expansion reduced average out-of-pocket health spending among low-income families.

The effects of the expansion occur in two ways. First, expanding Medicaid reduces the probability that enrolled state residents will have any out-of-pocket spending on health insurance premiums or cost-sharing. Second, for people who are eligible but not enrolled, Medicaid provides a safety net if someone becomes unexpectedly ill or injured. These people do not have to wait for an open enrollment period and can instead sign up immediately, which will effectively cap their out-of-pocket spending and prevent them from incurring substantial out-of-pocket costs. These aspects of Medicaid coverage are especially important for low-income families, since they have so little room in their budgets to pay for insurance or health care.

HOW THIS STUDY WAS CONDUCTED

Our analysis uses data from the annual Consumer Expenditure Survey. We examined total health care spending, spending on health insurance, spending on health care services, and several categories of services. We also compare effects in states that expanded Medicaid with a Section 1115 waiver to those that expanded without a waiver. The waiver analyses should be viewed as preliminary, because the sample is quite small and the number of observations in the relevant income groups in waiver states is limited.

We drew our sample from the Consumer Expenditure Survey 2010–2015. Our sample was restricted to low-income families (i.e., those with incomes under 138 percent of the federal poverty level), between the ages of 18 and 64. These restrictions left us with 7,161 observations over the span of six years.

We fit two-part models (the standard approach to health insurance expenditure estimation) for each expenditure category where the first part estimates the probability of using any services in that category and the second part examines the level of spending among those with spending. We use a standard method for combining these estimates, called a generalized linear model with a log-link function. In both sets of regressions, we control for year and state, along with education, age, sex, race, family size, family type, and gross salary income.

The explanatory variable that measures the effect of Medicaid expansion is a comparison between the change in outcomes over time (before and after 2014, or the year an expansion was implemented) in states that did expand Medicaid and those that did not.

We repeated the same analysis for states that expanded with and without waivers.

Finally, we examined spending at different points among high and low spenders using a method called quantile regression.

NOTES

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

2 K. Baicker and A. Finkelstein, "The Effects of Medicaid Coverage — Learning from the Oregon Experiment," *New England Journal of Medicine,* Aug. 25, 2011 365(8):683–85; and T. Gross and M. J. Notowidigdo, "Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid," *Journal of Public Economics,* Aug. 2011 95(7–8):767–78.

3 S. Basseyn, B. Saloner, G. M. Kenney et al., "Primary Care Appointment Availability for Medicaid Patients: Comparing Traditional and Premium Assistance Plans," *Medical Care,* Sept. 2016 54(9):878–83; B. D. Sommers, R. J. Blendon, and E. J. Orav, "Both the 'Private Option' and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults," *Health Affairs,* Jan. 2016 35(1):96–105; B. D. Sommers, R. J. Blendon, E. J. Orav et al., "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Internal Medicine,* published online Aug. 8, 2016; R. Tipirneni, K. V. Rhodes, R. A. Hayward et al., "Primary Care Appointment Availability and Nonphysician Providers One Year After Medicaid Expansion," *American Journal of Managed Care,* June 2016 22(6):427–31; C. Courtemanche, J. Marton, and A. Yelowitz, "Who Gained Insurance Coverage in 2014, the First Year of Full ACA Implementation?" *Health Economics,* June 2016 25(6):778–84; and C. Courtemanche, J. Marton, B. Ukert et al., "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States," *Journal of Policy Analysis and Management*, Winter 2017 36(1):178–210.

4 B. D. Sommers, R. J. Blendon, E. J. Orav et al., "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Internal Medicine,* published online Aug. 8, 2016.

5 M. Frean, J. Gruber, and B. D. Sommers, *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act* (National Bureau of Economic Research, April 2016); and C. Courtemanche, J. Marton, B. Ukert et al., "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States," *Journal of Policy Analysis and Management*, Winter 2017 36(1):178–210.

6 Kaiser Commission on Medicaid and the Uninsured, *Current Status of State Medicaid Expansion Decisions* (Henry J. Kaiser Family Foundation, Jan. 1, 2017).

7 J. B. Wishner, J. Holahan, D. Upadhyay et al., *Medicaid Expansion, the Private Option, and Personal Responsibility Requirements* (Urban Institute, May 2015).

8 A. M. Baker and L. M. Hunt, "Counterproductive Consequences of a Conservative Ideology: Medicaid Expansion and Personal Responsibility Requirements," *American Journal of Public Health,* July 2016 106(7):1181–87.

9 B. D. Sommers, R. J. Blendon, and E. J. Orav, "Both the 'Private Option' and Traditional Medicaid Expansions Improved Access to Care for Low-Income Adults," *Health Affairs,* Jan. 2016 35(1):96–105.

10 B. D. Sommers, R. J. Blendon, E. J. Orav et al., "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *JAMA Internal Medicine,* published online Aug. 8, 2016.

11 S. Beutel, M. Z. Gunja, and S. R. Collins, *How Much Financial Protection Do Marketplace Plans Provide in States Not Expanding Medicaid?* (The Commonwealth Fund, June 2016).

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August 2017 | Issue Brief

An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges

Rabah Kamal, Cynthia Cox, Care Shoaibi, Brian Kaplun, Ashley Semanskee, and Larry Levitt

Each year insurers submit filings to state regulators detailing their plans to participate on the Affordable Care Act marketplaces (also called exchanges). These filings include information on the premiums insurers plan to charge in the coming year and which areas they plan to serve. Each state or the federal government reviews premiums to ensure they are accurate and justifiable before the rate goes into effect, though regulators have varying types of authority and states make varying amounts of information public.

In this analysis, we look at preliminary premiums and insurer participation in the 20 states and the District of Columbia where publicly available rate filings include enough detail to be able to show the premium for a specific enrollee. As in previous years, we focus on the second-lowest cost silver plan in the major city in each state. This plan serves as the benchmark for premium tax credits. Enrollees must also enroll in a silver plan to obtain reduced cost sharing tied to their incomes. About 71% of marketplace enrollees are in silver plans this year.

States are still reviewing premiums and participation, so the data in this report are preliminary and could very well change. Rates and participation are not locked in until late summer or early fall (insurers must sign an annual contract by September 27 in states using Healthcare.gov).

Insurers in this market face new uncertainty in the current political environment and in some cases have factored this into their premium increases for the coming year. Specifically, insurers have been unsure whether the individual mandate (which brings down premiums by compelling healthy people to buy coverage) will be repealed by Congress or to what degree it will be enforced by the Trump Administration. Additionally, insurers in this market do not know whether the Trump Administration will continue to make payments to compensate insurers for cost-sharing reductions (CSRs), which are the subject of a lawsuit, or whether Congress will appropriate these funds. (More on these subsidies can be found here).

The vast majority of insurers included in this analysis cite uncertainty surrounding the individual mandate and/or cost sharing subsidies as a factor in their 2018 rates filings. Some insurers explicitly factor this uncertainty into their initial premium requests, while other companies say if they do not receive more clarity or if cost-sharing payments stop, they plan to either refile with higher premiums or withdraw from the market. We include a table in this analysis highlighting examples of companies that have factored this uncertainty into their initial premium increases and specified the amount by which the uncertainty is increasing rates.

Changes in the Second-Lowest Cost Silver Premium

The second-lowest silver plan is one of the most popular plan choices on the marketplace and is also the benchmark that is used to determine the amount of financial assistance individuals and families receive. The table below shows these premiums for a major city in each state with available data. (Our analyses from 2017, 2016, 2015, and 2014 examined changes in premiums and participation in these states and major cities since the exchange markets opened nearly four years ago.)

Across these 21 major cities, based on preliminary 2018 rate filings, the second-lowest silver premium for a 40-year-old non-smoker will range from $244 in Detroit, MI to $631 in Wilmington, DE, before accounting for the tax credit that most enrollees in this market receive.

Of these major cities, the steepest proposed increases in the unsubsidized second-lowest silver plan are in Wilmington, DE (up 49% from $423 to $631 per month for a 40-year-old non-smoker), Albuquerque, NM (up 34% from $258 to $346), and Richmond, VA (up 33% from $296 to $394). Meanwhile, unsubsidized premiums for the second-lowest silver premiums will decrease in Providence, RI (down -5% from $261 to $248 for a 40-year-old non-smoker) and remain essentially unchanged in Burlington, VT ($492 to $491).

As discussed in more detail below, this year's preliminary rate requests are subject to much more uncertainty than in past years. An additional factor driving rates this year is the return of the ACA's health insurance tax, which adds an estimated 2 to 3 percentage points to premiums.

Most enrollees in the marketplaces (84%) receive a tax credit to lower their premium and these enrollees will be protected from premium increases, though they may need to switch plans in order to take full advantage of the tax credit. The premium tax credit caps how much a person or family must spend on the benchmark plan in their area at a certain percentage of their income. For this reason, in 2017, a single adult making $30,000 per year would pay about $207 per month for the second-lowest-silver plan, regardless of the sticker price (unless their unsubsidized premium was less than $207 per month). If this person enrolls in the second lowest-cost silver plan is in 2018 as well, he or she will pay slightly less (the after-tax credit payment for a similar person in 2018 will be $201 per month, or a decrease of 2.9%). Enrollees can use their tax credits in any marketplace plan. So, because tax credits rise with the increase in benchmark premiums, enrollees are cushioned from the effect of premium hikes.

Table 1: Monthly Silver Premiums and Financial Assistance for a 40 Year Old Non-Smoker Making $30,000 / Year										
State	Major City	2nd Lowest Cost Silver Before Tax Credit			2nd Lowest Cost Silver After Tax Credit			Amount of Premium Tax Credit		
		2017	2018	% Change from 2017	2017	2018	% Change from 2017	2017	2018	% Change from 2017
California*	Los Angeles	$258	$289	12%	$207	$201	-3%	$51	$88	71%
Colorado	Denver	$313	$352	12%	$207	$201	-3%	$106	$150	42%
Connecticut	Hartford	$369	$417	13%	$207	$201	-3%	$162	$216	33%
DC	Washington	$298	$324	9%	$207	$201	-3%	$91	$122	35%
Delaware	Wilmington	$423	$631	49%	$207	$201	-3%	$216	$430	99%
Georgia	Atlanta	$286	$308	7%	$207	$201	-3%	$79	$106	34%
Idaho	Boise	$348	$442	27%	$207	$201	-3%	$141	$241	70%
Indiana	Indianapolis	$286	$337	18%	$207	$201	-3%	$79	$135	72%
Maine	Portland	$341	$397	17%	$207	$201	-3%	$134	$196	46%
Maryland	Baltimore	$313	$392	25%	$207	$201	-3%	$106	$191	81%
Michigan*	Detroit	$237	$244	3%	$207	$201	-3%	$29	$42	44%
Minnesota**	Minneapolis	$366	$383	5%	$207	$201	-3%	$159	$181	14%
New Mexico	Albuquerque	$258	$346	34%	$207	$201	-3%	$51	$144	183%
New York***	New York City	$456	$504	10%	$207	$201	-3%	$249	$303	21%
Oregon	Portland	$312	$350	12%	$207	$201	-3%	$105	$149	42%
Pennsylvania	Philadelphia	$418	$515	23%	$207	$201	-3%	$211	$313	49%
Rhode Island	Providence	$261	$248	-5%	$207	$201	-3%	$54	$47	-13%
Tennessee	Nashville	$419	$507	21%	$207	$201	-3%	$212	$306	44%
Vermont	Burlington	$492	$491	0%	$207	$201	-3%	$285	$289	2%
Virginia	Richmond	$296	$394	33%	$207	$201	-3%	$89	$193	117%
Washington	Seattle	$238	$306	29%	$207	$201	-3%	$31	$105	239%

NOTES: *The 2018 premiums for MI and CA reflect the assumption that CSR payments will continue. **The 2018 premium for MN assumes no reinsurance. ***Empire has filed to offer on the individual market in New York in 2018 but has not made its rates public.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Looking back to 2014, when changes to the individual insurance market under the ACA first took effect, reveals a wide range of premium changes. In many of these cities, average annual premium growth over the 2014-2018 period has been modest, and in two cites (Indianapolis and Providence), benchmark premiums have actually decreased. In other cities, premiums have risen rapidly over the period, though in some cases this rapid growth was because premiums were initially quite low (e.g., in Nashville and Minneapolis).

