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By Steven C. Hill, Salam Abdus, Julie L. Hudson, and Thomas M. Selden

Adults In The Income Range For The Affordable Care Act's Medicaid Expansion Are Healthier Than Pre-ACA Enrollees

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ABSTRACT The Affordable Care Act (ACA) has dramatically increased the number of low-income nonelderly adults eligible for Medicaid. Starting in 2014, states can elect to cover individuals and families with modified adjusted gross incomes below a threshold of 133 percent of federal poverty guidelines, with a 5 percent income disregard. We used simulation methods and data from the Medical Expenditure Panel Survey to compare nondisabled adults enrolled in Medicaid prior to the ACA with two other groups: adults who were eligible for Medicaid but not enrolled in it, and adults who were in the income range for the ACA's Medicaid expansion and thus newly eligible for coverage. Although differences in health across the groups were not large, both the newly eligible and those eligible before the ACA but not enrolled were healthier on several measures than pre-ACA enrollees. Twenty-five states have opted not to use the ACA to expand Medicaid eligibility. If these states reverse their decisions, their Medicaid programs might not enroll a population that is sicker than their pre-ACA enrollees. By expanding Medicaid eligibility, states could provide coverage to millions of healthier adults as well as to millions who have chronic conditions and who need care.

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The Affordable Care Act (ACA) seeks to dramatically increase the number of low-income nonelderly adults who are eligible for Medicaid. Eligibility for this federal-state program has traditionally been restricted to low-income pregnant women; poor children; elderly people; people with disabilities; and, to varying degrees, the parents of poor children. Little coverage has been available to childless adults. In 2009 only six states provided full Medicaid benefits to some childless adults, and twelve states provided more-limited Medicaid benefits.[1] However, many of these programs were closed to new applicants. In 2009 an additional nineteen states extended coverage to some people ages nineteen and twenty.[2]

Beginning in 2014, states can elect to offer Medicaid coverage to adults whose incomes do not exceed an effective threshold of 138 percent of the federal poverty level (133 percent of poverty with a 5 percent income disregard). Adults whose incomes are at or below 138 percent of poverty and who were not eligible for full Medicaid benefits under their state's eligibility rules in December 2009 are termed *newly eligible*.[3]

Even if a state decides not to expand coverage under the ACA, it may still experience increased enrollment. This is because Medicaid, like all public programs, has populations that are eligible but not enrolled. The outreach efforts related to the ACA and the rollout of private insurance through state and federal exchanges, also known as Marketplaces, may prompt adults who had been eligible before the ACA to enroll now.[4]

The newly eligible and adults who were eligible

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before the passage of the ACA but not enrolled have different fiscal implications for states. States and the federal government share the costs of the Medicaid program. States pay for none of the care for the newly eligible from 2014 through 2016, with states' shares gradually rising to 10 percent between 2017 and 2020. For the pre-ACA eligible, including those not yet enrolled, each state generally must pay its usual share of expenditures for care—which ranged from 26 percent to 50 percent across the states in fiscal year 2013—with the federal government paying the remainder. The exception is the seven or so states that expanded eligibility for both parents and childless adults with incomes up to or exceeding 100 percent of poverty prior to March 2010: These states receive a higher match rate from the federal government for some adults, but the federal government has not yet determined which of those states will qualify.

States, the federal government, and providers can use information about the characteristics of adults who are newly eligible for Medicaid and of those eligible before the ACA but not enrolled to help implement the ACA. Pre-ACA insurance status among these two groups of adults is a key characteristic, because it will likely influence their decisions about enrolling in Medicaid.

Knowing details about the demographic characteristics of the target population could help states, plans, providers, and advocates for eligible populations conduct outreach. Knowing the health status of newly eligible adults could help states understand what services those adults are likely to need and the potential costs of the services for the federal and state governments.[5–8] We compared the target population with pre-ACA enrollees—a population more familiar to state policy makers.

In addition, comparing pre-ACA enrollees and adults eligible before the ACA but not enrolled can shed light on the extent to which less healthy members of an eligible population enroll. States could be concerned about how enrollment patterns by health status affect their share of the costs of covering the ACA expansion population after 2016, when the percentage of costs they must pay will gradually rise from zero, reaching 10 percent in 2020.

Study Data And Methods

We used simulation methods and data from the Medical Expenditure Panel Survey (MEPS) to compare nonelderly adults enrolled in Medicaid, those eligible before the ACA but not enrolled, and those likely to be newly eligible. Simulation methods have been used in previous studies to inform state policy options under the ACA.[9–11]

STUDY ADVANTAGES Our study has four advantages. First, it used a large number of health status measures. Second, we built on previous studies[5,6] by better identifying newly eligible adults, especially by distinguishing between the newly Medicaid-eligible and those eligible before the ACA but not enrolled.

Third, we excluded adults enrolled in Medicaid because of disability. The adults in this group differ from other adults in numerous ways. For example, compared to other adults in Medicaid, their health status is poorer, and their per capita Medicaid expenditures are five times higher, on average.[12] As we show below, both adults eligible before ACA but not enrolled and adults who are newly eligible have health profiles that are similar to—indeed, even better than—those of nondisabled pre-ACA Medicaid enrollees. Thus, including the adults enrolled because of disability would lead to incorrect conclusions about the extent to which sicker adults enroll in Medicaid.

Fourth, our results are for both the United States as a whole—assuming that all states were to expand Medicaid eligibility—and for states that are expanding Medicaid eligibility to adults targeted by the ACA and states that are not.

MEDICAL EXPENDITURE PANEL SURVEY MEPS is a nationally representative household survey of the civilian noninstitutionalized population.[13] Each year a new panel of households is sampled and interviewed five times in a two-and-a-half-year period to obtain annual data for two consecutive years. To obtain larger samples, we pooled data from six years, 2005–10. We report "point in time" insurance and eligibility at the first interview in each calendar year.

MEPS collects detailed information that facilitates simulating Medicaid eligibility, such as amounts and types of income and assets, family relationships, and pregnancy status. MEPS also collects data on health, demographic characteristics, and attitudes.

We measured general health with the widely used twelve-item Short-Form Health Survey (SF-12) in MEPS.[14] Physical and mental health summary components of the SF-12 were created from twelve questions on topics including general health, pain, energy level, affect, and limitations in physical and major activities. Higher scores indicate better health.

To assess mental health, we used two validated measures that are based on reported symptoms. Serious psychological distress was assessed using a six-question scale.[15] We used two screening questions to measure the prevalence of depressive symptoms.[16]

MEPS asks whether a doctor ever told the sample member that she or he had certain chronic conditions, such as diabetes. MEPS calculates

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Knowing the health status of newly eligible adults could help states understand what services those adults are likely to need.

obesity from reported height and weight. For details about the chronic conditions, see the online Appendix.[17]

THE PUBSIM MODEL The PUBSIM model uses detailed, state-specific Medicaid eligibility rules and MEPS to simulate adult eligibility for Medicaid. PUBSIM simulates the numerous pathways to pre-ACA Medicaid eligibility, which vary across states and years. Eligibility under the ACA was simulated using final federal regulations for Medicaid eligibility based on modified adjusted gross income (MAGI), assuming that all states elected to expand coverage.[18] Further details about PUBSIM are available in the online Technical Appendix.[17]

GROUPS OF ADULTS We divided nonelderly adults ages 19–64 who were not Medicare beneficiaries into three groups. The first group consisted of pre-ACA enrollees in Medicaid. As explained above, we excluded those who were eligible because of disability. We also excluded those who had only limited benefits, which were typically offered through state-specific waiver programs and eligibility because of pregnancy.

We classified adults as pre-ACA eligible but not enrolled—our second group—if they were eligible for full Medicaid benefits and their MAGIs did not exceed 138 percent of poverty. This category also included adults with higher incomes (above 138 percent of poverty but not exceeding the pre-ACA eligibility threshold) in the two states that will continue to offer eligibility for full benefits to higher-income adults.

The third group consisted of adults who were newly eligible for Medicaid under the ACA, including those previously eligible for limited benefits. Under the ACA, *newly eligible adults* are defined as those whose MAGIs do not exceed 138 percent of poverty and who were not eligible for full Medicaid benefits under their states' rules as of December 2009. We included with the newly eligible adults people who would be newly eligible if their states expanded Medicaid.

GROUPS OF STATES We compared adults in two groups of states. The first group consisted of the states that were expanding Medicaid to cover adults with MAGIs of up to 138 percent of poverty in early 2014—as of this writing, twenty-five states and the District of Columbia. The second group consisted of the twenty-five states that were not expanding Medicaid in early 2014 but that might do so in the future.[19]

STATISTICS All of our estimates used sampling weights to generate nationally representative, average annual estimates for the period 2005–10. All statistical tests and confidence intervals accounted for the complex design of MEPS, but not for additional variation associated with simulation.

LIMITATIONS The main limitations for our study are as follows. First, PUBSIM generates estimates for eligibility at a point in time, but income—and thus Medicaid eligibility—can change throughout the year.[20] Second, we studied simulated eligibility because true eligibility for Medicaid was not directly measured. Third, our eligibility estimates could be sensitive to macroeconomic conditions and demographic trends that were not projected and to ACA rules and state decisions that had not been finalized.

Two additional limitations were addressed in sensitivity analyses and are described in detail in the online Appendix.[17] First, we did not simulate enrollment decisions by individuals and families. Instead, we focused on uninsured people who were eligible for Medicaid and those who had insurance through the nongroup market and state and local programs. We did this because those adults may be more likely to enroll in Medicaid than adults with employment-related insurance. However, our main results were robust when we included newly eligible adults with employment-related insurance. Even among eligible adults without employment-related insurance, differential participation by health status could affect the results, particularly if adults who are less healthy are more likely to enroll.[6]

Second, the total prevalence of chronic conditions is likely to be higher than reported in MEPS, because some conditions were not diagnosed. Evidence from another study[5] suggests that the prevalence of undiagnosed conditions does not differ by insurance status.[17] Furthermore, obesity, an important chronic condition, was calculated from reported height and weight. Weight could have been underreported, but it is unlikely that such underreporting was correlated with insurance status. The prevalence of obesity followed the same pattern as diagnosed conditions across the three eligibility groups.

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Study Results

We used data from the period 2005–10. Our point-in-time estimates indicate that on average, 4.4 million adults (95% confidence interval: 4.0, 4.7) were eligible but not enrolled, compared with 6.8 million (95% CI: 6.3, 7.3) enrolled in Medicaid through a nondisability pathway. Another 23.3 million adults (95% CI: 22.3, 24.3) were newly eligible. These estimates do not reflect changes in the economy, demographic characteristics, or the health sector between the study period and 2014.

INSURANCE STATUS Among newly eligible adults, 60.9 percent were uninsured before the ACA; 30.5 percent had employment-related insurance; 2.8 percent had Medicaid with limited benefits; and 5.8 percent had other coverage, either private insurance not through an employer (individual or nongroup insurance) or another government program (Exhibit 1). Among the pre-ACA eligible but not enrolled, 71.0 percent were uninsured, 24.0 percent had employment-related insurance, and 5.0 percent had other coverage.

ADULTS WITHOUT EMPLOYMENT-RELATED INSURANCE The rest of our analysis focused on uninsured eligibles and those with insurance through the nongroup market and state and local programs, because these adults may be more likely to enroll in Medicaid than those with employment-related insurance. The average point-in-time populations in 2005–10 without employment-related insurance were 3.3 million pre-ACA eligible but not enrolled (95% CI: 3.0, 3.6) and 16.2 million newly eligible (95% CI: 15.4, 17.0).

DEMOGRAPHICS Exhibit 2 compares the demographic characteristics of the newly eligible and pre-ACA eligible but not enrolled with those of the pre-ACA enrollees. The categories of pre-ACA enrollees and those eligible before ACA but not enrolled had small differences in their regional distributions. In comparison, the newly eligible were more concentrated in the South. Pre-ACA enrollees and those eligible but not enrolled were also similar in their age distribution, while the newly eligible had a greater proportion of adults ages 45 and older.