Table 2: Monthly Benchmark Silver Premiums for a 40 Year Old Non-Smoker, 2014-2018								
State	Major City	2014	2015	2016	2017	2018	Average Annual % Change from 2014 to 2018	Average Annual % Change After Tax Credit, $30K Income
California	Los Angeles	$255	$257	$245	$258	$289	3%	-1%
Colorado	Denver	$250	$211	$278	$313	$352	9%	-1%
Connecticut	Hartford	$328	$312	$318	$369	$417	6%	-1%
DC	Washington	$242	$242	$244	$298	$324	8%	-1%
Delaware	Wilmington	$289	$301	$356	$423	$631	22%	-1%
Georgia	Atlanta	$250	$255	$254	$286	$308	5%	-1%
Idaho	Boise	$231	$210	$273	$348	$442	18%	-1%
Indiana	Indianapolis	$341	$329	$298	$286	$337	0%	-1%
Maine	Portland	$295	$282	$288	$341	$397	8%	-1%
Maryland	Baltimore	$228	$235	$249	$313	$392	15%	-1%
Michigan*	Detroit	$224	$230	$226	$237	$244	2%	-1%
Minnesota**	Minneapolis	$162	$183	$235	$366	$383	24%	6%
New Mexico	Albuquerque	$194	$171	$186	$258	$346	16%	1%
New York***	New York City	$365	$372	$369	$456	$504	8%	-1%
Oregon	Portland	$213	$213	$261	$312	$350	13%	-1%
Pennsylvania	Philadelphia	$300	$268	$276	$418	$515	14%	-1%
Rhode Island	Providence	$293	$260	$263	$261	$248	-4%	-1%
Tennessee	Nashville	$188	$203	$281	$419	$507	28%	2%
Vermont	Burlington	$413	$436	$468	$492	$491	4%	-1%
Virginia	Richmond	$253	$260	$276	$296	$394	12%	-1%
Washington	Seattle	$281	$254	$227	$238	$306	2%	-1%

NOTES: *The 2018 premiums for MI and CA reflect the assumption that CSR payments will continue. **The 2018 premium for MN assumes no reinsurance. ***Empire has filed to offer on the individual market in New York in 2018 but has not made its rates public.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Changes in Insurer Participation

Across these 20 states and DC, an average of 4.6 insurers have indicated they intend to participate in 2018, compared to an average of 5.1 insurers per state in 2017, 6.2 in 2016, 6.7 in 2015, and 5.7 in 2014. In states using Healthcare.gov, insurers have until September 27 to sign final contracts to participate in 2018. Insurers often do not serve an entire state, so the number of choices available to consumers in a particular area will typically be less than these figures.

Table 3: Total Number of Insurers by State, 2014 – 2018					
State	Total Number of Issuers in the Marketplace				
	2014	2015	2016	2017	2018 (Preliminary)
California	11	10	12	11	11
Colorado	10	10	8	7	7
Connecticut	3	4	4	2	2
DC	3	3	2	2	2
Delaware	2	2	2	2	1 (Aetna exiting)
Georgia	5	9	8	5	4 (Humana exiting)
Idaho	4	5	5	5	4 (Cambia exiting)
Indiana	4	8	7	4	2 (Anthem and MDwise exiting)
Maine	2	3	3	3	3
Maryland	4	5	5	3	3 (Cigna exiting, Evergreen[1] filed to reenter)
Michigan	9	13	11	9	8 (Humana exiting)
Minnesota	5	4	4	4	4
New Mexico	4	5	4	4	4
New York	16	16	15	14	14
Oregon	11	10	10	6	5 (Atrio exiting)
Pennsylvania	7	8	7	5	5
Rhode Island	2	3	3	2	2
Tennessee	4	5	4	3	3 (Humana exiting, Oscar entering)
Vermont	2	2	2	2	2
Virginia	5	6	7	8	6 (UnitedHealthcare and Aetna exiting)
Washington	7	9	8	6	5 (Community Health Plan of WA exiting)
Average (20 states + DC)	5.7	6.7	6.2	5.1	4.6

NOTES: Insurers are grouped by parent company or group affiliation, which we obtained from HHS Medical Loss Ratio public use files and supplemented with additional research.
[1]The number of preliminary 2018 insurers in Maryland includes Evergreen, which submitted a filing but has been placed in receivership.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Uncertainty Surrounding ACA Provisions

Insurers in the individual market must submit filings with their premiums and service areas to states and/or the federal government for review well in advance of these rates going into effect. States vary in their deadlines and processes, but generally, insurers were required to submit their initial rate requests in May or June of 2017 for products that go into effect in January 2018. Once insurers set their premiums for 2018 and sign final contacts at the end of September, those premiums are locked in for the entire calendar year and insurers do not have an opportunity to revise their rates or service areas until the following year.

Meanwhile, over the course of this summer, the debate in Congress over repealing and replacing the Affordable Care Act has carried on as insurers set their rates for next year. Both the House and Senate bills included provisions that would have made significant changes to the law effective in 2018 or even retroactively, including repeal of the individual mandate penalty. Additionally, the Trump administration has sent mixed

signals over whether it would continue to enforce the individual mandate or make payments to insurers to reimburse them for the cost of providing legally required cost-sharing assistance to low-income enrollees.

Because this policy uncertainty is far outside the norm, insurers are making varying assumptions about how this uncertainty will play out and affect premiums. Some states have attempted to standardize the process by requesting rate submissions under multiple scenarios, while other states appear to have left the decision up to each individual company. There is no standard place in the filings where insurers across all states can explain this type of assumption, and some states do not post complete filings to allow the public to examine which assumptions insurers are making.

In the 20 states and DC with detailed rate filings included in the previous sections of this analysis, the vast majority of insurers cite policy uncertainty in their rate filings. Some insurers make an explicit assumption about the individual mandate not being enforced or cost-sharing subsidies not being paid and specify how much each assumption contributes to the overall rate increase. Other insurers state that if they do not get clarity by the time rates must be finalized – which is August 16 for the federal marketplace – they may either increase their premiums further or withdraw from the market.

Table 4 highlights examples of insurers that have explicitly factored into their premiums an assumption that either the individual mandate will not be enforced or cost-sharing subsidy payments will not be made *and* have specified the degree to which that assumption is influencing their initial rate request. As mentioned above, the vast majority of companies in states with detailed rate filings have included some language around the uncertainty, so it is likely that more companies will revise their premiums to reflect uncertainty in the absence of clear answers from Congress or the Administration.

Insurers assuming the individual mandate will not be enforced have factored in to their rate increases an additional 1.2% to 20%. Those assuming cost-sharing subsidy payments will not continue and factoring this into their initial rate requests have applied an additional rate increase ranging from 2% to 23%. Because cost-sharing reductions are only available in silver plans, insurers may seek to raise premiums just in those plans if the payments end. We estimate that silver premiums would have to increase by 19% on average to compensate for the loss of CSR payments, with the amount varying substantially by state.

Several insurers assumed in their initial rate filing that payment of the cost-sharing subsidies would continue, but indicated the degree to which rates would increase if they are discontinued. These insurers are *not* included in the Table 4. If CSR payments end or there is continued uncertainty, these insurers say they would raise their rates an additional 3% to 10% beyond their initial request – or ranging from 9% to 38% in cases when the rate increases would only apply to silver plans. Some states have instructed insurers to submit two sets of rates to account for the possibility of discontinued cost-sharing subsidies. In California, for example, a surcharge would be added to silver plans on the exchange, increasing proposed rates an additional 12.4% on average across all 11 carriers, ranging from 8% to 27%.

Table 4: Examples of Preliminary Insurer Assumptions Regarding Individual Mandate Enforcement and Cost-Sharing Reduction (CSR) Payments					
State	Insurer	Average Rate Increase Requested	Individual Mandate Assumption	CSR Payments Assumption	Requested Rate Increase Due to Mandate or CSR Uncertainty
CT	ConnectiCare	17.5%	Weakly enforced[1]	Not specified	Mandate: 2.4%
DE	Highmark BCBSD	33.6%	Not enforced	Not paid	Mandate and CSR: 12.8% combined impact
GA	Alliant Health Plans	34.5%	Not enforced	Not paid	Mandate: 5.0% CSR: Unspecified
ID	Mountain Health CO-OP	25.0%	Not specified	Not paid	CSR: 17.0%
ID	PacificSource Health Plans	45.6%	Not specified	Not paid	CSR: 23.2%
ID	SelectHealth	45.0%	Not specified	Not paid	CSR: 20.0%
MD	CareFirst BlueChoice	45.6%	Not enforced	Potentially not paid	Mandate: 20.0%
ME	Harvard PilgrimHealth Care	39.7%	Weakly enforced	Potentially not paid	Mandate: 15.9%
MI	BCBS of MI	26.9%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 5.0%
MI	Blue Care Network of MI	13.8%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 5.0%
MI	Molina Healthcare of MI	19.3%	Weakly enforced	Potentially not paid (two rate submissions)	Mandate: 9.5%
NM	CHRISTUS Health Plan	49.2%	Not enforced	Potentially not paid	Mandate: 9.0%, combined impact of individual mandate non-enforcement and reduced advertising and outreach
NM	Molina Healthcare of NM	21.2%	Weakly enforced	Paid	Mandate: 11.0%
NM	New Mexico Health Connections	32.8%	Not enforced	Potentially not paid	Mandate: 20.0%
OR*	BridgeSpan	17.2%	Weakly enforced	Potentially not paid	Mandate: 11.0%
OR*	Moda Health	13.1%	Not enforced	Potentially not paid	Mandate: 1.2%
OR*	Providence Health Plan	20.7%	Not enforced	Potentially not paid	Mandate: 9.7%, largely due to individual mandate non-enforcement
TN	BCBS of TN	21.4%	Not enforced	Not paid	Mandate: 7.0% CSR: 14.0%
TN	Cigna	42.1%	Weakly enforced	Not paid	CSR: 14.1%
TN	Oscar Insurance	NA (New to state)	Not enforced	Not paid	Mandate: 0%, despite non-enforcement CSR: 17.0%, applied only to silver plans
VA	CareFirst BlueChoice	21.5%	Not enforced	Potentially not paid	Mandate: 20.0%
VA	CareFirst GHMSI	54.3%	Not enforced	Potentially not paid	Mandate: 20.0%
WA	LifeWise Health Plan of Washington	21.6%	Weakly enforced	Not paid	Mandate: 5.2% CSR: 2.3%
WA	Premera Blue Cross	27.7%	Weakly enforced	Not paid	Mandate: 4.0% CSR: 3.1%
WA	Molina Healthcare of WA	38.5%	Weakly enforced	Paid	Mandate: 5.4%

NOTES: The CSR assumption "Potentially not paid" refers to insurers that filed initial rates assuming CSR payments are made and indicated that uncertainty over CSR funding would change their initial rate requests. In Michigan, insurers were instructed to submit a second set of filings showing rate increases without CSR payments; the rates shown above assume continued CSR payments. *The Oregon Division of Financial Regulation reviewed insurer filings and advised adjustment of the impact of individual mandate uncertainty to between 2.4% and 5.1%. Although rates have since been finalized, the increases shown here are based on initial insurer requests. [1]Connecticare assumes a public perception that the mandate will not be enforced.
SOURCE: Kaiser Family Foundation analysis of premium data from Healthcare.gov and insurer rate filings to state regulators.

Discussion

A number of insurers have requested double-digit premium increases for 2018. Based on initial filings, the change in benchmark silver premiums will likely range from -5% to 49% across these 21 major cities. These rates are still being reviewed by regulators and may change.

In the past, requested premiums have been similar, if not equal to, the rates insurers ultimately charge. This year, because of the uncertainty insurers face over whether the individual mandate will be enforced or cost-sharing subsidy payments will be made, some companies have included an additional rate increase in their initial rate requests, while other companies have said they may revise their premiums late in the process. It is therefore quite possible that the requested rates in this analysis will change between now and open enrollment.

Insurers attempting to price their plans and determine which states and counties they will service next year face a great deal of uncertainty. They must soon sign contracts locking in their premiums for the entire year of 2018, yet Congress or the Administration could make significant changes in the coming months to the law – or its implementation – that could lead to significant losses if companies have not appropriately priced for these changes. Insurers vary in the assumptions they make regarding the individual mandate and cost-sharing subsidies and the degree to which they are factoring this uncertainty into their rate requests.

Because most enrollees on the exchange receive subsidies, they will generally be protected from premium increases. Ultimately, most of the burden of higher premiums on exchanges falls on taxpayers. Middle and upper-middle income people purchasing their own coverage off-exchange, however, are not protected by subsidies and will pay the full premium increase, switch to a lower level plan, or drop their coverage. Although the individual market on average has been stabilizing, the concern remains that another year of steep premium increases could cause healthy people (particularly those buying off-exchange) to drop their coverage, potentially leading to further rate hikes or insurer exits.

Methods

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Premium data are current as of August 7, 2017; however, filings in most states are still preliminary and will likely change before open enrollment. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes.

How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care

Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016

August 10, 2017

Authors

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Citation

M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care,* The Commonwealth Fund, August 2017.

Abstract

(http://www.commonwealthfund.org/interactives-and-data/surveys/biennial-health-insurance-surveys/2017/biennial-explorer)

- **Issue:** Prior to the Affordable Care Act (ACA), one-third of women who tried to buy a health plan on their own were either turned down, charged a higher premium because of their health, or had specific health problems excluded from their plans. Beginning in 2010, ACA consumer protections, particularly coverage for preventive care screenings with no cost-sharing and a ban on plan benefit limits, improved the quality of health insurance for women. In 2014, the law's major insurance reforms helped millions of women who did not have employer insurance to gain coverage through the ACA's marketplaces or through Medicaid.
- **Goals:** To examine the effects of ACA health reforms on women's coverage and access to care.
- **Method:** Analysis of the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2016.

- **Findings and Conclusions:** Women ages 19 to 64 who shopped for new coverage on their own found it significantly easier to find affordable plans in 2016 compared to 2010. The percentage of women who reported delaying or skipping needed care because of costs fell to an all-time low. Insured women were more likely than uninsured women to receive preventive screenings, including Pap tests and mammograms.

Background

Compared with men, women on average have more interaction with the health care system over their lifetimes. Not only do women have relatively greater health care needs during their reproductive years, they also often serve as family caregivers and play a central role in coordinating the health care needs of multiple generations of family members, including children, spouses, and aging parents.[1 (#/#1)]

Accessing health care became increasingly challenging for women in the decade prior to the passage of the Affordable Care Act (ACA), as increasing numbers lost insurance coverage. The percentage of adult women under age 65 without insurance climbed from 13 percent in 2001 to 20 percent in 2010 — from 11 million to 19 million women (Exhibit 1). Women who lost their employer coverage had few places to turn. In most states, Medicaid was available only to women who were pregnant, parents with very low incomes, or people with disabilities. In the individual insurance market in most states, women could be charged more for a health plan, or denied coverage altogether, based on a preexisting health condition.

Exhibit 1

After Rising Steadily Through 2010, the Number of Uninsured Women in the U.S. Had Fallen by Nearly Half by 2016

Women ages 19–64

	2001	2003	2005	2010	2012	2014	2016
Uninsured now	13% 11 million	17% 15 million	18% 17 million	20% 19 million	17% 16 million	13% 12 million	11% 11 million
Insured now, had a gap	10% 9 million	9% 8 million	11% 10 million	9% 8 million	11% 11 million	13% 12 million	10% 9 million
Continuously insured	77% 64 million	74% 66 million	71% 65 million	71% 67 million	72% 68 million	74% 70 million	79% 75 million

Notes: "Uninsured now" refers to women who reported being uninsured at the time of the survey; "Insured now, had a gap" refers to women who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Continuously insured" refers to women who were insured for the full year up to and on the survey field date.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, 2014, 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

To insurers, women's gender was, in effect, a preexisting condition that signaled the potential for higher health care use and higher costs. That is why in most states insurers selling plans in the individual market charged young women higher premiums than young men — to protect themselves from this greater risk. The U.S. Government Accountability Office found in 2013 that in 38 states, individual-market plans with the lowest premiums charged a nonsmoking 30-year-old single woman a higher premium than they charged her male counterpart.[2 (#/#2)]

Insurers also protected themselves by excluding from coverage services that women would likely need, like maternity care. A 2012 study found only 12 percent of plans in the individual market offered maternity coverage, and only nine states required insurers to include this benefit.[3 (#/#3)] Consequently, women with individual-market plans had less comprehensive policies, on average, than those with employer coverage. In 2012, the Commonwealth Fund Biennial Health Insurance Survey found only 44 percent of women with individual-market coverage had maternity benefits, compared to 81 percent of women in an employer plan (data not shown). And only one-third (34%) of privately insured women with individual policies had a plan that covered birth control or contraceptives, roughly half the rate for women (62%) with employer coverage.

The ACA brought about sweeping changes in insurance for women. Because of the law, women who buy coverage on their own are no longer charged higher premiums than men in their own age group, can no longer be denied coverage because of preexisting conditions, and must be covered for essential services like maternity care. Tax credits have helped make individual plans affordable for women with low or moderate incomes, and millions of women have become eligible for Medicaid. Young women, meanwhile, can stay covered on a parent's health plan until age 26. In addition, all private plans, including employer plans, cannot place limits on how much they will pay annually or over a lifetime, and most plans must cover preventive services, including contraception, without cost-sharing.[4,5 (#/#4)] One 2015 study found the ACA collectively saved privately insured women about $1.4 billion per year on contraception.[6 (#/#6)]

This analysis of the 2016 Commonwealth Fund Biennial Health Insurance Survey compares women's health insurance and health care experiences in the years before and after the ACA's major coverage expansions in 2014.

Survey Findings

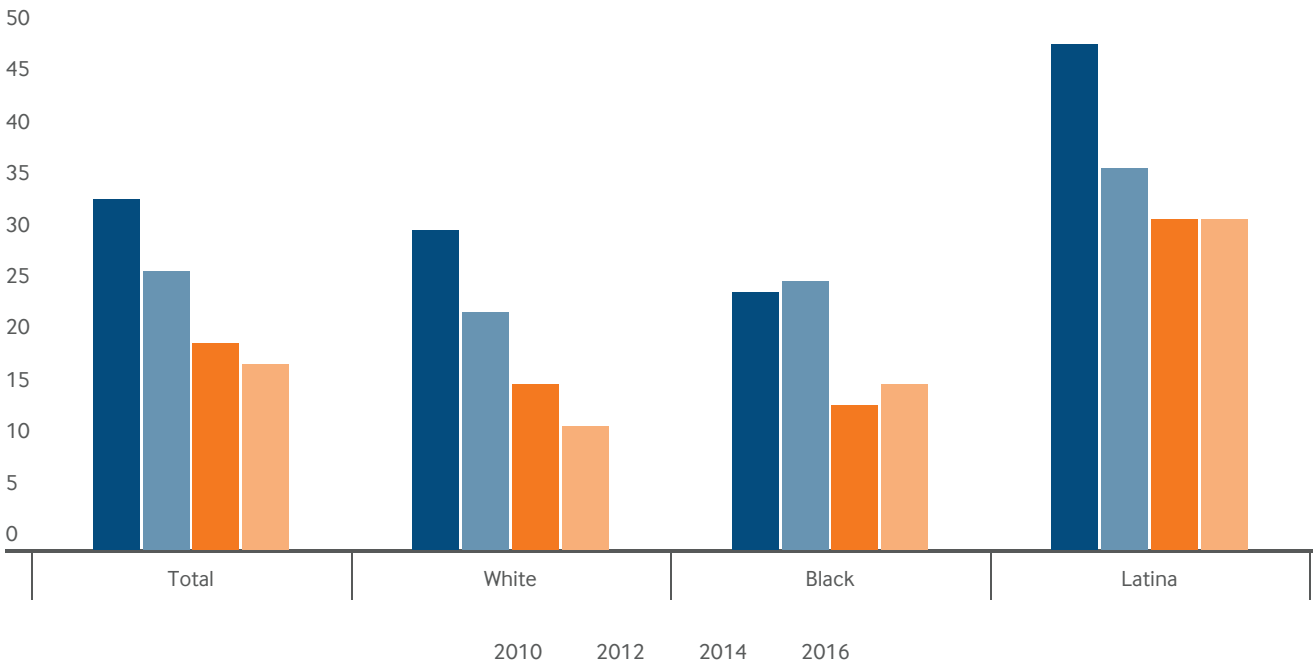
The Uninsured Rate for Women Is at an All-Time Low

By 2016, the number of working-age women (ages 19–64) lacking health insurance had fallen by almost half since 2010, from 19 million to 11 million, or from 20 percent to 11 percent of this population (Exhibit 1, Appendix 1 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)). Women with low incomes have made particularly large gains: uninsured rates for those with incomes below 200 percent of the federal poverty level ($23,760 for an individual or $48,600 for a family of four), fell from 34 percent in 2010 to 18 percent in 2016 (Exhibit 2). The findings are similar for low-income women of all races and ethnicities.

Exhibit 2

Women with Low Incomes Have Made Gains in Coverage Across Race and Ethnic Groups

Percent of women ages 19–64 who are uninsured and earn less than 200% FPL



Notes: FPL refers to federal poverty level. Income levels are for a family of four in 2016. Rates are for those uninsured at the time of the survey.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

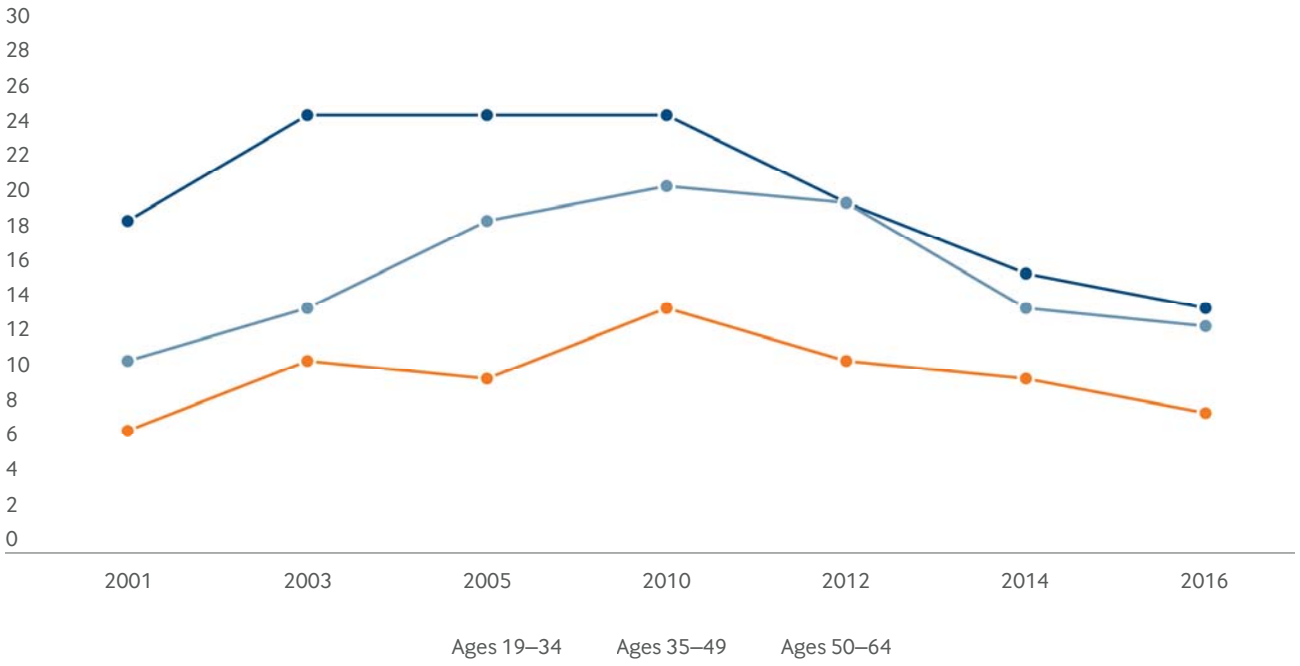
Share

Of all age groups, women 19 to 34 have seen the greatest improvements in their coverage (Exhibit 3). In 2010, 25 percent of young women reported being uninsured, compared to 14 percent in 2016. The early improvements seen in 2012 reflected young adults' recent ability to stay on a parent's policy until age 26. After 2014, young women made further gains through the expansion of Medicaid eligibility, new subsidies for private coverage, and reforms of the individual market.