Both groups not enrolled before the ACA were more likely than pre-ACA enrollees to be male and to be single males (Exhibit 2). Among the newly eligible, 28.9 percent had minor children, in contrast with about three-quarters of pre-ACA enrollees and those eligible but not enrolled. The newly eligible were more likely than pre-ACA enrollees to be non-Hispanic whites (54.2 percent); nonetheless, Hispanics and non-Hispanic blacks accounted for 21.3 percent and 17.4 percent of the newly eligible, respectively. The pre-ACA eligible but not enrolled were less likely than pre-ACA enrollees to be non-Hispanic blacks and more likely to be Hispanic. The newly eligible were also slightly more likely than pre-ACA enrollees to be comfortable speaking English (93.1 percent versus 90.8 percent); those eligible before the ACA but not enrolled were similar to pre-ACA enrollees in terms of their comfort speaking English. The newly eligible tended to have more education than pre-ACA enrollees did.

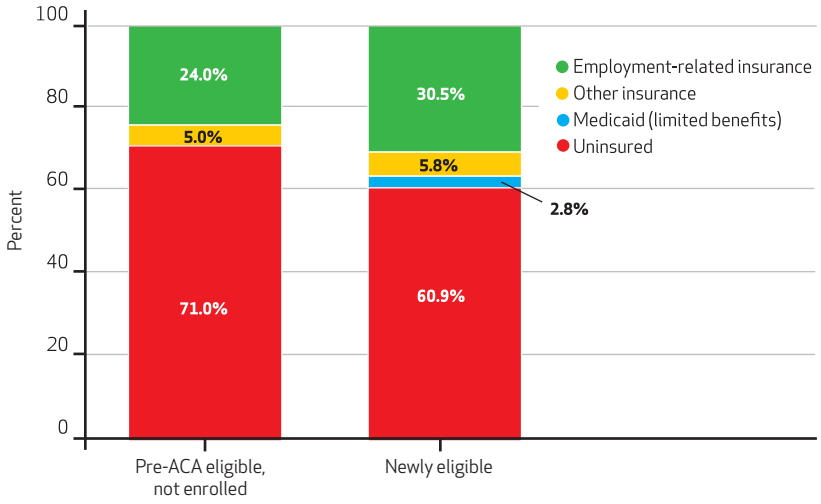
ATTITUDES Exhibit 2 also presents information on attitudes about health insurance, risks, and care seeking—factors that may affect a person's decision about enrolling in Medicaid. Compared with pre-ACA enrollees, newly eligible and pre-ACA eligible but nonenrolled adults were more likely to believe that they did not need health insurance, were "more likely to take risks than the average person," and could "overcome illness without the help of a medically trained person."

These attitudes were held by only a minority of adults likely to be eligible for Medicaid. However, people with such attitudes may be less likely than others to enroll.

HEALTH STATUS On average, adults who were newly eligible for Medicaid or pre-ACA eligible but not enrolled had equal or better physical and mental health and fewer depressive symptoms than pre-ACA enrollees (Exhibit 3). For example, compared with pre-ACA Medicaid enrollees, peo-

EXHIBIT 1

Insurance Coverage Of Nonelderly Adults Not Enrolled In Medicaid Before Implementation Of The Affordable Care Act (ACA), By Medicaid Eligibility



SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2005–10. **NOTES** Ages 19–64. Adults with Medicare are excluded. Insurance coverage and Medicaid eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. "Employment-related insurance" includes TRICARE, the Department of Defense's health care program. "Other insurance" is private insurance not through an employer (individual or nongroup insurance) or government program other than Medicaid.

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EXHIBIT 2

Demographic Characteristics And Attitudes About Health Of Nonelderly Adults, By Medicaid Enrollment And Eligibility

Characteristic	Pre-ACA enrollees	Pre-ACA eligible, not enrolled	Newly eligible
Number of observations	6,005	3,352	12,559
GEOGRAPHICAL LOCATION			
Region			
Northeast	28.3%	32.3%	10.0%***
Midwest	22.2	19.3*	19.7*
South	19.9	23.0*	46.7***
West	29.7	25.4*	23.6***
Metropolitan Statistical Area	84.9	85.8	81.3**
AGE, YEARS			
19–29	42.8	42.1	42.5
30–44	37.8	39.1	26.1***
45–54	12.7	12.5	17.8***
55–64	6.7	6.3	13.5***
SEX			
Men	28.9	42.1***	50.5***
Women	71.1	57.9***	49.5***
MARITAL STATUS AND SEX			
Married men	14.6	14.9	13.1**
Married women	19.2	14.5***	13.7***
Single men	14.3	27.2***	37.5***
Single women	51.9	43.4***	35.7***
PARENT OR CARETAKER OF MINOR CHILDREN			
Yes	76.5	72.3**	28.9***
No	23.5	27.7**	71.1***
RACE OR ETHNICITY			
Non-Hispanic white	41.7	44.4	54.2***
Non-Hispanic black	25.3	19.0***	17.4***
Non-Hispanic other	7.9	7.2	7.2
Hispanic	25.1	29.4**	21.3**
ENGLISH PROFICIENCY			
Comfortable speaking English	90.8	89.3	93.1***
EDUCATION			
Did not complete high school or GED	31.7	30.8	24.9***
High school or GED	41.3	39.0	40.5
Some college	20.9	22.5	24.1***
College degree	6.1	7.7	10.4***
AGREED WITH THE FOLLOWING STATEMENTS			
I am healthy enough that I do not need health insurance	9.4	14.5***	16.1***
I am more likely to take risks than the average person	22.1	26.8***	29.7***
I can overcome illness without the help of a medically trained person	20.1	27.5***	26.8***

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2005–10. **NOTES** Adults with Medicare, Medicaid because of disability, and employment-related insurance are excluded. Medicaid enrollment and eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. Some percentages may not sum to 100 because of rounding. Significance is compared with pre–Affordable Care Act (ACA) Medicaid enrollees. GED is completed general education development or equivalent test. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

ple who were pre-ACA eligible but not enrolled had higher mean scores (indicating that they were healthier) on the SF-12 physical and mental health summary components and were less likely to report symptoms of serious psychological distress.

Chronic conditions tended to be less prevalent among adults who were newly eligible and pre-ACA eligible but not enrolled than among pre-ACA enrollees (Exhibit 3). For example, 35.3 percent of pre-ACA enrollees were obese, compared with 28.4 percent of the newly eligible and 28.8 percent of the pre-ACA eligible but nonenrolled. And 62.1 percent of pre-ACA enrollees had at least one of the chronic conditions we measured, compared to 57.1 percent of the newly

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EXHIBIT 3

Health Status Of Nonelderly Adults, By Medicaid Enrollment And Eligibility

Health status	Pre-ACA enrollees	Pre-ACA eligible, not enrolled	Newly eligible
GENERAL HEALTH, MEAN SUMMARY COMPONENTS OF THE SHORT FORM 12[a]			
Physical	49.4	50.8***	49.8
Mental	48.0	49.2***	48.5*
PERCENT WITH MENTAL HEALTH SYMPTOMS			
Depressive symptoms[b]	16.5%	12.6%***	14.4%**
Serious psychological distress[c]	9.7	7.3***	9.3
PERCENT WITH CHRONIC CONDITIONS			
Active asthma	7.8	5.3***	5.6***
Arthritis	27.7	23.4***	30.1**
Diabetes	7.7	5.1***	5.9***
Emphysema	1.6	0.8**	1.6
Heart disease	8.8	5.7***	7.9
High blood pressure	17.2	12.8***	16.1
High cholesterol	16.8	12.2***	16.4
Obesity	35.3	28.8***	28.4***
Stroke	1.5	1.1	1.9*
1 or more conditions	62.1	52.7***	57.1***

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2005–10. **NOTES** For number of observations, see Exhibit 2. Ages 19–64. Adults with Medicare, Medicaid because of disability, and employment-related insurance are excluded. Medicaid enrollment and eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. Significance is compared with pre–Affordable Care Act (ACA) Medicaid enrollees. [a]Twelve-item short-form health survey (see Note 14 in text). The higher the values of the summary components, the better the respondent's health. [b]Based on the Patient Health Questionnaire-2 (see Note 16 in text). [c]Based on the Kessler Index (see Note 15 in text). *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

eligible and 52.7 percent of the eligible but nonenrolled.

STATES Among adults who were newly eligible and not covered by employment-related insurance, 53.7 percent lived in states that were not expanding adult Medicaid eligibility. Comparisons of the demographics of the newly eligible population in the two groups of states are presented in Appendix Table 6.[17]

We observed similar patterns of health status and conditions across enrollment and eligibility groups when we focused on the nation as a whole and when we grouped states by whether or not they were expanding Medicaid eligibility in early 2014 (Exhibit 4). For example, the health status of the newly eligible was similar across the two groups of states. And in both groups of states, the newly eligible were generally healthier than pre-ACA Medicaid enrollees. The newly eligible had lower rates of obesity, active asthma, and diabetes and were less likely to have one or more chronic conditions. In the states that were expanding Medicaid, however, the newly eligible were more likely than pre-ACA enrollees to have arthritis.

Although the newly eligible population had better health than pre-ACA enrollees, the number of newly eligible adults will likely change the volume of the Medicaid caseload with chronic conditions because of the large increase in the total number of eligible adults. In states that have elected to expand Medicaid, if all eligible adults without employment-related insurance enrolled in the program, the number of adult Medicaid enrollees who were not eligible through a disability pathway would be three times higher than the number of adults who had Medicaid with full benefits before the ACA. In these states an additional 5.4 million (95% CI: 5.0, 5.9) adults with diagnosed chronic conditions would have full benefits, bringing the total to 2.8 times the number before the ACA, 3.0 million (95% CI: 2.7 million, 3.3 million).

Eligibility thresholds are low in states that are not expanding Medicaid in early 2014.[19] If all eligible adults without employment-related insurance in these states enrolled in the program, an additional 0.5 million (95% CI: 0.4 million, 0.6 million) adults with diagnosed chronic conditions would have full benefits.

In these states, there were 8.7 million (95% CI: 8.0, 9.4) adults in the income range targeted for the eligibility expansion and lacking employment-related insurance. Based on their reported incomes, we estimated that 34.0 percent were eligible for subsidies in the Marketplaces, and 66.0 percent were not eligible for Medicaid or for Marketplace subsidies. There were 5.0 million (95% CI: 4.6, 5.5) adults with diagnosed chronic conditions who would not be eligible for Medicaid unless those states elected to expand coverage.

Discussion

Adults who were eligible for Medicaid but not enrolled before passage of the ACA and those in the income range for the ACA's Medicaid expansion ("newly eligible") had similar or better health than adults enrolled in Medicaid through a pathway other than disability before the ACA—in spite of the fact that the newly eligible were somewhat older than the currently enrolled.

The pattern of results was similar for physical and mental health, and whether health was measured with validated symptom-based scales or reports of chronic conditions. Even in states that are not expanding Medicaid in early 2014, adults in the income range for the ACA's Medicaid expansion were healthier than pre-ACA enrollees.