Exhibit 3

Young Women Have Made the Greatest Coverage Gains of Any Age Group Since 2010

Percent of women ages 19–64 who are uninsured



Data: The Commonwealth Fund Biennial Health Insurance Surveys (2001, 2003, 2005, 2010, 2012, 2014, 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

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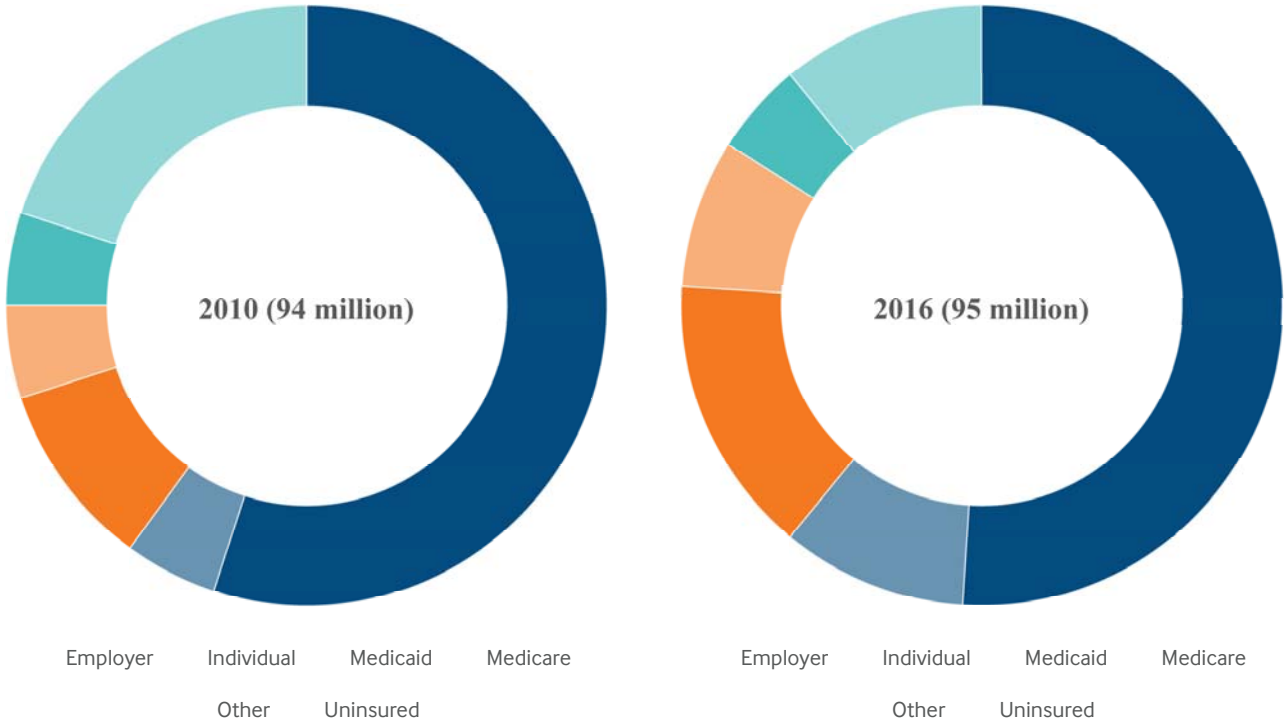
This broader availability of affordable insurance has led to striking changes in women's coverage. In 2010, just 5 percent of working-age women had coverage through the individual market and just 10 percent had Medicaid (Exhibit 4). By 2016, the share of women with individual coverage had doubled and the share with Medicaid had climbed to 15 percent.

Exhibit 4

More Women Have Coverage Through Medicaid and the Individual Market Since the ACA's Passage

Percent of women ages 19–64



Note: Segments may not sum to 100 percent because of rounding.

* Individual includes women who are enrolled in either marketplace plans or purchased directly from an insurance company.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010 and 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

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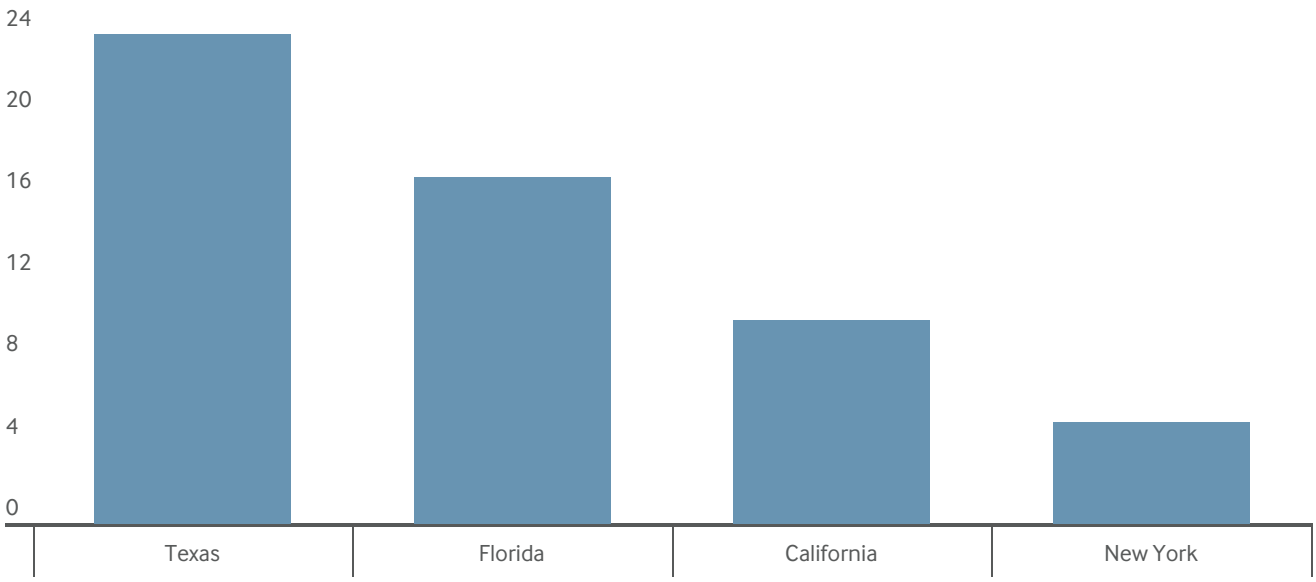
But coverage options are more limited for women in the 19 states that have not yet expanded eligibility for Medicaid, and consequently uninsured rates are often much higher. In Texas, for example, women are uninsured at nearly five times the rate in New York and one and a half times the rate in California, both of which expanded Medicaid under the ACA (Exhibit 5). And women in Florida, which like Texas chose not to expand Medicaid, are also uninsured at much higher rates than those living in California and New York.

Exhibit 5

Women in Texas and Florida Are More Likely to Report Being Uninsured Compared to Women in California and New York

Percent of women ages 19–64 who are uninsured



Note: Rates are for those uninsured at the time of the survey.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

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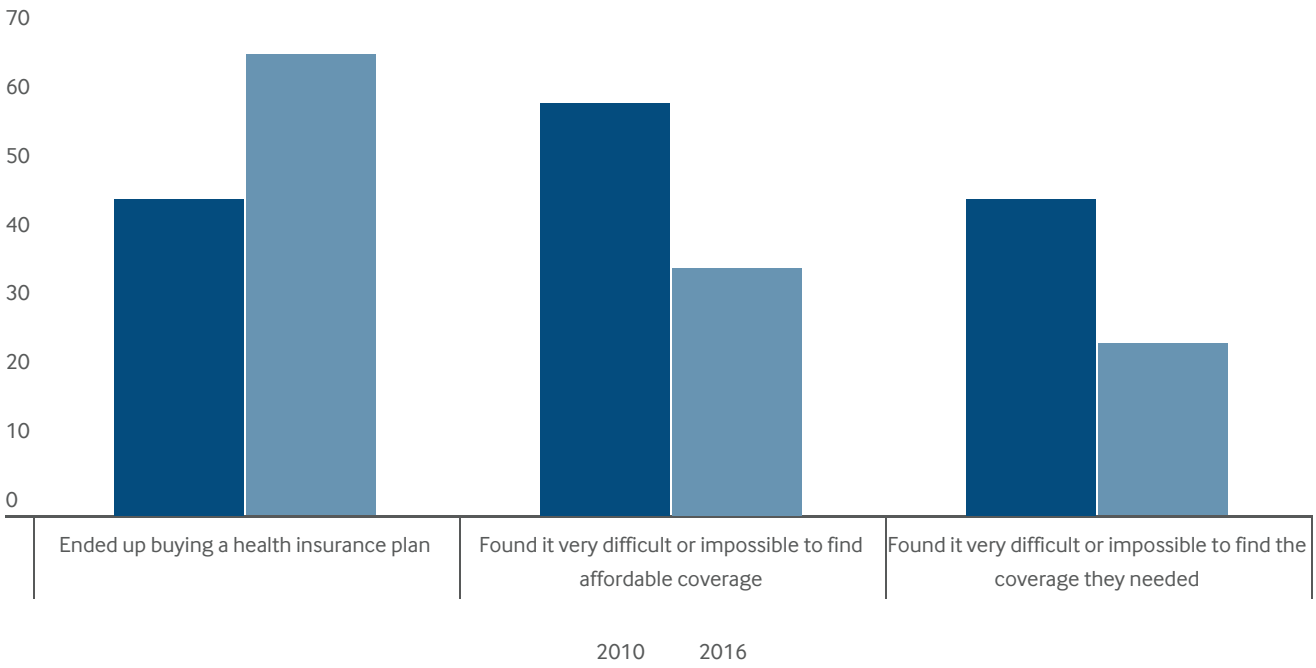
Reforms Have Made It Easier for Women to Buy Health Plans on Their Own

The ACA's consumer protections and subsidies for individual-market coverage have particularly benefited women. In 2010, one-third of women who had a health plan or tried to buy one in the individual market in the prior three years had either been turned down by an insurance company, charged a higher premium because of their health, or had a specific health problem excluded from coverage.[7](#/#7) Among women with health problems, 46 percent reported one or more of these problems. In the end, fewer than half (46%) of women who had tried to buy a plan ended up enrolling (Exhibit 6).

Exhibit 6

The ACA's Individual-Market Reforms and Subsidies Have Made It Easier for Women to Buy Health Plans on Their Own

Percent of women ages 19–64 with individual coverage or who tried to buy it in past three years***



Notes: * Bought in past three years. ** Base: In 2010, 13 million women ages 19–64 either had individual coverage or tried to buy it within the past three years. In 2016, this number increased to 24 million.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2010 and 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

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By 2016, things had improved significantly. The proportion of women who had shopped for a plan in the individual market and ultimately enrolled in one climbed to more than two-thirds (67%) (Exhibit 6). And the proportion reporting difficulty finding an affordable plan fell by nearly half. There was similar improvement in the share of women experiencing trouble finding a plan that fit their needs. Women with health problems made particularly large gains (Appendix 2 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)).

Fewer Women Are Skipping or Delaying Needed Care Because of Costs

Gains in health insurance coverage have led to nationwide improvements in measures of health care access for women. In 2010, nearly half (48%) of women ages 19 to 64, or an estimated 45 million people, reported not getting needed care because of the cost, including they had not filled a prescription, not seen a specialist when needed, skipped a recommended medical test or treatment, or not gone to a doctor when sick (Exhibit 7, Appendix 3 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)). By 2016, the share of women reporting any one of these cost-related problems getting needed care fell to 38 percent, or about 37 million people (Exhibit 7, Appendix 3 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en), and Appendix 4 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)).

Exhibit 7

Fewer Women Say They Are Not Getting Needed Care Because of Costs

Percent of women ages 19–64 who reported any of the following cost-related access problems in the past year:

	2003	2005	2010	2012	2014	2016
Did not fill prescription	29%	30%	32%	32%	22%	23%
Skipped recommended test, treatment, or follow-up	23%	24%	30%	31%	22%	22%
Had a medical problem, did not visit doctor or clinic	25%	27%	31%	32%	25%	21%
Did not get needed specialist care	15%	21%	21%	23%	14%	15%
Any of the above	42%	43%	48%	49%	40%	38%

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

Share

Access to prescription drugs for women with health problems also significantly improved between 2010 and 2016. In 2010, 31 percent of women who reported having one of five chronic health problems or being in fair or poor health reported not filling a prescription for their condition because of costs (data not shown).[8 (#/#8)] By 2016, this rate had fallen to 21 percent (Appendix 4 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)).

Fewer Women Are Reporting Medical Bill Problems

Expanded coverage has also led to modest declines in medically related financial problems. In 2012, 47 percent of women, or 44 million, reported either having a problem paying a medical bill, being contacted by a collection agency for unpaid medical bills, having to change their way of life to pay medical bills, or that they were paying off medical debt over time (Exhibit 8, Appendix 3 (/~/media/files/publications/issue-

brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)). In 2016, 42 percent of women, or 40 million, reported having a medical bill problem in the past year or medical debt (Exhibit 8, Appendix 3 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en), and Appendix 5 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)).

Exhibit 8

There Has Been a Modest Reduction in Reports of Medical Bill Problems by Women

Percent of women ages 19–64 who reported any of following bill or medical debt problems in the past year:

	2005	2010	2012	2014	2016
Had problems paying or unable to pay medical bills	26%	34%	34%	27%	26%
Contacted by a collection agency for unpaid medical bills	16%	19%	22%	18%	16%
Had to change way of life to pay bills	15%	19%	19%	17%	15%
Medical bills/debt being paid off over time	24%	27%	31%	23%	28%
Any of the above	38%	44%	47%	38%	42%

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2005, 2010, 2012, 2014, 2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

However, after substantial improvement on these indicators of financial stress in 2014, there was little improvement, and even erosion on some measures, in 2016. Most notably, the share of women who reported they were paying off medical debt over time rose significantly. Rates of medical debt in 2016 were highest among women with private insurance, both employer-based and individual-market, and among women with disabilities covered through Medicare. Rates were lowest for women with Medicaid coverage. As on all measures of medical bill problems, women are more likely than men to say they are paying off medical debt over time (data not shown).

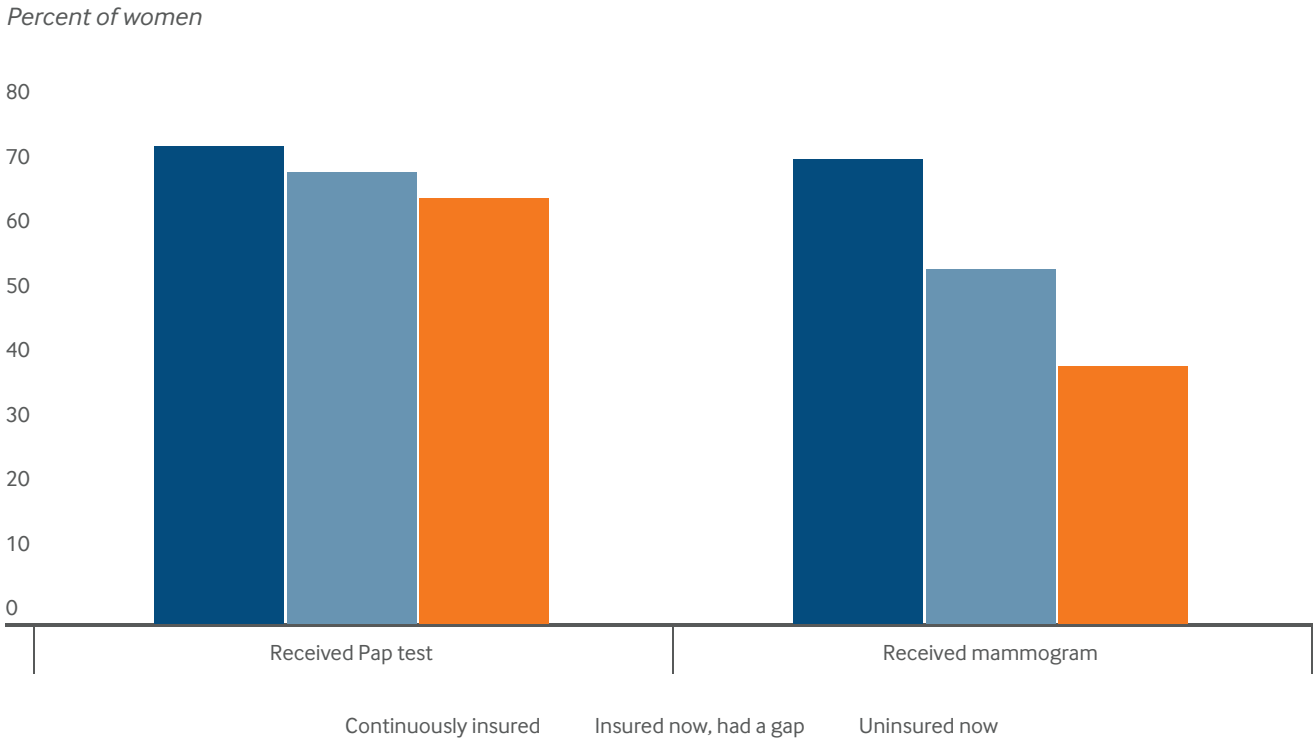
Insured Women Are More Likely to Receive Preventive Care

Research shows increased use of preventive services saves lives. For example, increasing the share of women 40 and older who receive breast cancer screening every two years to 90 percent could save 3,700 lives annually, while increasing the number of young women who receive chlamydia screening to that level would save an estimated 30,000 lives.[9 (#/#9)] A 2015 study found that the ACA's dependent-coverage provision was associated with higher early detection of cervical cancer in young women ages 21 to 25.[10 (#/#10)] Another recent study showed that early detection of breast cancer has also improved post-ACA.[11 (#/#11)]

Our survey findings indicate the difference insurance makes in whether women receive timely preventive care and cancer screenings. Women ages 40 to 64 continuously insured for the full year were significantly more likely than uninsured women to have had a mammogram within the past two years (Exhibit 9, Appendix 4 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)). And insured women 21 and older were somewhat more likely than uninsured women to have received a Pap test in the past three years. This narrower gap may be a result of women's widespread access to contraception and affordable cancer screening through clinics like those run by Planned Parenthood, where 79 percent of patients have incomes at or below 150 percent of poverty, and through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.[12 (#/#12)] In 2014 alone, Planned Parenthood provided more than 270,000 Pap tests to women.[13 (#/#13)]

Exhibit 9

Insured Women Are More Likely to Receive Cancer Screenings Than Uninsured Women, 2016



Notes: "Continuously insured" refers to adults who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to adults who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to women who reported being uninsured at the time of the survey. Respondents were asked if they: received a Pap test within the past three years for females ages 21–64 and received a mammogram within the past two years for females ages 40–64.

Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

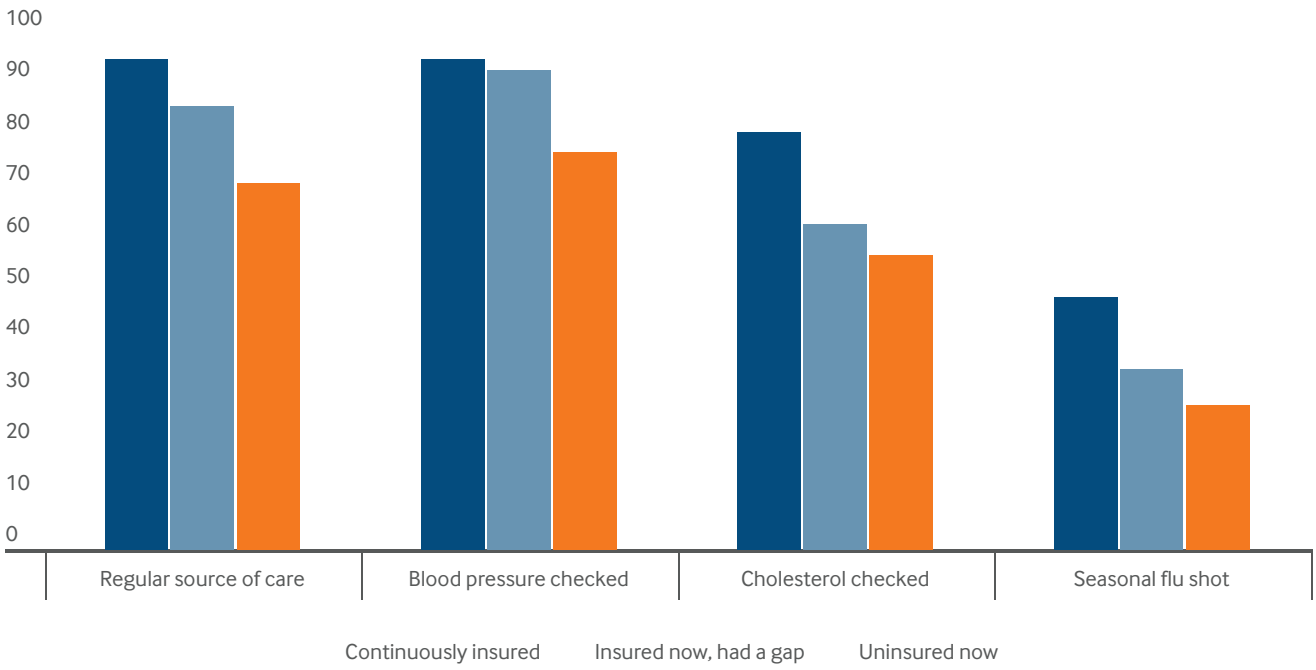
Share

Insurance also makes a difference in women's access to primary care and other preventive services. For example, insured women were more likely to report having a regular doctor and having their blood pressure and cholesterol checked in the recommended time frame (Exhibit 10, Appendix 4 (/~/media/files/publications/issue-brief/2017/aug/gunja_women_health_coverage_care_biennial_appendices.pdf?la=en)).