Moreover, in an alternative analysis described in the Appendix,[17] we found that the newly eligible were not less healthy than the pre-ACA eligible (combining both enrollees and those eligible but not enrolled). The newly and pre-ACA eligi-

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EXHIBIT 4

Health Status Of Nonelderly Adults In States That Are Expanding Medicaid Eligibility And States That Are Not, By Medicaid Enrollment And Eligibility

	States expanding eligibility			States not expanding eligibility		
Health status	**Pre-ACA enrollees**	**Pre-ACA eligible, not enrolled**	**Newly eligible**	**Pre-ACA enrollees**	**Pre-ACA eligible, not enrolled**	**Newly eligible if states were expanding**
Number of observations	4,392	2,457	5,608	1,613	895	6,951
GENERAL HEALTH, MEAN SUMMARY COMPONENTS OF THE SHORT FORM 12[a]						
Physical	49.6	51.3***	50.0	48.8	49.5	49.6*
Mental	48.0	49.7***	48.3	47.9	47.9	48.7*
PERCENT WITH MENTAL HEALTH SYMPTOMS						
Depressive symptoms[b]	16.3%	11.4%***	14.6%	16.8%	15.8%	14.3%*
Serious psychological distress[c]	9.6	6.1***	9.5	10.0	10.5	9.2
PERCENT WITH CHRONIC CONDITIONS						
Active asthma	7.9	5.0***	5.8**	7.6	6.1	5.4**
Arthritis	26.4	21.3***	30.2***	30.9	29.4	30.0
Diabetes	7.2	5.3**	5.7**	8.8	4.6***	6.1***
Emphysema	1.3	0.7	1.4	2.4	1.2[d]	1.8
Heart disease	7.9	5.5***	7.7	11.0	6.3***	8.0**
High blood pressure	16.1	12.5***	15.1	19.9	13.9***	17.0*
High cholesterol	17.0	12.6***	17.1	16.4	11.3**	15.8
Obesity	33.7	27.0***	27.0***	39.6	33.8**	29.7***
Stroke	1.3	1.0	1.5	1.9	1.6[d]	2.2
1 or more conditions	61.2	50.3***	56.1***	64.4	59.6	57.9***

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey, 2005–10. **NOTES** Ages 19–64. Adults with Medicare, Medicaid because of disability, and employment-related insurance are excluded. Medicaid enrollment and eligibility are as of the first MEPS interview of the calendar year. "Newly eligible" are adults in the income range targeted for the eligibility expansion, whether or not their state expands eligibility for Medicaid. Significance is compared with pre–Affordable Care Act (ACA) Medicaid enrollees in their group of states. [a]Twelve-item short-form health survey (see Note 14 in text). The higher the values of the summary components, the better the respondent's health. [b]Based on the Patient Health Questionnaire-2 (see Note 16 in text). [c]Based on the Kessler Index (see Note 15 in text). [d]Relative standard error exceeds 0.3. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

ble were similar in global measures of health and in the percentage that had at least one chronic condition.

Two other studies have also found that pre-ACA enrolled adults were less healthy than adults who would be eligible under the expansion (combining the newly eligible and the pre-ACA eligible but not enrolled). Compared with a study by Sandra Decker and coauthors that used data from the National Health and Nutrition Examination Survey,[5] we found smaller differences in health between the two groups. This was because we excluded adults who were eligible because of disability—a population with considerably worse health than other Medicaid enrollees.[12] We also found smaller health differences than John Holahan and colleagues reported,[6] because they measured the treated prevalence of chronic conditions, whereas we used diagnosed prevalence. Compared to people with coverage and the same health status, the uninsured are less likely to be treated. Thus, the treated prevalence of their conditions is lower than the diagnosed prevalence.

Policy Implications

FOR STATES EXPANDING ELIGIBILITY Our findings could have implications for the likely degree of adverse selection among newly eligible adults. Medicaid experiences adverse selection when enrollment rates are higher among sicker people than among healthier people.

Using the health status measures available in MEPS, we found that before the ACA, Medicaid experienced only modest adverse selection: Enrollees were less healthy than people who were eligible but not enrolled, but the differences—although statistically significant—were not large. Differences in the prevalence of most conditions and symptoms were in the range of 2–5 percentage points. But 62.1 percent of Medicaid enrollees had one or more chronic conditions, compared with 52.7 percent of those eligible but not enrolled (Exhibit 3).

These findings might appear to be at odds with findings reported by Stephen Somers and coauthors.[7] Using administrative data on the health care costs of enrollees in state programs and pre-ACA Medicaid expansions for childless

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adults, they found that childless adult enrollees had much higher costs than other nondisabled adult Medicaid enrollees. However, nearly all of the states studied by Somers and colleagues had enrollment caps, which the authors note might have caused disproportionate enrollment by adults with health problems.

Indeed, we also found more adverse selection when we examined the subset of childless adults (Appendix Table 5).[17] The magnitude of the difference was similar to that found in an analysis of Connecticut's recent expansion of Medicaid to childless adults.[21] Our results suggest that expansions of Medicaid to childless adults before the ACA, which capped enrollment in some states, could have different enrollment patterns than the uncapped ACA expansion. We found less adverse selection than Somers and colleagues did. However, we did find more in our analysis of programs for childless adults than in our main analysis.

The potential growth in Medicaid enrollment has implications for planning to meet the needs of future enrollees. Of course, not all eligible adults will enroll, and take-up could be particularly low among the third of people who were eligible for Medicaid before the ACA but who were covered through employment-related insurance.

Nevertheless, if all adults without employment-related insurance who become eligible for Medicaid in 2014 enroll, then the number of nondisabled adults with chronic conditions in the program will likely be 2.8 times the pre-ACA numbers in the states that expand eligibility. This increase is entirely due to the growth in the number of enrollees, because the newly eligible are less likely than pre-ACA enrollees to have chronic conditions. States might wish to determine whether or not services are available to meet the needs of these new enrollees.

FOR STATES NOT EXPANDING ELIGIBILITY

States that are not expanding eligibility could nonetheless experience increased enrollment from a somewhat healthier pool of adults who were eligible before the ACA. In 2014 states are responsible for a portion of Medicaid expenditures for this population.

The number of newly eligible adults will likely change the volume of the Medicaid caseload with chronic conditions.

There is a much larger group of adults—8.7 million (95% CI: 8.0, 9.4)—who are in the income range targeted for the eligibility expansion and who lack employment-related insurance. We estimated that 66 percent of this population had incomes too low to participate in the health insurance Marketplaces. More than half of this population had chronic conditions, and these adults are likely to have difficulty paying for care and may instead obtain uncompensated care. Expanding Medicaid eligibility could help this population.

Conclusion

Adults in the income range for the ACA's Medicaid expansion had similar or better health than adults enrolled in Medicaid through a pathway other than disability before the ACA. As of January 2014, twenty-five states had decided not to use the ACA to expand Medicaid eligibility for adults. If these states reverse their decisions, their Medicaid programs might be unlikely to enroll a population that is sicker than their pre-ACA enrollees. By electing to expand Medicaid eligibility, states could provide coverage to millions of healthier adults as well as to millions who have chronic conditions and who need care. ■

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Changes in Health Insurance Enrollment Since 2013

Evidence from the RAND Health Reform Opinion Study

Katherine Grace Carman and Christine Eibner

Summary

RAND's Health Reform Opinion Study (HROS), a survey conducted using the RAND American Life Panel, allows us to estimate how many people have become enrolled in all sources of health care coverage since the implementation of the Affordable Care Act (ACA). The analysis presented here examines changes in health insurance enrollment between September 2013 and March 2014; overall, we estimate that 9.3 million more people had health care coverage in March 2014, lowering the uninsured rate from 20.5 percent to 15.8 percent. This increase in coverage is driven not only by enrollment in health insurance marketplace plans, but also by gains in employer-sponsored insurance and Medicaid. Enrollment in employer-sponsored insurance plans increased by 8.2 million and Medicaid enrollment increased by 5.9 million, although some individuals did lose insurance. We also found that 3.9 million people are now covered through the state and federal marketplace—the so-called insurance exchanges—and less than 1 million people who previously had individual-market insurance became uninsured during the period in question. While the survey cannot tell if the people in this latter group lost their insurance due to cancellation or because they simply felt the cost was too high, the overall number is very small, representing less than 1 percent of people between the ages of 18 and 64.

Over the past few months, there has been intense focus on the number of sign-ups in the new health insurance marketplaces established under the Affordable Care Act (ACA).[1] But marketplace enrollment is only a small piece of the puzzle: The ACA seeks to achieve nearly universal health insurance coverage using all sectors of the health insurance market. First, the law makes coverage more affordable for people with low and moderate incomes by providing health insurance subsidies for individuals lacking affordable employer insurance and by encouraging states to expand their Medicaid programs. Second, the law makes coverage more accessible to those in poor health through insurance-rating reforms that prohibit insurers from basing premiums on health status and from denying coverage to older and sicker people. Third, the law includes an individual mandate that penalizes people if they do not enroll in coverage (ultimately, mid- and large-sized businesses will also be penalized if they do not offer affordable coverage to their workers). The ACA's individual mandate creates a new incentive for individuals to enroll in health insurance coverage, regardless of whether they are eligible for subsidies on the marketplaces. Medicaid expansion in participating states, along with the "welcome-mat" effect created by increased awareness of the program, may similarly encourage enrollment in Medicaid both among newly eligible people and among previously eligible people who were not already enrolled.

RAND's Health Reform Opinion Study (HROS)[2] allows us to estimate how many people have become enrolled in all sources of coverage since January 2014, the date when many of the ACA's coverage expansion reforms took effect. Based on our analyses of responses to HROS, between September 2013 and March 2014, the number of adults with health insurance coverage increased by about 9.3 million, the result of a mixture of increases in

employer-sponsored insurance (ESI), Medicaid enrollment, and the marketplaces.

The HROS is conducted using the RAND American Life Panel, a nationally representative panel of individuals who regularly participate in surveys. More than 350 surveys have been fielded with the panel to date on a wide variety of topics. The HROS has been fielding monthly surveys with the panel since November 2013, contacting the same group of individuals each month. In addition to asking respondents about their opinions of the ACA, each month we collect information about enrollment in health insurance, including ESI, Medicaid, Medicare, insurance purchased on a marketplace, and other insurance purchased on the individual market. We can identify the health insurance status of HROS respondents in September 2013 by linking them to data previously collected through the RAND American Life Panel, allowing us to estimate the number of individuals transitioning from one source of coverage to another.

This detailed information about insurance coverage combined with the fact that we survey the same individuals each month provides us with a unique ability to track how insurance coverage has changed since the implementation of the ACA. We are able to observe changes in uninsurance, enrollment in Medicaid, enrollment through marketplaces, changes in employer coverage, and other changes in coverage in one comprehensive data source. This allows us to look at gross and net changes in insurance coverage. In other words, we can look at the number of people gaining coverage, the number of people losing coverage, and the overall net impact. Transitions in health insurance coverage are common in the United States, and they occur for a variety of reasons, including losing or gaining employment, family transitions, and aging in and out of eligibility for certain programs.[3] Of the transitions we observe in HROS, we cannot say for certain which are due to the ACA and which resulted from one of these background factors, although we can draw some limited conclusions.

A total of 2,641 individuals ages 18 to 64 responded to the survey in March of 2014. Our sample is based on the 2,425 of these individuals (91.8 percent) who also reported a valid insurance coverage status in September of 2013.[4] Although our data were collected through March 28, 2014, most responded earlier in the month, and some may have made new insurance choices since participating in our survey. However, we will survey respondents again in April 2014 and update our figures once this new data is available.

We extrapolated from our sample to estimate the number of people in the population as a whole in each insurance category, as discussed in more detail below. We use sample weights to ensure that our sample is representative of the population, benchmarking to the Current Population Survey, a large national survey conducted by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics.[5] We then use the weighted percentage of respondents from our survey multiplied by the total population between the ages of 18 and 64 (198.5 million) to extrapolate to the national level.[6] For example, 5 percent of respondents in our survey would be associated with 9.9 million individuals in the population as a whole. When estimating based on a subset of the population, there is always some margin of error (sometimes referred to as *sampling error*). In this case, we report the margin of error as the 95 percent confidence interval. This means that, if the survey were repeated multiple times, and the 95 percent confidence interval was calculated in each case, the true estimate would be within the 95 percent confidence interval in about 95 percent of the repeated surveys.

Table 1 highlights what our survey tells us about how insurance coverage has changed from 2013 to 2014. Each cell of the table reports the estimated number of people who have transitioned from the category indicated in the heading of that column to the category indicated in the row of that column. We see that of the 40.7 million who were uninsured in 2013,

Table 1: Transitions Between Uninsured and Insured from 2013 to 2014

	Uninsured in 2014	Insured in 2014	Total in 2013
Uninsured in 2013	26.2 *(+/– 3.7)*	14.5 *(+/– 2.8)*	**40.7** *(+/– 4.4)*
Insured in 2013	5.2 *(+/– 2.0)*	152.7 *(+/– 4.6)*	**157.9** *(+/– 4.4)*
Total in 2014	**31.4** *(+/– 4.1)*	**167.2** *(+/– 4.1)*	**198.5** *(—)*

NOTES: All numbers (including margin of error) are in millions of individuals. Margin of error represents a 95 percent confidence interval.
Light gray cells show numbers that did not change from 2013 to 2014 (i.e., individuals who experienced no transition). Dark gray cells show numbers of transitions from 2013 to 2014. Numbers in italics show margins of error. Margin of error represents a 95 percent confidence interval.

Transitions in health insurance coverage are common in the United States, and they occur for a variety of reasons, including losing or gaining employment, family transitions, and aging in and out of eligibility for certain programs.