Exhibit 10

Insured Women Are More Likely to Have a Regular Source of Care and Receive Preventive Services

Percent of women ages 19–64



Notes: "Continuously insured" refers to women who were insured for the full year up to and on the survey field date; "Insured now, had a gap" refers to women who were insured at the time of the survey but were uninsured at any point during the year before the survey field date; "Uninsured now" refers to women who reported being uninsured at the time of the survey. Respondents were asked if they: had their blood pressure checked within the past two years (in past year if has hypertension or high blood pressure); had their cholesterol checked in past five years (in past year if has hypertension, heart disease, or high cholesterol); and had their seasonal flu shot within the past 12 months.
Data: The Commonwealth Fund Biennial Health Insurance Survey (2016).

Source: M. Z. Gunja, S. R. Collins, M. M. Doty, and S. Beutel, *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016*, The Commonwealth Fund, August 2017.

Conclusion

The Affordable Care Act has improved health care for women and their families through the law's insurance market reforms, mandatory coverage of free preventive care, and subsidized, comprehensive insurance options for people lacking access to affordable employer coverage.

Particularly important for young women and their families have been the requirements that insurers in the individual market offer a comprehensive benefit package with maternity coverage and that most private plans cover contraception. Some observers have claimed that maternity coverage has been a driver of higher premiums in the individual market, but research shows otherwise. Eibner and Whaley found that cutting maternity benefits from the

ACA's essential benefit package would lower premiums by just 4 percent, but doing so would significantly increase costs to women having babies.[14 (#/#14)] Without maternity coverage, a family's out-of-pocket costs would jump by roughly 1,000 percent to nearly 3,000 percent, depending on the complexity of a delivery.

But the Commonwealth Fund survey findings also suggest that more work needs to be done to make health care accessible and affordable for all U.S. women. First, an estimated 11 million working-age women remain uninsured. The 19 states that have yet to expand Medicaid eligibility could bring critical coverage to low-income women in their states by moving forward with expansion. State and federal outreach and enrollment efforts also have been shown to increase awareness of and enrollment in Medicaid or marketplace coverage among the remaining uninsured. And national immigration reform or a loosening of restrictions for undocumented immigrants' eligibility for Medicaid and marketplace plans would help to lower the much higher uninsured rates of Latinas.[15 (#/#15)]

Second, although reforms to the individual market have made finding affordable health insurance coverage significantly easier, one-third of women still experience difficulty. One option to improve the affordability of plan premiums is to extend eligibility for tax credits to people earning more than 400 percent of poverty (about $50,000 for an individual and $98,000 for a family of four). This simple change could bring coverage to 1.2 million currently uninsured people, at a relatively modest annual federal cost of $6 billion.[16 (#/#16)]

And while we have seen declines in cost-related obstacles to getting needed care and reductions in medical bill problems, rates remain very high. What is likely necessary is a fundamental redesign of private insurance, including employer plans, so that deductibles and cost-sharing encourage, rather than discourage, people to seek timely health care and do not leave people burdened with debt when they do seek care.

In the aftermath of Congress's failed effort to repeal and replace the ACA, the most immediate concern for policymakers is ensuring that the 17 million to 18 million people with marketplace coverage are able to enroll this fall. Congress could take three key modest steps toward this end:

1. A permanent appropriation for payments to insurers that, by law, must offer cost-sharing reductions for low-income enrollees in the marketplaces.
2. A fallback health plan option for the fewer than 20 counties where consumers may not have a plan to choose from this fall.
3. Reinsurance to help carriers cover unexpectedly high claims costs.[17 (#/#17)]

The Trump administration can also play an important role by signaling to insurers participating in the marketplaces that it will enforce the individual mandate. The administration also can help by affirming its commitment to ensuring that all eligible Americans have the tools they need to enroll in the coverage that is right for them.

How This Study Was Conducted

The Commonwealth Fund Biennial Health Insurance Survey, 2016, was conducted by Princeton Survey Research Associates International from July 12 to November 20, 2016. The survey consisted of 25-minute telephone interviews in English or Spanish conducted among a random, nationally representative sample of 6,005 adults age 19 and older living in the continental United States. A combination of landline and cellular phone random-digit dial samples was used to reach people. In all, 2,402 interviews were conducted with respondents on landline telephones and 3,603 interviews were conducted on cell phones, including 2,262 with respondents who live in households with no landline telephone access.

The sample was designed to generalize to the U.S. adult population and to allow separate analyses of responses of low-income households. This report limits the analysis to respondents ages 19 to 64 (n=4,186). Statistical results were weighted to correct for the stratified sample design, the overlapping landline and cell phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, population density, and household telephone use, using the U.S. Census Bureau's 2016 Annual Social and Economic Supplement.

The resulting weighted sample is representative of the approximately 187.4 million U.S. adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 14 percent response rate and the cell phone component achieved a 10 percent response rate.

We also report estimates from the 2001, 2003, 2005, 2010, 2012, and 2014 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy that was used in 2016, except the 2001, 2003, and 2005 surveys did not include a cell phone random-digit dial sample. In 2001, the survey was conducted from April 27 through July 29, 2001, and included 2,829 adults ages 19 to 64; in 2003, the survey was conducted from September 3, 2003, through January 4, 2004, and included 3,293 adults ages 19 to 64; in 2005, the survey was conducted from August 18, 2005, to January 5, 2006, among 3,352 adults ages 19 to 64; in 2010, the survey was conducted from July 14 to November 30, 2010, among 3,033 adults ages 19 to 64; in 2012, the survey was conducted from April 26 to August 19, 2012, among 3,393 adults ages 19 to 64; and in 2014, the survey was conducted from July 22 to December 14, 2014, among 4,251 adults ages 19 to 64.

Notes

[1] S. D. Rustgi, M. M. Doty, and S. R. Collins, *Women at Risk: Why Many Women Are Forgoing Needed Health Care (/publications/issue-briefs/2009/may/women-at-risk)* (The Commonwealth Fund, May 2009); and A. Ho, S. R. Collins, K. Davis, and M. M. Doty, *A Look at Working-Age Caregivers' Roles, Health Concerns, and Need for Support (/publications/issue-briefs/2005/aug/a-look-at-working-age-caregivers-roles--health-concerns--and-need-for-support)* (The Commonwealth Fund, Aug. 2005).

[2] U.S. Government Accountability Office, *Private Health Insurance: The Range of Base Premiums in the Individual Market by State in January 2013 (http://www.gao.gov/products/GAO-13-712R)* (GAO, July 2013).

[3] D. Garrett, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act (https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf)* (National Women's Law Center, March 2012).

[4] Religious employers, including churches, and certain religious organizations and employers are exempt from this requirement if they object to it on religious grounds.

[5] A. Sonfield, *What Is at Stake with the Federal Contraceptive Coverage Guarantee? (https://www.guttmacher.org/sites/default/files/article_files/gpr2000816_0.pdf)* (Guttmacher Institute, Jan. 2017).

[6] N. V. Becker and D. Polsky, "Women Saw Large Decrease in Out-of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing (http://content.healthaffairs.org/content/34/7/1204.full)," *Health Affairs,* July 2015 34(7):1204–11.

[7] R. Robertson and S. R. Collins, *Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help (/publications/issue-briefs/2011/may/women-at-risk)* (The Commonwealth Fund, May 2011).

[8] Chronic health problems include: hypertension or high blood pressure; heart failure or heart attack; diabetes requiring insulin; asthma, emphysema, or lung disease; and high cholesterol.

[9] U.S. Departments of Treasury, Labor, and Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act (https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of)," *Federal Register,* 17242, July 19, 2010.

[10] A. S. Robbins, X. Han, and E. M. Ward, "Association Between the Affordable Care Act Dependent Coverage Expansion and Cervical Cancer Stage and Treatment in Young Women (http://jamanetwork.com/journals/jama/fullarticle/2471561)," *Journal of the American Medical Association,* Nov. 24, 2015 314(20):2189–91.

[11] N. Bakalar, "With Obamacare, More Breast Cancers Diagnosed at Earlier Stages (https://www.nytimes.com/2017/06/27/well/live/with-obamacare-more-breast-cancers-diagnosed-at-earlier-stages.html)," *New York Times,* June 27, 2017.

[12] *By the Numbers (https://www.plannedparenthood.org/files/9313/9611/7194/Planned_Parenthood_By_The_Numbers.pdf),* Fact Sheet (Planned Parenthood, Jan. 2014).

[13] *2014–2015 Annual Report (https://www.plannedparenthood.org/files/2114/5089/0863/2014-2015_PPFA_Annual_Report_.pdf)* (Planned Parenthood Federation of America, 2015).

[14] C. Eibner and C. Whaley, "Loss of Maternity Care and Mental Health Coverage Would Burden Those in Greatest Need (/publications/blog/2017/may/maternity-care-and-mental-health-coverage-requirements)," *To the Point,* The Commonwealth Fund, June 19, 2017.

[15] M. M. Doty and S. R. Collins, "Millions More Latino Adults Are Insured Under the Affordable Care Act (/publications/blog/2017/jan/more-latino-adults-insured)," *To the Point,* The Commonwealth Fund, Jan. 19, 2017.

[16] J. Liu and C. Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults (/publications/issue-briefs/2017/jul/marketplace-tax-credit-extension)* (The Commonwealth Fund, July 2017).

[17] D. Blumenthal and S. R. Collins, "In the Aftermath (/publications/blog/2017/jul/in-the-aftermath)," *To the Point,* The Commonwealth Fund, July 28, 2017; and T. S. Jost, "Fixing Our Most Pressing Health Insurance Problems: A Bipartisan Path Forward (/publications/blog/2017/jul/fixing-health-insurance-problems-bipartisan-approach)," *To the Point,* The Commonwealth Fund, July 13, 2017.

What's the Near-Term Outlook for the Affordable Care Act?

Aug 04, 2017 | Cynthia Cox (https://www.kff.org/person/cynthia-cox/) (https://twitter.com/cynthiaccox) **and Larry Levitt (https://www.kff.org/person/larry-levitt/)** (https://twitter.com/larry_levitt)

If Congress abandons efforts to repeal and replace the Affordable Care Act (ACA), President Trump has said he would "let Obamacare fail (https://twitter.com/realDonaldTrump/status/887280380423938048)." This Q&A examines what could happen if the Affordable Care Act, also called "Obamacare," remains the law and what it might mean to let Obamacare fail.

Is Obamacare failing?

The Affordable Care Act was a major piece of legislation that affects virtually all payers in the U.S. health system, including Medicaid, Medicare, employer-sponsored insurance and coverage people buy on their own. One of the biggest changes under the health reform law was the expansion of the Medicaid program, which now covers nearly 75 million (https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) people, about 14 million (https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) of whom are signed up under the expansion. Most Americans, including most Republicans, believe the Medicaid program is working well (https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-june-2017-aca-replacement-plan-and-medicaid/).

When people talk about the idea of the ACA failing, they are usually referring to the exchange markets, also called Marketplaces. These markets, which first opened in 2014 are part of the broader individual insurance market where just 5-7% (https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) of the U.S. population gets their insurance. People who get insurance from other sources like their work or Medicaid ar not directly affected by what happens in the individual insurance market.

The exchange markets have not been without problems: There have been some notable exits by insurance companies (https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2017/) and premium increases (https://www.kff.org/health-reform/issue-

brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/) going into 2017, and in the early years of the exchanges, insurers were losing money (https://www.kff.org/health-reform/issue-brief/insurer-financial-performance-in-the-early-years-of-the-affordable-care-act/). The structure of the ACA's premium subsidies – which rise along with premiums and cap what consumers have to pay for a benchmark plans a percentage of their income – prevents the market from deteriorating into a "death spiral." However, premiums could become unaffordable in some parts of the country for people with incomes in excess of 400% of the poverty level, who are ineligible for premium assistance.

Insurer participation in this market has received a great deal of attention, as about 1 in 3 counties (https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2017/) – primarily rural areas – have only one insurer on exchange. Rural counties have historically had limited competition even before the ACA, but data now available because of the Affordable Care Act brings the urban/rural divide into sharper focus. On average at the state level, competition in the individual market has been relatively stable (https://www.kff.org/other/state-indicator/individual-insurance-market-competition/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) – neither improving nor worsening.

Premiums in the reformed individual market started out relatively low and remained low in the first few years – about 12% lower (https://www.kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/) than the Congressional Budget Office had projected as of 2016 –before increasing more rapidly i 2017. Most (83% (https://www.kff.org/health-reform/state-indicator/2017-marketplace-plan-selections-by-financial-assistance-status/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)) of the 12 million people buying their own coverage on the exchange receive subsidies and therefore are not as affected by the premium increases but many of the approximately 9 million people buying off-exchange may have difficulty affording coverage, despite having higher incomes. As might be expected, after taking into account financial assistance and protections for people with pre-existing conditions, some people ended up paying more and others paying less than they did before the ACA. Our early polling (https://www.kff.org/report-section/survey-of-non-group-health-insurance-enrollees-section-2/) in this market found that people in this market were nearly evenly split between paying more and paying less. About 3 million (https://www.kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/) people who remain uninsured are not eligible for assistance or employer coverage and many of them may be going without coverage due to costs.

Our recent analysis (https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-early-2017/) of first quarter 2017 insurer financial results finds that the market is not showing signs of collapse. Rather, insurers are on track to be profitable

and the market appears to be stabilizing in the country overall. In other words, those premium increases going into 2017 may have been enough to make the market stable without discouraging too many healthy people from signing up. However, there are stil markets – particularly rural ones – that are fragile.

Figure 1: Average First Quarter Individual Market Gross Margins Per Member Per Month, 2011 – 2017

How would administrative actions affect market stability?

Despite signs that the individual insurance market is generally stabilizing on its own, certain administrative actions could cause the market to destabilize again. Actions the Administration might take that would weaken the market include:

STOP ENFORCING OR WEAKEN THE INDIVIDUAL MANDATE

The individual mandate is the Obamacare requirement that most people either have insurance or pay a penalty. The purpose of it is to get young and healthy people into th market to bring down average costs. If there are not enough young and healthy people signing up, insurers have to raise premiums. If the administration signals it will either stop enforcement of the individual mandate or give broad exemptions, insurers will respond by raising premiums or exiting the market. The Congressional Budget Office (CBO) estimates that without the individual mandate, premiums in the individual insurance market could rise by 20% (https://www.cbo.gov/budget-options/2016/52232).

SCALE BACK OUTREACH AND CONSUMER ASSISTANCE

The individual market is often a transitional source of insurance when life circumstances change. People who are temporality unemployed, in school, or early retirees make up a substantial share (https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/) of the individual market. Additionally, people in this market often experience income volatility (https://www.kff.org/health-reform/issue-brief/repayments-and-refunds-estimating-the-effect of-2014-premium-tax-credit-reconciliation/) and may cycle between Medicaid and subsidized exchange coverage. Those who are sick will be most likely to seek insurance coverage on their own when they go through a change in life circumstances, but outreach and consumer assistance programs – particularly those targeted at young and healthy individuals – can help balance out the risk pool and bring down average costs.

This coming open enrollment period (November 1 – December 15, 2017) is shorter than previous periods and may require more outreach to get people signed up before the deadline. This will also be the first enrollment period run from start to finish by the Trump administration and it is not yet clear how much outreach the administration wi take on. Toward the end of the last open enrollment period, the Trump administration cut marketing and more recently has used outreach funds for messages critical of the health care law.

STOP MAKING COST-SHARING SUBSIDY PAYMENTS

Under the Affordable Care Act, insurers are required to offer low-deductible plans (https://www.kff.org/health-reform/issue-brief/impact-of-cost-sharing-reductions-on-deductibles-and-out of-pocket-limits/) to low-income people (58% (https://www.kff.org/health-reform/state-indicator/2017-marketplace-plan-selections-by-financial-assistance-status/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) of marketplace enrollees benefit from these cost-sharing subsidies). For the lowest-incom enrollees, these subsidies can bring down the deductible from a few thousand dollars t a couple hundred dollars (Figure 2 below). Providing these higher-value plans to low-income enrollees costs insurers more money (an estimated $10 billion (https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf) dollars in

2018), so under the ACA the federal government reimburses insurers in the form of a cost-sharing subsidy payment. However, these payments are the subject of a lawsuit and the Administration has signaled they might stop making payments.

If these payments stop, we estimate that insurers would need to raise rates on silver-level plans – which are the only plans where consumers can access cost-sharing reductions – by 19 percent (https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/), with states that did not expand Medicaid (primarily red states (https://www.kff.org/health-costs/press-release/estimates-average-aca-marketplace-premiums-for-silver-plans-would-need-to-increase-by-19-to-compensate-for-lack-of-funding-for-cost-sharing-subsidies/)) facing higher premium increases (Figure 3 below). Lower-income marketplace enrollees receiving premium subsidies would be protected from premium increases because subsidies would rise as well. However, higher-income enrollees not receiving premium subsidies would face higher premiums if insurers expect cost-sharing subsidy payments to end.

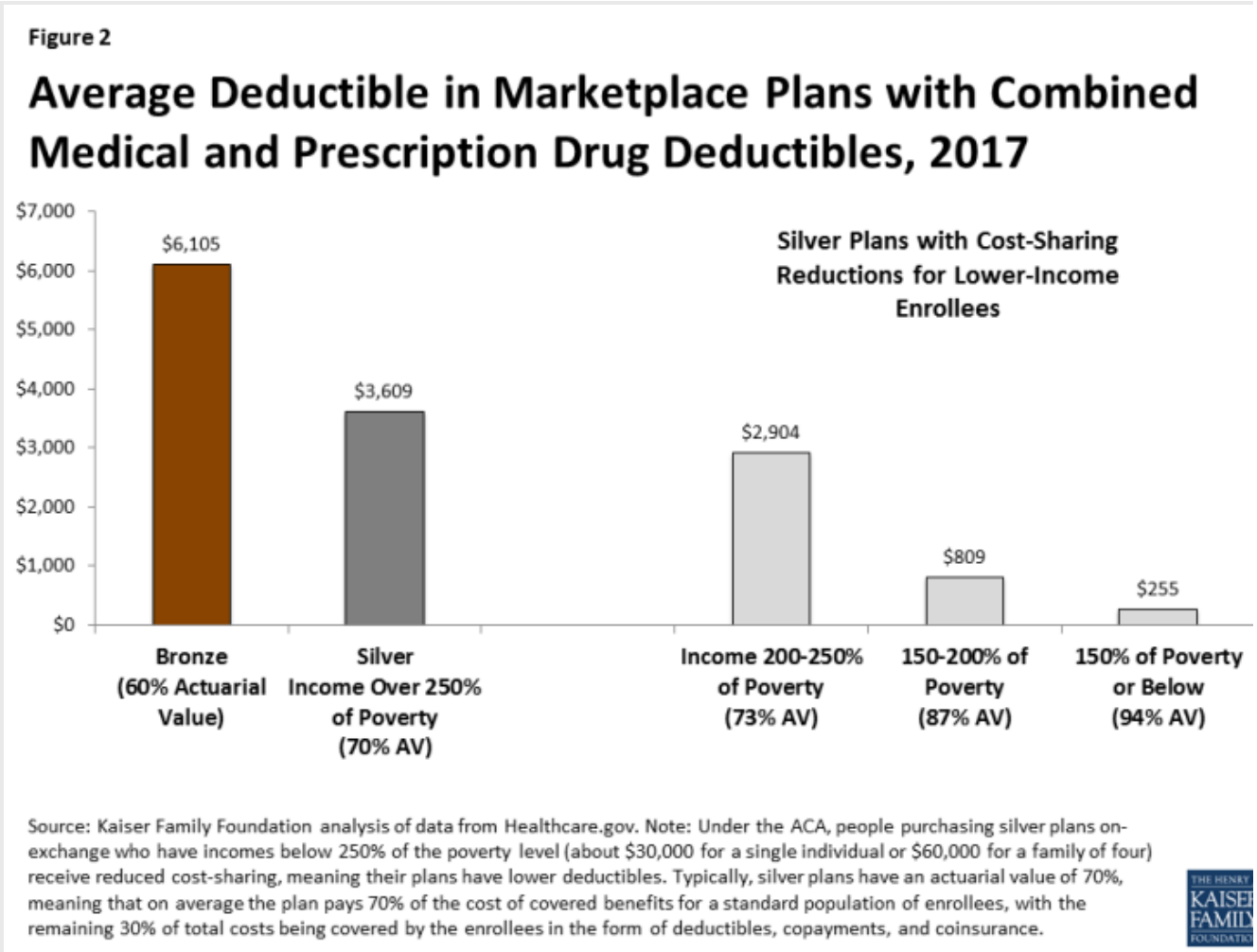


Figure 2: Average Deductible in Marketplace Plans with Combined Medical and Prescription Drug Deductibles, 2017

The combined effect of these policy changes (not enforcing the individual mandate and defunding cost-sharing subsidies) could cause some insurers to raise premiums on some plans by as much as 40 percentage points higher than they otherwise would. Because premium subsidies increase as premiums rise, administrative actions that cause premiums to rise can also cause taxpayer costs to increase. For example, we estimate that ending cost-sharing subsidy payments could increase net federal costs by about $2.3 billion per year (https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/).

Insurers have already submitted their preliminary premiums for the upcoming calendar year to state regulators. Since there has not been clarity on these issues, some insurers are already assuming that the Trump Administration or Congress may take an action that would destabilize the market. Some companies have either significantly raised premiums for next year, scaled back their footprints, or made plans to exit the

exchange or individual market all together. Insurers are still negotiating rates for 2018, so if they do not get clarity soon, premiums could go up even more or more insurers could leave.