14.5 million gained coverage, but 5.2 million lost coverage, for a net gain in coverage of approximately 9.3 million. This represents a drop in the uninsured rate from 20.5 percent to 15.8 percent.

In all of the tables, the number below each estimate shows the margin of error. For example, the estimate for the number insured in 2013 is 157.9 million with a margin of error of 4.4 million people; this means that we can have a high degree of confidence that the true number lies in the range between 153.5 and 162.3 million.

Table 2 presents our survey findings regarding net changes in enrollment between September 2013 and March 2014 for the following five categories: no insurance, ESI, Medicaid, insurance purchased on the individual market, and other forms of insurance (which include military insurance, Medicare, other governmental plans, and retiree insurance).[7] Within insurance purchased on the individual market, we can separately segment plans purchased on the marketplaces and off-marketplace plans. Enrollment in marketplace plans is clearly related to the ACA—marketplace coverage first became available in 2014 as a direct result of the law's implementation. But the changes in enrollment among other sources of coverage could reflect some combination of the effects of the ACA and other changes, such as changing jobs.

Table 2 illustrates that the 9.3-million-person increase in insurance is driven not only by enrollment in marketplace plans, but also by gains in ESI and Medicaid:

- Enrollment in ESI increased by 8.2 million. Most of this increase was driven by people who were previously uninsured. Some of these newly insured individuals may have taken up an employer plan as a result of the incentive created by the individual mandate; others may have newly found a job. The U.S. unemployment rate fell slightly between September 2013 and March 2014, so part of the increase in ESI enrollment could have been due to economic recovery rather than the ACA. While the 8.2-million-person increase seems large, more than 100 million 18- to 64-year-olds were covered by ESI in 2013. Since ESI is the dominant source of insurance coverage among this age group, it is not surprising that we could see relatively large effects of the individual mandate and economic recovery in this category.
- Medicaid enrollment increased by 5.9 million. New enrollees are primarily drawn from those who were uninsured in 2013, or those who previously had forms of insurance in the *other* category.
- By our estimate, 3.9 million people are now covered through the state and federal marketplaces. This number is lower

Table 2: Net Changes in Insurance Coverage from September 2013 to March 2014

Plan	2013	2014	Difference
ESI	108.7 *(+/– 5.2)*	116.9 *(+/– 5.1)*	8.2 *(+/– 3.6)*
Medicaid	12.3 *(+/– 2.3)*	18.2 *(+/– 3.0)*	5.9 *(+/– 2.8)*
Individual Market	9.4 *(+/– 2.1)*	7.8 *(+/– 1.8)*	–1.6 *(+/– 1.8)*
Marketplace	— *(—)*	3.9 *(+/– 1.1)*	3.9 *(+/– 1.1)*
Other	27.5 *(+/– 3.7)*	20.3 *(+/– 3.0)*	–7.1 *(+/– 1.6)*
Subtotal (Insured)	**157.9** ***(+/– 4.4)***	**167.2** ***(+/– 4.1)***	**9.3** ***(+/– 3.5)***
Uninsured	**40.7** ***(+/– 4.4)***	**31.4** ***(+/– 4.1)***	**–9.3** *(+/– 3.5)*

NOTE: All numbers (including margin of error) are in millions of individuals. Numbers in italics reflect margins of error. Margin of error represents a 95 percent confidence interval. Some numbers may not sum perfectly due to rounding.

than current estimates of marketplace enrollment through the end of March from the Department of Health and Human Services (DHHS), perhaps because some of the HROS data were collected in early March. All HROS data collection reported here ended on March 28, and therefore missed the last three days of the open enrollment period, during which time there was a surge in enrollment.

Table 3 presents detailed estimates of transitions in insurance coverage from late 2013 to early 2014. The table shows not only the net change in insurance coverage, but also transitions across insurance categories. It thus helps us to better understand the net changes we identified above. As in Table 1, each cell of the table reports the estimated number of people who have transitioned from the category indicated in the heading of that column to the category indicated in the row of that column. For example, 40.7 million were uninsured in 2013. Of those 7.2 million now receive insurance through ESI.

Table 3 makes clear that the ACA has not led to changes in the health insurance coverage of most people. Among adults, fully 80 percent still had the same form of coverage in March 2014 as in September 2013. Most notably, more than 100 million had ESI before and have ESI now, while 26 million remain uninsured.

While there has been an overall net increase in enrollment, there was a 7.1-million-person decline in the *other* insurance category. Although a small percentage of those who previously had other coverage are now uninsured, most have moved to an alternative source of coverage, such as employer coverage, Medicaid, or the marketplaces. In addition, enrollment in off-marketplace individual market plans fell from 9.4 to 7.8 million. Many of those losing coverage in the off-marketplace individual market found coverage in marketplace plans or through another source.

Other key findings shown in Table 3:

- Of those who were previously uninsured but are now insured, 7.2 million gained ESI, 3.6 million are now covered by Medicaid, 1.4 million signed up through the marketplaces, and the remainder gained coverage through other sources.
- Our estimates suggest that only about one-third of new marketplace enrollees were previously uninsured. While this seems relatively low, it is slightly higher than findings reported earlier by McKinsey & Company.[8]
- More than 2 million people who previously had ESI are now uninsured, representing 1 percent of the population from ages 18 to 64—this is around one-third as large as the number moving from no insurance to ESI. Within this group, some may no longer hold the same jobs and may not have access to the same coverage.
- Among the 7.8 million people who were enrolled in off-marketplace individual market plans in early 2014, more than

Table 3: Transitions Across Insurance Categories from September 2013 to March 2014

		2014						
		No Insurance	ESI	Medicaid	Individual Market	Marketplace	Other	Totals in 2013
2013	No Insurance	26.2 *(+/– 3.7)*	7.2 *(+/– 2.2)*	3.6 *(+/– 1.3)*	0.5 *(+/– 0.4)*	1.4 *(+/– 0.7)*	1.8 *(+/– 1.0)*	**40.7** *(+/– 4.4)*
	ESI	2.1 *(+/– 1.3)*	102.4 *(+/– 5.3)*	0.9 *(+/– 0.7)*	1.3 *(+/– 0.7)*	0.4 *(+/– 0.3)*	1.7 *(+/– 0.7)*	**108.7** *(+/– 5.2)*
	Medicaid	1.0 *(+/– 0.7)*	1.3 *(+/– 0.9)*	9.2 *(+/– 2.0)*	0.1 *(+/– 0.1)*	0.2 *(+/– 0.2)*	0.7 *(+/– 0.5)*	**12.3** *(+/– 2.3)*
	Individual Market	0.7 *(+/– 0.9)*	1.8 *(+/– 1.0)*	0.2 *(+/– 0.2)*	5.4 *(+/– 1.5)*	0.8 *(+/– 0.4)*	0.5 *(+/– 0.7)*	**9.4** *(+/– 2.1)*
	Other	1.5 *(+/– 1.0)*	4.2 *(+/– 1.6)*	4.3 *(+/– 2.0)*	0.6 *(+/– 0.5)*	1.2 *(+/– 0.7)*	15.6 *(+/– 2.6)*	**27.5** *(+/– 3.7)*
Totals in 2014		**31.4** *(+/– 4.1)*	**116.9** *(+/– 5.1)*	**18.2** *(+/– 3.0)*	**7.8** *(+/– 1.8)*	**3.9** *(+/– 1.1)*	**20.3** *(+/– 3.0)*	**198.5** *(–)*

NOTE: All numbers (including margin of error) are in millions of individuals. Light gray cells show numbers that did not change from 2013 to 2014 (i.e., individuals who experienced no transition). Numbers in italics reflect margins of error. Margin of error represents a 95 percent confidence interval.

90 percent were previously insured; nearly 70 percent were previously insured through an individual market plan.

- Less than 1 million people who previously had individual market insurance transitioned to being uninsured. While we cannot tell if these people lost their insurance due to cancellation or because they simply felt the cost was too high, the overall number is very small, representing less than 1 percent of people between the ages of 18 and 64.

While there are benefits to using survey data to estimate enrollment, there are of course also limitations. One of the most important benefits is that survey data allow us to observe a wide variety of sources of information that could not be elicited from any single administrative data source. For example, since the opening of the marketplaces, the federal government has regularly reported the total number of enrollees through the marketplaces, but these same data tell us nothing about changes in ESI. However, as with any data collected through surveys, we run the risk that individuals will report inaccurately. For example, people may not report having Medicaid because their state uses a different name for the program or because they do not understand the true source of their insurance. Furthermore, all survey data has a margin of error related to the fact that only a small share of the population is surveyed. Because of this, the margin of error when looking at detailed insurance categories can be relatively high. However, the net increase of 9.3 million we report is outside of what we would expect given normal churn or sampling error.

Given the strong interest in understanding the impact of the ACA, a variety of different organizations, including the Urban Institute and Gallup, are also conducting surveys to estimate the effect of the ACA on insurance enrollment. When making comparisons across studies, it is important to keep in mind that each comes with its own margin of error. Furthermore, the timing of surveys may vary. With the surge in enrollment at the end of March, whether that period is included in a survey could dramatically affect the resulting numbers. Additionally, not all surveys report results about the same age groups; our survey focuses on those from age 18 to 64, the adults most likely to be affected. Thus, it should not be surprising that estimates from different studies may not match perfectly.

. . . early evidence from our nationally representative survey indicates that the ACA has already led to a substantial increase in insurance coverage.

The findings presented here represent changes across the entire United States. Because the implementation of the ACA has differed across states, and because states have different demographic characteristics, it is likely that patterns of insurance gains, losses, and transitions may differ substantially across states. Unfortunately, we cannot analyze state-specific changes in our data because the sample sizes for many cells would be too small to provide reliable estimates.

While these results are indicative of respondents' coverage at the time of their response (as noted, between March 1 and March 28) there is still time for more people to enroll, especially given the recent extensions. Furthermore, it is still early in the life of the ACA. Over the coming months and years, further changes in enrollment figures can be expected as people become more familiar with the law, the individual mandate penalties increase to their highest levels, the employer mandate kicks in, and other changes occur. But early evidence from our nationally representative survey indicates that the ACA has already led to a substantial increase in insurance coverage. Consistent with law's design, this gain has come not only from new enrollment in the marketplaces, but also from new enrollment in employer coverage and Medicaid.

Notes

[1] Marketplaces are also known as *exchanges*.

[2] Please visit www.rand.org/health/projects/health-reform-opinion.html

[3] Graves, John A., and Katherine Swartz. 2013. "Understanding State Variation in Health Insurance Dynamics Can Help Tailor Enrollment Strategies for ACA Expansion." *Health Affairs*, 32(10): 1832–1840.

[4] One hundred seventy-six respondents (6.7 percent) were dropped because they did not respond to the September 2013 survey. An additional 40 respondents (1.5 percent) were dropped because of unusable information about the source of their insurance.

[5] Data are weighted to match the age, sex, race/ethnicity, education, and income distribution of the 2012 March Supplement of the Current Population Survey (CPS). We also match the joint bivariate distributions of race and sex and education and sex.

[6] U.S. Census Bureau. March 27, 2014. "State and County QuickFacts." As of April 7, 2014: http://quickfacts.census.gov/qfd/states/00000.html

[7] For respondents who report more than one source of insurance, we assign a primary insurance source, according to the following hierarchy: no insurance, insurance through a marketplace plan (unless listed with ESI, in which case ESI is considered primary), Medicaid (excluding those dually enrolled in Medicaid and Medicare), ESI, private nonmarketplace insurance, other forms of insurance (including Medicare, dual Medicaid-Medicare enrollees, military insurance, other governmental plans, and retiree insurance). The first type of insurance listed in the hierarchy is considered the primary insurance type.

[8] McKinsey and Company. 2014. "Individual Market Enrollment: Updated View." McKinsey Center for U.S. Health System Reform. As of April 7, 2014: http://healthcare.mckinsey.com/sites/default/files/Individual-Market-Enrollment.pdf

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Christine Eibner is a senior economist at the RAND Corporation and director of RAND COMPARE, a project that uses economic modeling to predict how individuals and employers will respond to major health care policy changes. She currently leads several projects related to the Affordable Care Act (ACA), including a study for the U.S. Department of Health and Human Services that will assist state Medicaid programs with income counting and federal matching assistance percentage calculations, given changes set forth in the ACA. Previously, Eibner led projects for the U.S. Department of Labor to assess the implications of the ACA for employers. As part of this work, she evaluated the possibility that firms might strategically avoid regulation (e.g., by self-insuring). Eibner's research has been published in major health policy journals, including *Health Affairs*, *Health Services Research*, and *The New England Journal of Medicine*. Eibner earned her bachelor's degree in English and economics from the College of William and Mary and her doctorate in economics from the University of Maryland, College Park.

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enrollment momentum

Enrollment

Accelerating the Affordable Care Act's Enrollment Momentum: 10 Recommendations for Future Enrollment Periods

SPECIAL REPORT / APRIL 2014

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The Purpose of the Recommendations

On March 31, 2014, the Affordable Care Act's first enrollment period ended. Though enrollment continues for some (for example, low-income individuals who are eligible for Medicaid, people with life transitions such as family changes or job loss, and those who began the enrollment process but could not complete it before March 31), general enrollment now ceases until November 15, 2014, when the next enrollment period begins.

This initial enrollment period has been an important first step toward securing health insurance for millions of uninsured people living in the United States. But there is still much work to be done to achieve the true promise of the Affordable Care Act. Learning from the lessons offered by this first enrollment period, we have identified 10 key steps that would significantly increase the number of people who can enroll in health insurance during the next open enrollment period. These steps should be taken promptly and well before November 15 to ensure that future enrollment periods fulfill the health coverage goals of the Affordable Care Act.

Background

The Affordable Care Act created an historic opportunity to provide health insurance to all legal residents of the United States. By offering unprecedented financial assistance to middle- and moderate-income families, and by expanding Medicaid for low-income people in approximately half the states, the health care law reduces uninsured rates across the country. A recent Gallup poll found that the uninsured rate dropped from 17.1 percent in the last quarter of 2013 to 15.9 percent in the first quarter of 2014.[1] The Affordable Care Act has significant potential to reduce the uninsured rate further—but its success will depend on robust, effective outreach and enrollment processes.

Fulfilling this goal is not easy, especially in the early stages of implementation. As we learned from other health program initiatives, such as the Children's Health Insurance Program (CHIP), the Medicare Part D prescription drug benefit, and the health reform program in Massachusetts, outreach and enrollment successes tend to be modest in the beginning. Due to the demographics, educational levels, and language limitations of uninsured Americans, the enrollment challenges we now face are even greater.

Initial problems with the federal website initially hampered enrollment, but those problems have been fixed, and enrollment has gained significant momentum. Millions of people have new health coverage: Enrollment in private health insurance has accelerated, with more than four out of five enrollees qualifying for financial assistance in the form of tax credit subsidies. And an even larger number of people have new coverage through Medicaid.

10 Key Steps for Strengthening Future Enrollment

We have identified improvements that will build on and strengthen the momentum gained over the past six months. The 10 recommendations summarized below share the following attributes:

- They would significantly improve the success of future enrollment efforts.
- They do not require the enactment of new legislation.
- The U.S. Department of Health and Human Services (HHS) and/or state marketplaces (exchanges) can undertake them.

The first seven of these recommendations have a direct impact on the enrollment process, while the latter three focus on improving coverage affordability—the key factor for uninsured people when they decide if they should enroll in health insurance.

1 Increase the number of, and resources for, enrollment navigators and assisters:

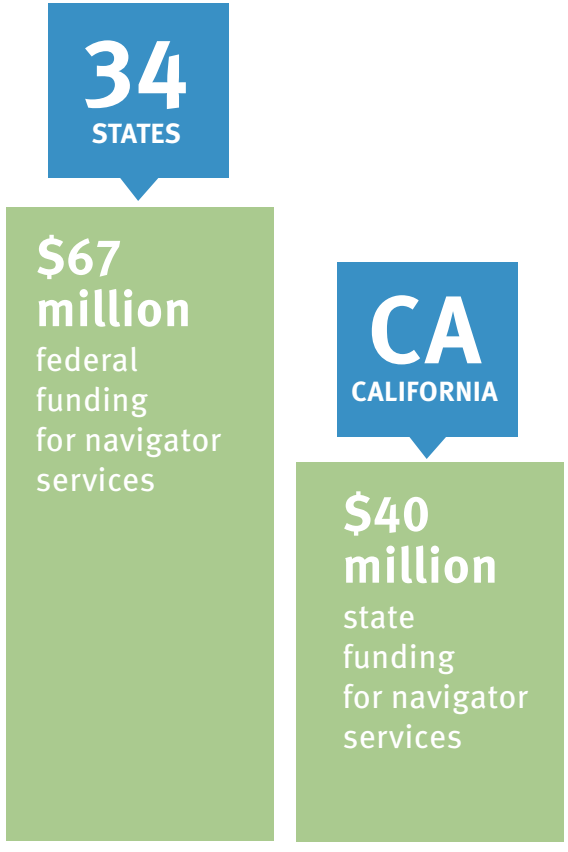
HHS and states should increase the resources available for enrollment assistance as much as possible to ensure that assisters have the tools they need to maximize their effectiveness generally, and especially in communities of color and other communities that experience significant barriers to coverage.

This first enrollment period has demonstrated the importance of in-person assistance, particularly for people who face barriers such as limited English proficiency, limited access to and experience with technology, low literacy levels, limited knowledge of health insurance, or complex family situations related to immigration status. These factors complicate the application process and make it much more difficult for people to complete the application on their own.

However, the need for individual assistance with the application process goes well beyond people in these groups. Research conducted by Enroll America before open enrollment began found that three out of four consumers would like in-person help with applying for health insurance.[2] Research conducted more recently

1 Increase the number of, and resources for, enrollment navigators and assisters

(continued)



by the Urban Institute found that almost half of uninsured people who did not plan to buy insurance in a marketplace (but who were aware of their option to do so) would be more likely to buy that insurance if they had in-person support.[3]

Buying health insurance is a complex matter. It requires people to make difficult decisions that affect whether their families can get the health care they need from providers they prefer, and that affect their families' financial well-being. The next open enrollment period runs for just three months (and includes the Thanksgiving and Christmas holidays), compared to six months for the first open enrollment period, making enrollment assistance even more important.

This year, HHS allotted a mere $67 million for navigator services across all 34 states with federally managed marketplaces. State-managed marketplaces, which did not experience the same congressional limitations on funding, had significantly more dollars per uninsured person. In California alone, for example, the funding for navigator services was approximately $40 million. Although budget pressures are likely to be more significant in the future, HHS and the states should allocate larger portions of their administrative funds to increase the effectiveness of navigators and assisters.

2 Build a substantial, sustained public education campaign coordinated between the public and private sectors about the tax credit subsidies that are available to make insurance premiums affordable:

HHS, state-managed marketplaces, insurers, and other private sector organizations that are interested in expanding health coverage should come together soon to develop a broad, coordinated, well-resourced public education campaign about the availability of these tax credits. This combined effort should use demographic data to create targeted, culturally-appropriate, consumer-friendly materials that will motivate uninsured people (especially in communities of color) to sign up for health insurance.

7 in 10
uninsured adults do not know financial help is available to reduce the cost of health insurance.

This year, HHS and private sector stakeholders spent less on advertising than originally planned, in part due to concerns that *healthcare.gov* was not working well enough to handle more traffic when open enrollment began. The advertising that did take place was, understandably, directed mostly to states with high rates of uninsured. This meant that large areas of the country lacked paid advertising to help educate consumers about affordable health insurance options and the financial help available to pay for health insurance.

Throughout 2013 and the open enrollment period that just ended, polling continued to show that many people remained unaware that financial help was available to reduce the cost of health insurance, and these people were therefore not applying for coverage.[4] Survey research shows that about seven in 10 uninsured adults (69 percent) do not know about this financial assistance.[5] The problem is particularly acute in communities of color, where ongoing work is needed to continue the progress made so far. Expanding existing public education campaigns between now and November 15 is critical.

3 Coordinate enrollment opportunities with tax filing:

The Administration should create a "special enrollment opportunity" for people who learn they will have to pay a tax penalty for being uninsured in 2014. Such an opportunity would give people a short window to enroll in a plan after they file their taxes, thereby minimizing the chances they will incur a second penalty for remaining uninsured in 2015.

In 2015, for the first time, people who were uninsured in 2014 will pay penalties for going without insurance when they file their taxes. But data show that many of the uninsured are not aware that they will face a tax penalty if they don't buy insurance.[6] Based on current rules, just when consumers realize the impact of their decision to go without insurance, they will have to wait another year–and pay another penalty–before they can correct their error and sign up for health insurance. This is because the next open enrollment period runs from November 15, 2014, through February 15, 2015, while the tax filing season runs from January 1 through April 15, 2015.

If the Administration creates a special enrollment opportunity for the tax filing period between February 15 and April 15, 2015, this time could be used to educate uninsured consumers and increase enrollment. It would also correct the unfair situation in which consumers have to pay an extra penalty by giving them time to correct the problem.

> "Fully aligning the open enrollment period with the tax filing period would significantly increase enrollment."

Fully aligning the open enrollment period with the tax filing period would significantly increase enrollment: It would enable professional tax preparers to play a much larger role in enrollment efforts, and it would help people have a better understanding of the tax consequences they would experience if they don't enroll in health insurance. Although it may be too late to establish such a change for the second open enrollment period, we encourage HHS to consider making such a change for future open enrollment periods. Those enrollment periods could start later than November 15 and end at or around April 15.

4 Continue streamlined Medicaid enrollment for people already enrolled in other public benefit programs:

HHS should allow states to indefinitely extend streamlined Medicaid enrollment (this permission is currently set to expire in 2015).

Streamlined enrollment saves outreach resources and makes it easier for eligible people to enroll in Medicaid. HHS currently allows states to streamline eligibility and enrollment for people who receive help through SNAP (the Supplemental Nutrition Assistance Program, formerly food stamps) or whose children are enrolled in other public programs by using the information those families have provided to "fast track" Medicaid applications.

When states already have the information needed to complete a Medicaid application, it makes sense for them to use that information to help people who are uninsured get coverage quickly and easily. This benefits consumers and states by reducing bureaucratic red tape, easing the burden on marketplaces, and getting people coverage more quickly. During the first open enrollment period, **Arkansas, California, Illinois, Oregon,** and **West Virginia** successfully used this strategy to increase Medicaid enrollment.

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5 Provide applications that can be completed in multiple languages, not just English and Spanish:

Making the application available in additional languages will help more people complete it independently, thus reducing the burden on call center staff and in-person enrollment assisters.

Many legal immigrants with limited English proficiency have difficulty completing English-language application materials. So far, the federally facilitated marketplace application can be completed only in English and Spanish. Although there are some tools to help people who speak other languages, the failure to provide applications that can be completed in other languages makes the enrollment process more complicated for many people. It also makes it hard for people who speak languages other than English or Spanish to complete the application without help from an enrollment assister.

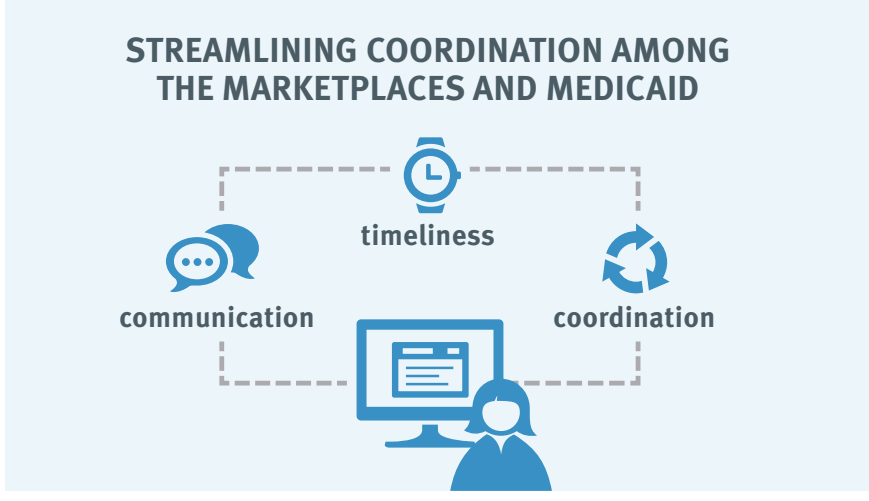
6 Strengthen coordination among the marketplaces and Medicaid to prevent applications from being lost or unduly delayed:

HHS should work with states to better coordinate computer systems and speed up the transfer and evaluation of applications for people who appear to be eligible for Medicaid. The agency should ensure that Medicaid eligibility assessments are transferred to state agencies within 24 hours, and state agencies should process these applications quickly. Individuals who apply through the marketplace should be notified when their application is transferred and informed about how to check its status.