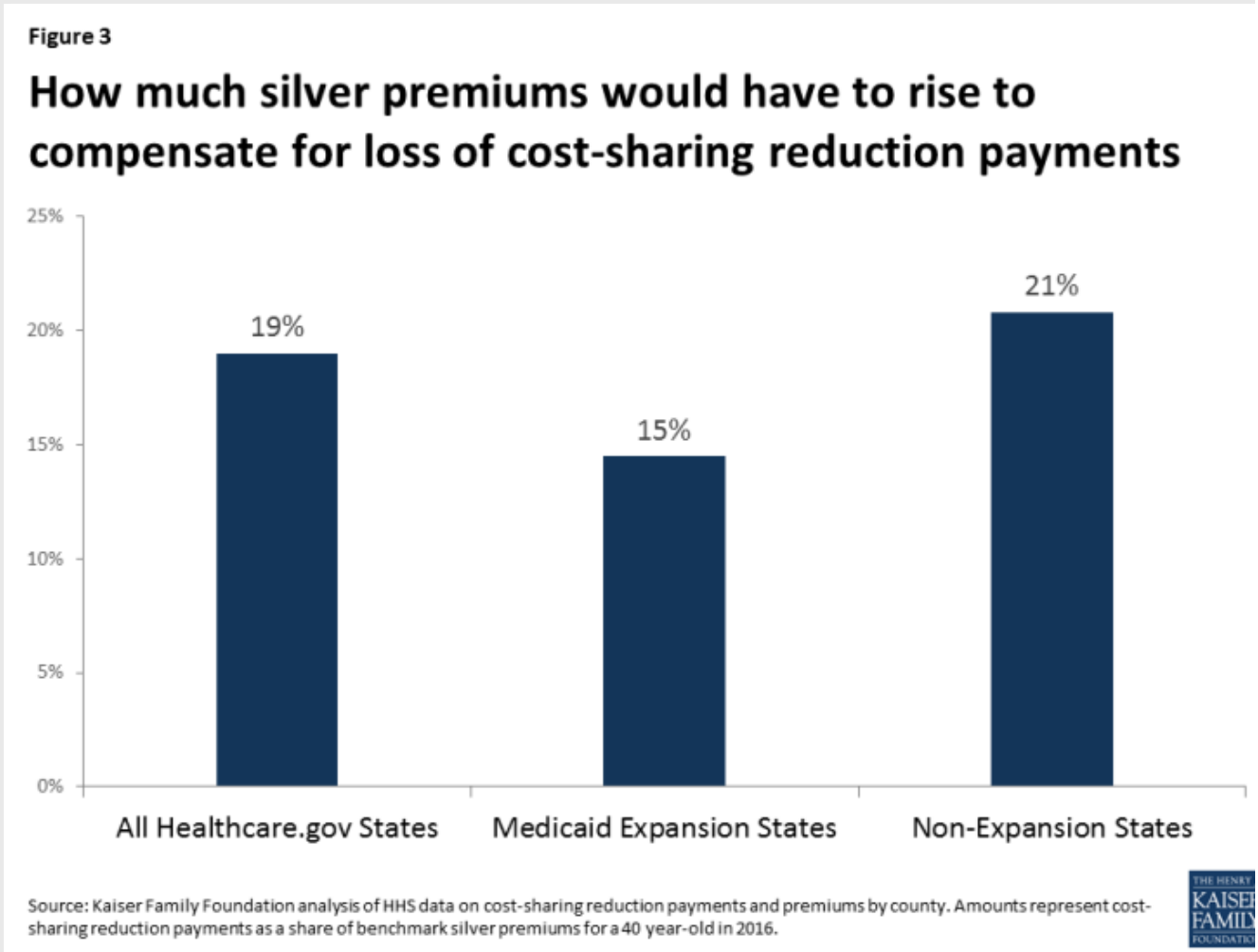


Figure 3: How much silver premiums would have to rise to compensate for loss of cost-sharing reduction payments

Again, these premium increases would only affect people who buy their own insurance (particularly middle-income or upper-middle-income people who buy their own insurance without a subsidy to offset the costs), and this group does not make up a larg share of the American public. Nonetheless, more insurer exits or large premium increases on the exchange markets could be seen as Obamacare failing. It is worth noting, though, that a majority (64 percent) of the public – including 53 percent of Republicans (https://www.kff.org/health-reform/report/kaiser-health-tracking-poll-late-april-2017-the-future-of-the-aca-and-health-care-the-budget/) – say that because President Trump and Republicans in Congress are now in control of the government, they are responsible for any problems with the ACA moving forward.

What happens if the market fails?

Following some announcements of 2018 exits by major insurers, there are some counties at risk (https://www.kff.org/interactive/counties-at-risk-of-having-no-insurer-on-the-marketplace-exchange-in-2018/) of having no insurer on the exchange next year. This would be a first; thus far, all counties have had at least one insurer on the exchange. As negotiations between insurers and state regulators are still underway, there is still time for other insurers to come in and fill these gaps. Thus far, in most cases, a new or expanding insurer has already moved in to cover counties once thought to be "bare." However, administrative actions that destabilize the market could encourage more insurers to exit.

If no exchange insurer ultimately moves in to some of these counties, people buying their own insurance will not be able to get subsidies and would have to pay full price for insurance. Paying for unsubsidized insurance would be particularly difficult for low-income and older adults living in high-cost areas like many rural parts of the country. Our subsidy calculator (https://www.kff.org/interactive/subsidy-calculator/) can show the difference in cost. For example, in Knox County Ohio, a low-income 60-year-old could get a silver plan for $83 per month (https://www.kff.org/interactive/subsidy-calculator/#state=oh&zip=43050&locale=Knox&income-type=dollars&income=20000&employer-coverage=0&people=1&alternate-plan-family=individual&adult-count=1&adults%5B0%5D%5Bage%5D=60&adults%5B0%5D%5Btobacco%5D=0&child-count=0&child-tobacco=0) but would have to pay $775 per month if he bought that plan without a subsidy, plus he would have a higher deductible because he would no longer benefit from cost sharing subsidies that are only available on the exchange. That same person would also qualify for a free ($0 premium) bronze plan if he buys on exchange, but off-exchange without a subsidy he would have to pay more than $600 per month for a similar plan. People shopping for coverage off-exchange in a county left without an exchange insurer – particularly lower income or older exchange shoppers – may not be able to afford any option and may drop their coverage.

If the market becomes destabilized, and particularly if the individual mandate is not enforced, insurers may decide to exit the off-exchange market as well. This would mean that people in these counties who would otherwise buy their own insurance may not have any option even if they could afford to pay full price.

What might be done to strengthen the Marketplaces?

Although the individual health insurance market is stabilizing on average, insurer financial performance varies and some companies in some states are still struggling. Additionally, some insurers have already decided to increase premiums significantly or exit the market in 2018 on the assumption that the Trump Administration or Congress

will take actions that destabilize the market. Although there are many ideas on both the left and the right for how to improve these markets, there are not many options that have bipartisan support.

One possible policy response that could receive bipartisan support would be to reestablish a reinsurance (https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/) program. Reinsurance programs provide funds to insurers that enroll high-cost (sicker) individuals and can work to lower premiums. The Affordable Care Act included a reinsurance program but it was temporary and phased out in 2016. Republicans in Congress and the Administration have also signaled a willingness to establish reinsurance programs: Both the House and Senate repeal bills included (https://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/) stability funds for reinsurance and Health and Human Services Secretary Price has supported Alaska's request for a waiver (https://www.kff.org/health-reform/issue-brief/section-1332-state-innovation-waivers-current-status-and-potential-changes/) to support its reinsurance program. Though such a program could receive bipartisan support, it would require additional funds (for example, taxing insurers in other markets).

Additional state flexibility to address local challenges in implementing the health care law may also receive some bipartisan support. The challenge of attracting insurers to rural areas or certain states, for example, may warrant state-specific solutions – either as part of the ACA's waiver (https://www.kff.org/health-reform/issue-brief/section-1332-state-innovation-waivers-current-status-and-potential-changes/) program or by Congress giving states additional flexibility.

Willis Towers Watson

U.S. employers expect health care costs to rise by 5.5% in 2018, up from 4.6% in 2017

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ARLINGTON, VA, August 2, 2017 – Employers expect health care costs to increase by 5.5%* in 2018, up from a 4.6% increase in 2017, according to the 22nd annual Best Practices in Health Care Employer Survey by Willis Towers Watson (NASDAQ: WLTW). In the face of these continued cost pressures, including employee affordability, employers plan to step up cost management strategies over the next three years, including evaluation of emerging health care delivery solutions and improved patient navigation and health engagement.

The survey also showed that despite uncertainty about the future of health care legislation, employer confidence in offering employee health care benefits has reached its highest level since the passage of the Affordable Care Act in 2010. Ninety-two percent of employers said they are "very confident" their organization will continue to sponsor health benefits in five years.

"Cost management of health benefit programs remains the top priority for employers in 2017 and 2018," said Julie Stone, a national health care practice leader at Willis Towers Watson. "While employers made significant progress over the last few years refining their subsidy and vendor/carrier strategies, many are now looking to other aspects of their health benefit programs in order to improve health and dampen future cost increases. Over the next three years, they will seek to improve patient engagement, expand the use of analytics, and efficiently manage pharmacy costs and utilization. Yet, with rising concerns about affordability, employers are challenged to keep costs low without overburdening employees financially."

Employers are pursuing a wider array of approaches to reduce health care cost and risk – both through improved program efficiencies and members' health engagement. These areas of focus will include encouraging patients to use preferred providers for health care delivery, e.g., telemedicine, centers of excellence, and high-performance networks; emphasizing better outcomes and cost savings in high-priority clinical conditions, such as diabetes, musculoskeletal health and mental health; and selecting partners based on their ability to achieve demonstrably improved outcomes, as well as hold the line on cost.

Employers also aim to enhance employee engagement by increasing choice of benefit plans, improving decision support, and offering health wearables and mobile apps.

Other key employer priorities over the next three years include:

Encouraging employees to use preferred health care delivery options:

- **Telemedicine for office visits** – 78% of employers currently use these consultations with another 16% planning to or considering to by 2019.
- **Centers of excellence within health plans** – 44% of employers currently use these centers with another 33% planning to or considering to by 2019.
- **High-performance networks** – 15% of employers currently use such networks with another 36% planning to or considering to by 2019.

Selecting carriers and vendors based on:

- **Competitiveness of negotiated provider discounts:** 94%

- **Competitiveness of vendor's network access:** 94%
- **Competitiveness of vendor's total cost of care:** 92%

Curbing pharmacy costs and utilization:

- **Evaluate pharmacy benefit contract terms** – 62% of employers are currently evaluating contract terms with another 32% planning to or considering to by 2019.
- **Adopt new coverage or utilization restrictions as part of specialty pharmacy strategy** – 60% of employers recently adopted these restrictions with another 24% planning to or considering to by 2019.
- **Address specialty drug costs and utilization performance through medical benefits** – 44% of employers currently do this with another 38% planning to or considering to by 2019.

Elevating employee health engagement through expanded choice and a more personalized experience:

- **Add choice in benefit types by offering voluntary benefits** – 66% of employers currently use this tactic with another 20% planning to or considering to by 2019.
- **Create a virtual shopping experience at the time of enrollment** – 24% of employers currently do this with another 26% planning to or considering to by 2019.
- **Provide decision-support tools for health navigation** – 55% of employers currently offer such tools with another 26% considering to for 2019.
- **Encourage the use of mobile apps for condition management or health risk reduction** – 19% of employers currently provide this to their employees with another 28% planning to or considering to by 2019.
- **Promote wearable devices for tracking physical activity** – 26% of employers currently promote these to their employees with another 18% planning to or considering to by 2019.

"Employers understand that there is no single strategy for success when it comes to health care, and it is critical to engage employees through education and communication that will create a win/win," said Catherine O'Neill, a senior health care consultant at Willis Towers Watson. "The most effective health programs will include a broad range of strategies that encompass employee and dependent participation, program design and subsidy levels, and plan efficiency. The ultimate goal is to offer a high-value plan that manages costs for both employers and employees while also improving health outcomes."

About the survey

The Annual Willis Towers Watson Best Practices in Health Care Employer Survey was completed by 678 U.S. employers between June and July 2017 and reflects respondents' 2017 health program decisions and strategies. Respondents collectively employ 11.9 million employees and operate in all major industry sectors. Results provided are based on 555 employers with at least 1,000 employees.

About Willis Towers Watson

Willis Towers Watson (NASDAQ: WLTW) is a leading global advisory, broking and solutions company that helps clients around the world turn risk into a path for growth. With roots dating to 1828, Willis Towers Watson has 40,000 employees in more than 140 territories. We design and deliver solutions that manage risk, optimize benefits, cultivate talent and expand the power of capital to protect and strengthen institutions and individuals. Our unique perspective allows us to see the critical intersections between talent, assets and ideas – the dynamic formula that drives business performance. Together, we unlock potential. Learn more at willistowerswatson.com.

Endnote

* Cost increases for 2017 and 2018 are after-plan changes; increases without plan changes are 6.0% for both 2017 and 2018. Cost trends are based on projected medical and drug claims for active employees, including both employer and employee contributions but excluding employee out-of-pocket costs.