The Affordable Care Act envisions a health insurance system that is coordinated and streamlined, with "one-stop shopping" for consumers. People who apply for insurance through the marketplace at *healthcare.gov* and appear to be eligible for Medicaid should be able to get an eligibility determination quickly and easily.

But in this first open enrollment period, the technology behind the federal website was not yet fully coordinated with the computer systems in most states. This led to communication problems among HHS and state Medicaid agencies, and it complicated the Medicaid eligibility determination process. Ultimately, it meant that many low-income consumers had to wait longer for coverage.

Speeding up these processes is especially important because the next open enrollment period will be significantly shorter than the first one.



7 Fix the roadblocks that prevent people from completing their applications:

Many consumers have now had significant experience using the online application for health coverage at *healthcare.gov* and in state marketplaces.

Throughout the open enrollment period, HHS significantly improved the online application in response to concerns raised by consumers and enrollment assisters. However, several significant issues remain that make it difficult for many people to complete the enrollment process. These issues, described here, should be addressed before the next open enrollment period.

› **The Administration should establish alternative avenues for verifying identity when a consumer creates an account on *healthcare.gov*:** Consumers should be able to either 1) upload electronic copies of their documents to be verified in real time by the marketplace, or 2) find out whether they qualify for financial assistance and be allowed to enroll in a plan pending the outcome of the alternative identity verification process.

One of the first steps that happens when a consumer applies for insurance is verification of his or her identity. This is important for many reasons, including preventing fraud and protecting consumers' privacy. The current system relies on Experian, a credit monitoring agency, to verify consumers' identities using their credit history. But people who lack a credit history because they rely on debit cards and/or cash (particularly people who have low incomes or who have recently come to the United States) must undergo a longer, paper-based verification process–often without much communication in the interim–before they find out if they are eligible for financial assistance and can enroll in a plan.

› **The Department of Labor should require employers to automatically provide a completed Employer Coverage Tool to all employees who have an offer of health insurance so that more people come into the application process with the information they need to apply:** We recommend that the Department of Labor implement this requirement because employees need this information to apply for financial assistance with premiums. Currently, employers are encouraged—but not required—to complete the tool for employees if requested to do so. ▸

7 Fix the roadblocks that prevent people from completing their applications (continued)

Currently, anyone applying for health insurance who has an offer of coverage from an employer (or who might have an offer of coverage during the year) can ask the employer to complete an Employer Coverage Tool document before that employee applies for insurance in the marketplace. This document allows the marketplace to confirm that an employer's coverage is either too expensive or too limited for the employee. Without that document, consumers cannot easily find out whether they qualify for financial assistance for a marketplace plan. This step has prevented many people from completing the enrollment application.

› **Provide clear mechanisms for resolving problems with applications:** Establishing a better process for resolving application problems will make the process easier for consumers and administrators.

Some people will experience problems filling out their application for health insurance, either because they have complicated life circumstances or because of technological glitches. HHS and state marketplaces should establish a clear system for consumers and enrollment assisters to get problems resolved using expert staff with the ability to override computer application systems and make decisions.

During the first open enrollment period, resolving application problems was often difficult. As a result, many consumers could not get their problems resolved, or they were forced to resolve their problems by appealing their eligibility decision (a process that is unnecessarily bureaucratic and that causes additional delays and administrative burdens) or by deleting their application and starting the process over again. This must be addressed before the next open enrollment period.

HHS and state marketplaces should establish a clear system for consumers and enrollment assisters to resolve application problems.

8 Ban health plans from continuing to impose premium surcharges that make insurance unaffordable for people who use tobacco:

To prevent people from being priced out of coverage by "tobacco rating," all states should either ban these surcharges or significantly reduce the amount that can be charged. For states that continue to allow this practice, HHS should require insurers to stop applying tobacco surcharges mid-year if people have quit using tobacco since they enrolled.

Although insurers can no longer charge people higher premiums because of their health status or gender, in most states, they can still charge people up to 50 percent more for insurance if they use tobacco, a practice known as "tobacco rating." Right now, when people apply for insurance, they may face this surcharge if they have used tobacco regularly in the previous six months. And even if they quit mid-year, insurers do not have to remove the surcharge.

These surcharges cannot be offset by tax credit subsidies, meaning tobacco rating can make insurance premiums unaffordable. Some states have barred insurers from establishing such surcharges or have limited surcharges to well below 50 percent.

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9 Ensure that marketplaces offer low-deductible silver plans:

To make it easier for insurers to design their plans, HHS has provided models of some plan designs that meet the required actuarial values. HHS should add models of low-deductible plans and/or plans that include routine care for people before they meet their deductible, especially for "bronze" and "silver" plans. HHS should encourage every state to make such plans more widely available.

Currently, as long as the total value of health plans meet certain actuarial levels, insurers have no guidelines that restrict how they design the cost-sharing that consumers must pay. This has been an impediment to enrollment. In particular, insurance plans with high deductibles deter people from seeking coverage because the upfront costs (premiums plus deductibles) can be too expensive.

10 Exclude health plans that set unacceptably high premiums:

Since making premiums affordable is crucial to improving enrollment, HHS should exclude plans with unreasonable premiums from the marketplace in 2015.

Some, but not all, states review the premiums charged by marketplace insurers (a process called "rate review") to ensure that premiums stay affordable and that rate increases are reasonable. Some states that conduct rate review require insurers to reconsider proposed premium increases that are too high. Rate review has been an important way to keep premiums affordable, but not all states use it to do so.

As part of this report, Families USA will issue additional materials on how these recommendations should be implemented.

Conclusion: Applying Action to Lessons Learned

During the first enrollment period, we made significant progress toward securing health insurance through private health plans and expanded Medicaid. We also built real momentum in our enrollment efforts. But since tens of millions of Americans remain uninsured, it is clear that our efforts need to go further—we must continue and accelerate this momentum. A major part of our success will hinge on our ability to look critically at this first enrollment period and act on the lessons that we learned. These 10 recommendations allow us to do just that. And, if implemented promptly and effectively during the seven and one-half months until the next open enrollment period, we hope to see even stronger enrollment efforts, a higher-quality consumer experience in the marketplace, and a greater decrease in the numbers of uninsured as the promise of the Affordable Care Act continues to become a reality for all Americans.

Endnotes

1 *Gallup-Healthways Well-Being Index*, March 10, 2014, available online at http://www.gallup.com/poll/167798/uninsured-rate-continues-fall.aspx.

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3 Garret et al., "Who among the Uninsured Do Not Plan to Look for Health Insurance in the ACA Marketplaces?," *Health Reform Monitoring Survey*, March 21, 2014.

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5 PerryUndem, *The Uninsured Midway through ACA Open Enrollment*, available online at http://www.enrollamerica.org/wp-content/uploads/2014/01/Perry_Undem_Uninsured_Survey.pdf.

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A selected list of relevant publications to date:

Financial Assistance and the Affordable Care Act: Who Benefits (March 2014)

Pre-Existing Health Conditions and the Affordable Care Act: Who Benefits (March 2014)

Young Adults and the Affordable Care Act: Who Benefits (February 2014)

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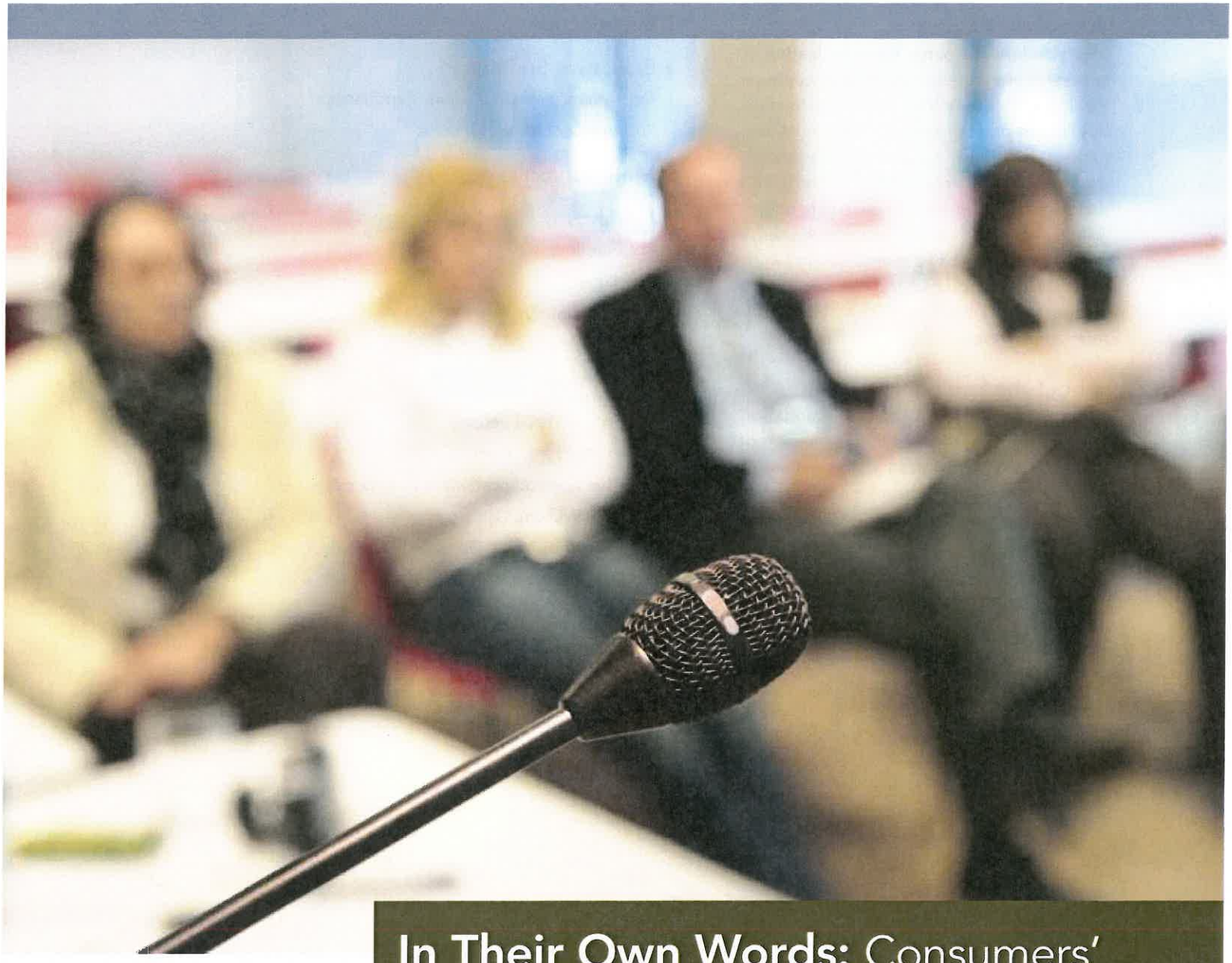

In Their Own Words: Consumers' and Enrollment Counselors' Experiences with Covered California

APRIL 2014

Contents

About the Author

PerryUndem Research/Communication is a non-partisan research firm that focuses on health policy issues. PerryUndem leads studies for non-profit organizations, foundations, universities, and government agencies, and specializes in conducting research with hard-to-reach audiences. Health care reform implementation has been PerryUndem's focus for the past two years, during which they have conducted polling for Enroll America and a number of states on implementation issues.

About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

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Introduction

Under the Affordable Care Act (ACA), millions of Californians have become eligible for new health insurance coverage options. On October 1st, 2013, Californians began applying for private health insurance and Medi-Cal (Medicaid) through Covered California, the state's new health insurance marketplace.

Many factors will influence the outcome of the ACA in California. Among these, consumer experience at the point of enrollment will have a profound impact on the number of eligible uninsured who ultimately enroll in and maintain health coverage. This report examines the early experiences of consumers enrolling in insurance through Covered California. The study captures consumers' motivations for applying for coverage, their experience of the enrollment process, and whether and how they have begun to use their new coverage. The primary aim of the research is to identify ideas to improve the enrollment process.

It is important to note that this study reflects consumers' experiences at a particular moment in time, early in Covered California's very first enrollment period. During the time the research took place, the electronic interface between Covered California and county social services offices, which make final Medi-Cal eligibility determinations, was not yet in place.

Faced with the enormous and unprecedented task of "standing up" the new system, California has managed to make significant improvements to the enrollment process. Indeed, some of the specific problems consumers reported in this study have now been addressed, but the themes and broader issues presented here remain salient; there is substantial opportunity for continued improvement.

Executive Summary

The California HealthCare Foundation sponsored this study of enrollment experiences through Covered California. PerryUndem Research/Communication conducted focus groups and interviews with 71 diverse consumers who had recently applied for health coverage through Covered California, 32 Certified Enrollment Counselors (CECs) and two Certified Insurance Agents. Of the consumers, 44 were eligible for premium tax credits to help pay for Qualified Health Plans (QHPs), and were eligible for premium tax credits and 27 were identified as being likely eligible for Medi-Cal. The research was conducted four months into Covered California's first open enrollment period — February 4th to February 20th, 2014. Participants had applied for coverage between October 1, 2013 and January 31, 2014. It included consumers who applied online, in-person, by telephone, or by filing the paper application. Following are highlights from the research.

Consumers' and Counselors' Experiences

Most were thankful to have health insurance. Those who successfully gained coverage felt relieved, secure, and more in control of their health once they had health insurance.

Consumers' motivations to enroll varied. The top motivator for consumers to enroll was financial security. They wanted protection from big medical bills. Also, enrolling "because it is the law" was important for many, as well as avoiding the ACA-mandated fine for remaining uninsured. A few applied because someone they trust — mother, girlfriend, adult child, or someone from their church or health clinic — encouraged them to do so.

Substantial knowledge gaps remained after enrollment. Even after completing the process, many participants were unclear about the relationship between Obamacare, Covered California, and Medi-Cal. A large number did not know they could receive in-person assistance to enroll. Many did not know Medi-Cal had been expanded and that they might now be eligible. Some did not know about the premium tax credits and most were unaware they might have to pay back some of the financial assistance if they inaccurately reported their income or if their income changed. Some were unfamiliar with how insurance works. Most of these knowledge gaps remained after enrollment was complete — the enrollment process did not answer many of these questions for these consumers.

Calculating income was difficult for some. Those with fluctuating income or who receive payments in cash had difficulty figuring out future earnings or averaging their incomes. Some just guessed when applying.

Choosing a plan was hard. Some consumers felt that the process did not fully prepare them to make a coverage choice. The physician search tool did not work well for some and others felt overwhelmed by too many plan choices. Most challenging was weighing the various insurance costs — premiums, deductibles, copays, and total out-of-pocket costs. It was an issue of "doing the math," as well as being confused about what each cost meant. In the end, many said they chose a plan based primarily on the premium.

Documentation requirements were challenging. The amount of documentation required to enroll surprised consumers — they thought this would be an entirely electronic process. Medi-Cal applicants had the heaviest burden — they often were instructed to supply proof of income, proof of residence, immigration information, and more.

Consumers had mixed experiences with the call center. Those who called Covered California's call center for enrollment help complained of long waits on hold and not being able to get through to a person. Many waited 45 minutes or longer for help. Most had to call multiple times. Once they got through, many said the customer service representative was helpful.

Views on affordability varied. Not surprisingly, those with lower premium amounts felt their costs were "affordable," while those with higher amounts were less satisfied. Other factors also influenced perceptions of costs, including prior experience with insurance, health status, and perceived need for coverage.

Medi-Cal applicants faced more problems. These consumers were most confused about and frustrated with the enrollment process. Those applying online through Covered California were surprised they could not complete the application online. Many were unsure of their next steps or how they would be contacted about their eligibility. Most had long waits to hear back from Medi-Cal — some more than four weeks. Most did not know how to track the progress of their application and did not know whom to call.

Latino consumers worried about immigration problems and losing their home to Medi-Cal. The detailed questions about family members — even those not applying for coverage — unsettled some Latino consumers and made them worry they could face problems with immigration. Also, some Latino consumers had heard Medi-Cal could take their home if they enrolled in the program.

Many Vietnamese- and Mandarin-speaking consumers faced language barriers. These consumers could not enroll online in their primary language. This was frustrating because some preferred to enroll online. They felt they had to rely instead on English-proficient family members or apply in-person with a CEC or agent who could speak their primary language.

CECs did not feel well trained and said they had limited ability to help Medi-Cal applicants. A new dedicated call center line for CECs was helping, but many felt on their own to figure out complex enrollment problems. Many also had limited experience with Medi-Cal and felt they could do little to help clients apply for that program. They said they have had little interaction with Medi-Cal.

Improvement Ideas

Ideas for improving the process emerged from consumers, CECs, and agents in this study, including:

- **Open the door wider.** Consumers wanted Covered California to reduce call center wait times; to educate Californians that in-person enrollment help is available; and to translate the Covered California online application into other languages. They also wanted the Medi-Cal processing time to be shortened.
- **Improve communications with consumers.** Consumers wanted Covered California and Medi-Cal to be clearer upfront about the documentation required for enrollment and to clearly explain the Medi-Cal enrollment process.
- **Enhance the Covered California website.** Consumers wanted Covered California to improve the online chat function, update the provider search function, and offer clearer guidance on how to calculate their incomes.
- **Conduct more outreach and education.** Latinos wanted Covered California to address their specific enrollment concerns (i.e., immigration worries, fear of losing their home to Medi-Cal). Mandarin-speaking and Vietnamese-speaking consumers also suggested going deeper into their communities with outreach. Many consumers wanted more resources that explain

how insurance works, particularly the various costs involved.

- **Offer more support to CECs and insurance agents.** CECs and agents wanted a refresher training course to address real-life scenarios and complex cases. Some also suggested a feedback loop so CECs could share what they learned. Finally, agents wanted their own dedicated help line as the CECs have.

Methodology

This study started with 11 interviews with experts in November 2013 to help frame the research. These interviews were conducted by telephone and lasted 45 minutes each. Their purpose was to gain insight into issues involved with Covered California enrollment and to receive feedback on the study's research plan. The experts were then recruited to serve as advisors to the project on an ongoing basis.

Expert Interview Participants

Verne Brizendine, Blue Shield of California

Linda Leu and Tamika Butler, Young Invincibles

Nicole Oehmke, Enroll America

Cary Sanders, Pan-Ethnic Health Network

Julie Silas, Consumers Union

Mark Temple and Larry Sirowy, Kaiser Permanente

Melissa Vargas, The Children's Partnership

Sonya Vasquez, Community Health Councils

Doreena Wong, Asian Americans Advancing Justice

Anthony Wright, Health Access California

Bobbie Wunsch and Rafael Gomez, Pacific Health Consulting Group

The next phase of research consisted of 15 in-depth interviews and eight focus groups with diverse consumers who had recently applied for health coverage through Covered California. In addition, four focus groups were conducted with Certified Enrollment Counselors (CECs) and two in-depth interviews with Certified Insurance Agents. (See Table 1.)

Table 1. Focus Group and In-depth Interview Composition

FOCUS GROUPS	NO.
Consumers Applying for QHPs	5
Consumers Applying for Medi-Cal	3
Certified Enrollment Counselors	4
Total	**12**
IN-DEPTH INTERVIEWS	
Consumers Applying for QHPs	7
Consumers Applying for Medi-Cal	8
Certified Insurance Agents	2
Total	**17**

Note: The focus group of Mandarin-speaking consumers was a mix of those who had applied for Medi-Cal and for QHPs.

The interviews and focus groups were held in Oakland, Bakersfield, Irvine, and Los Angeles between February 4th and February 20th, 2014. Participants were recruited by professional focus group facilities in each location. Local Certified Enrollment Entities and community-based organizations involved in outreach about new coverage options also assisted in finding participants for this study.

Each in-depth interview lasted approximately 45 minutes. The focus groups were approximately 90 minutes long and included six to 12 people per group.

The consumer interviews and focus groups were composed of those who had applied through Covered California and either 1) been found eligible for premium tax credits to help pay for coverage in a Qualified Health Plan, or 2) been found likely to be Medi-Cal-eligible through the application process. All research participants initiated the enrollment process through Covered California. The study did not include individuals who applied for Medi-Cal solely through county social services or who enrolled in a QHP directly through a private insurance company. A total of 105 consumers, CECs, and Certified Insurance Agents participated in this project. (See Table 2 on page 6.)

While many of the participants had successfully enrolled in a QHP through Covered California by the time they

Table 2. Participant Composition, by City

	OAKLAND (Feb. 4)	BAKERSFIELD (Feb. 10)	IRVINE (Feb. 11)	LOS ANGELES (Feb. 12, 13, 20)	TOTAL
QHP Applicants	10	0	10	24	**44**
Medi-Cal Applicants	6	9	2	10	**27**
Certified Enrollment Counselors	9	10	7	6*	**32**
Certified Insurance Agents	0	0	0	2	**2**
			Total Number of Participants		**105**

participated in this study in February, some had not yet received final confirmation of plan enrollment. Similarly, while some consumers had been found eligible for Medi-Cal, and selected a managed care plan, others who were identified as likely eligible for Medi-Cal through Covered California had not yet received a final eligibility determination from county social services at the time of the study.

Throughout this report, for convenience, consumer participants are sometimes referred to as having "applied for Medi-Cal" through Covered California. In fact, many of these consumers did not set out to apply for Medi-Cal. Rather, it was through the Covered California enrollment process that they discovered they were likely to be Medi-Cal-eligible.

Focus groups and interviews included a diverse group of consumers. In addition to the geographic diversity indicated by the four study locations, discussions were conducted in four languages — English, Spanish, Mandarin, and Vietnamese — with consumers of five races/ethnicities. (See Table 3.) CECs who participated in this study work with a number of populations whose primary language is not English, including speakers of Spanish, Mandarin, Cantonese, Korean, Vietnamese, Cambodian, and Arabic.

Participating consumers consisted of adults 64 years of age or younger, including ten consumers under age 30. The study included a mix of men and women.

Consumer participants in this study applied for coverage through a variety of means, including online, with in-person assistance, and over the telephone. (See Table 4.) In some cases, consumers used more than one of these methods during their enrollment process.

Table 3. Participant Profile, by Race/Ethnicity and Primary Language Spoken

RACE/ETHNICITY	NO.
White	27
Latino	24
African American	8
Chinese American	8
Vietnamese American	4
PRIMARY LANGUAGE	**NO.**
English	42
Spanish	18
Mandarin	8
Vietnamese	3

Table 4. Enrollment Pathways of Consumers

METHOD OF ENROLLMENT*	NO.
Online	44
In-person	14
Telephone	14
Paper application	7

*Some consumers used multiple methods.

Findings

Pre-Enrollment

This section gives insight into the mindset of the Californians in the study before they applied for health coverage through Covered California. What did they know? What were their expectations? Why did they apply? This section also addresses consumers' health insurance status prior to applying and the reasons many were uninsured. Finally, it identifies the knowledge gaps consumers had about Covered California, which many still had even after going through the enrollment process.

The Californians in this study wanted health insurance.

Most consumers in this study felt that health insurance was important but believed it was out of reach for them until Covered California. Some had been looking for a while but just could not find an affordable plan while others had given up the search, feeling discouraged, and had not been looking for insurance recently. Some consumers were used to having insurance — they had never had a break in coverage — and Covered California came along at the right time, allowing them to move smoothly from one plan to another. And a small segment, particularly those with chronic health conditions, said they had been paying attention to the national discussion about the ACA and were waiting to apply for coverage as soon as Covered California opened for business.

PRE-EXISTING CONDITIONS

"My husband has had a broken neck, a broken back, he's been in the burn ward... We could not get insurance so now we have the possibility of it."

— Irvine woman who applied for a QHP

Before applying, most were uninsured, for a variety of reasons.

Some consumers in the study had been uninsured for many years; for others, it was recent. Regardless of how long they were uninsured, these consumers offered a variety of reasons why they had no health insurance before applying for coverage through Covered California. Some explained that they had recently lost a job and that the insurance went with the job; some of these could not afford COBRA coverage, which meant they were immediately uninsured when the job ended. Others explained that while their employers offered insurance, it was too expensive so they did not enroll. A small number of consumers recently started new businesses and reasoned that they could do without insurance at least for a year or two.

Some consumers in the study reported that they were unable to obtain coverage due to pre-existing conditions and that only now, because of the ACA, could they qualify. Finally, healthy and younger consumers in the study acknowledged that they had been putting off insurance because it was a low priority. They did not feel a pressing need for check-ups and other preventive care and figured they could just pay out of pocket for medication or a doctor's visit if they became sick.

While uninsured, many learned to manage their own care, though this was an anxious period in their lives.

Without insurance, consumers said they figured out ways — beyond occasional medical visits — to take care of their health. Many used holistic methods of care, or relied on over-the-counter medications.

People with ongoing medical conditions usually had to make more concessions, either with their care or their pocketbooks. This meant seeing a doctor for a procedure or a prescription and paying for it themselves. A few of these consumers had been paying substantial sums out-of-pocket to obtain the care they needed. During the course of the discussion, a couple of consumers revealed that they had gone into debt, and were being contacted frequently by collections agencies due to an ER visit or expensive medical treatment.

One Los Angeles woman found to be likely eligible for Medi-Cal explained that she had a number of serious ailments and allergies that required monthly prescriptions. She went into anaphylactic shock regularly and needed to use an EpiPen. She was uninsured and paying over $300 out of pocket each month because she could not risk going without her prescriptions. As high as these amounts were, they were less than the monthly premium amounts she was quoted when she had previously shopped for insurance. When she learned about Covered California, she saw it as her chance to finally find more affordable health insurance.

Consumers said that while uninsured, they would often delay care or adopt a "bare necessities" mindset — putting off more comprehensive care in favor of just getting by. As one Irvine man enrolling in a QHP said, "I just went to the local clinic for my drugs once a year or so."

Regardless of how they had been coping, many described this period in their lives as anxious and tense. Even the healthy and younger consumers in the study said that in the back of their minds, they never forgot that they were uninsured, causing them worry about accidents and big medical bills.

Many learned about Covered California through the news, ads, or word of mouth.

News stories about Covered California and the ACA (Obamacare) seemed to be the main source of information on this topic for a number of consumers in this study. Many also reported having seen ads on television, in local newspapers, on billboards, and online, or heard them on radio. Consumers also mentioned hearing about Covered California through friends and family, churches, insurance brokers, health centers, health fairs, mailers to their homes, community-based organizations, and other local sources.

Latino consumers also mentioned seeing and hearing ads about Covered California in Spanish. A few Latino consumers commented that there had been a lot of information available in Spanish about Covered California. To a lesser degree, some of the non-English-proficient Vietnamese- and Mandarin-speaking consumers in the study said they had seen Covered California ads in publications geared to their communities, but they generally reported seeing less advertising about the marketplace than was reported by English- and Spanish-proficient consumers.

Most consumers were confused about the relationship between Obamacare, Covered California, and Medi-Cal.

Among consumers there was a conflation between Obamacare, Covered California, and Medi-Cal. Some thought these different health coverage efforts and websites were actually the same entity. A few Certified Enrollment Counselors confirmed that consumers, particularly Latinos, refer to them collectively as Obamacare.

For example, a number of consumers who applied online said they went first to the federally facilitated marketplace, HealthCare.gov, because they were unaware that Covered California was where they were supposed to go. Others who ended up being likely eligible for Medi-Cal were also confused — they thought they were applying for private insurance through Covered California, and had no idea that Medi-Cal was connected to Covered California. Even following the enrollment process, some of these consumers wondered whether Medi-Cal and Covered California were the same thing.

Many said they were unaware that they could receive in-person help to enroll through Covered California.

This was particularly true of the 44 consumers in this study who applied online. Most of these consumers said they had not heard about CECs and had not considered working with an insurance agent before applying online. After hearing of these in-person resources during this study, some consumers said they wished they had known they could receive such enrollment help — they had questions during the enrollment process and would have appreciated the ability to get immediate, in-person answers. Consumers who were not English-proficient — those speaking primarily Spanish, Mandarin, or Vietnamese — seemed particularly to value knowing they could receive in-person help with enrollment.

Word of mouth about CECs and agents was one way participants knew in-person help was available. But those who knew the most about CECs and agents tended to be those who were "connected" consumers — they had a prior relationship with a health clinic, community-based organization, or other organization involved with outreach for Covered California.

There was a lack of knowledge that Medi-Cal had expanded.

Some consumers applying for coverage did not know that Medi-Cal eligibility had changed and that they might now be eligible for the program. These consumers tended to be those who applied online and they said they only learned about their potential eligibility once they were midway through the application. Among these consumers, there was often little awareness about Medi-Cal and how the program works. On the other hand, some consumers who had prior experience with Medi-Cal suspected they might be eligible and purposely set out to enroll in Medi-Cal.

A woman in Bakersfield did not think — before applying — that she would qualify for Medi-Cal. She recounted: "I did not want to apply. [Someone] told me that this was for Obamacare and that if you did not qualify they would give you Medi-Cal. And, so then I said 'No'... I tried to get Medi-Cal (before) and I was not able to."

Knowledge Gaps

Many consumers in this study did not know:

- CECs and agents were available to help them enroll
- Financial help was available (or that they might need to pay some of it back at the end of the year if their income changed)
- Medi-Cal had been expanded

Some did not know they could qualify for premium tax credits through Covered California or that they might have to repay part of this financial assistance if their income changed or was inaccurately entered.

Some consumers said they did not know about the ACA tax credits before applying. They hoped the insurance plans available through Covered California would be less costly than those they had seen before on the private market, but they did not know that the tax credit was one mechanism for that lower cost. Only once they started the application process or used the "Shop and Compare" tool on the Covered California website did they learn they qualified for financial help.

Even those consumers who became aware of the tax credit, however, were largely unaware that they might have to pay back part of that credit if they miscalculated their income on the application or if their income increased. This issue emerged in a Los Angeles focus group with individuals who had recently applied for QHP coverage. A participant explained that her accountant had recently told her that she might have to pay back part of the financial assistance in her taxes. When asked about this, most of the other consumers in the focus group said they were unaware of this risk.

Numerous consumers said they applied for coverage through Covered California because they "hoped insurance would now be affordable."

There was a sense among some consumers in this study that health insurance might now fit in their budget, thanks to the ACA. "I think the commercials, the ads, made it pretty clear that it would be affordable," said a Los Angeles QHP applicant. But coupled with this hope of affordability was substantial skepticism. Some doubted that they could actually afford the costs of health insurance but still wanted to go to Covered California to check out their options.

Many applied because they wanted protection from big medical bills.

Many consumers reported they wanted financial security when they enrolled in coverage — to avoid big medical bills that can come with accidents and unexpected medical issues. This motivation was particularly important to some of the younger and healthier consumers seeking coverage.

A few were heavily influenced by the experience of family members and friends who had incurred medical debt while uninsured. A Los Angeles woman who applied for a QHP acknowledged that the experience of her sister — who was uninsured when she was diagnosed with cancer — influenced her own decision to enroll in Covered California.

Some enrolled in coverage because it was the law, or they wanted to avoid the fine.

Some consumers said they applied because "everyone has to have health insurance." They wanted to be in compliance with the law and to be "good citizens," or believed that being uninsured is illegal under the ACA and could cause legal problems. A number of CECs in this study said that complying with the mandate was particularly motivating for their Latino clients.

The possibility of a fine also played a role. While consumers were not always clear on the amount of the fine, they were aware that they would be required to pay something in their taxes if they did not have health coverage. "There is a penalty. That is why I signed up already," explained an Irvine man who enrolled in a QHP.

Motivations to Apply for Coverage Through Covered California

- A hope that insurance would now be affordable
- Avoiding big medical bills – financial security
- Complying with the law and/or avoiding the fine
- Encouragement to enroll from someone in their life

Consumers were motivated when a family member, friend, or someone they trusted urged them to apply.

A few younger consumers commented that their mothers had encouraged them to apply. There were also instances when a grown daughter pushed an older parent into enrolling. For example, an African American woman from Los Angeles said that she had not considered applying for health coverage through Covered California until her adult daughter told her, "Mom, you need to apply for this!" For a Mandarin-speaking participant, it was her sister-in-law. Others explained that it was someone from the health center where they went for health care who told them about Covered California and helped them to apply.

Enrollment

This section describes consumer feedback about the Covered California enrollment process. Of the consumers in this study, 44 applied online, 14 applied in-person, 14 applied by telephone, and seven completed paper applications. A number of these consumers used a combination of methods.

Overall Enrollment Process

Those who applied online during October and November 2013 faced more problems.

Consumers in the study applied during different periods of open enrollment — October, November, December, and January (the research was conducted in February). Based on their comments, those consumers who applied during the first two months experienced a number of technical problems with the Covered California website. They complained of long loading times, webpage freezes, and the application shutting down unexpectedly. "I tried to apply about three times in November and then like one or two times in December and the website was really bad and it kept timing out," recounted a Los Angeles consumer. Despite these glitches, the consumers kept trying and eventually made it through. They were frustrated but determined to complete the application.

Those who waited until December and January to apply found the experience easier — especially online — though they still encountered some of the same frustrations.

ONLINE STRUGGLES

"When I started inputting my husband's information then myself and my kids' information... I could not go to the next page. They would go blank then I put my husband's data in and it did it over and over and over. It took 10, 12 minutes for the page to change."

— Spanish-speaking Los Angeles woman who applied for a QHP

The online application was the primary entry point.

Some of the 44 consumers who applied online said that they did not know there were alternative ways to apply — their impression was that this was an online enrollment process. A few said they would have preferred in-person enrollment so they could have asked questions along the way. Not all used the Shop and Compare online tool beforehand to estimate costs and look at plans — some just started off with the full application.

The majority of these online consumers appreciated that they could apply online. They said they were used to online bill paying, using computers for work, and getting their news online. Of note, they did not voice any security or privacy concerns about online enrollment.

Not everyone could apply online in their preferred language.

While English- and Spanish-speaking consumers appreciated that they could enroll online, some of the Mandarin- and Vietnamese-speaking consumers were frustrated that they could not apply online in their

primary language. Although not all of the Mandarin- and Vietnamese-speaking consumers preferred online enrollment, they want Covered California to create an online application in their primary language. A Mandarin-speaking woman who applied with a CEC (and was found likely Medi-Cal-eligible) said an online application in Chinese would have been easier for her. But she cautioned that the online application would need to be in a clear translation, preferably done by a first-language Chinese speaker.

Other enrollment methods were used when consumers encountered problems online.

At different points in the online process, some consumers decided to use the Covered California call center because they wanted to ask questions or because they grew frustrated with website glitches. A small segment of consumers in the study tried to solve their problems online by using the chat function. Of those who used that function, none were able to get a response or have questions answered even after numerous attempts. Most of the consumers in the study began the process online, but as a result of frustrations with the website, the call center, or the chat function, not all of them finished the process that way.

CHAT HELP FRUSTRATION

"I [tried online chat help] five or six times and every time it would show like a countdown of like 56 minutes, 54 minutes, 53 minutes. It would get to the end of the time and it would say, there is no one available."

— Los Angeles man
who applied for a QHP

Consumers had mixed results with the call center.

Based on consumer comments, the call center was an important resource. Some consumers, in fact, were able to finish their application when on the phone with a Covered California representative and they appreciated the help. Getting to that point, however, was difficult and time consuming.

Consumers mentioned long waits on the phone (up to an hour and a half). People recounted having to call multiple times before getting through to someone. These experiences were the norm for those who contacted the call center and provoked some of the most negative responses about the enrollment process. However, once they got through to a customer service agent, many said they had a positive experience. Consumers found the person to be patient, friendly, and, for the most part, informative; they were able to have their questions answered.

CALL CENTER DELAYS

"Every day of December I was calling every single day...waiting on speaker while cooking dinner, doing chores. Half an hour, 45 minutes, over an hour"

— Spanish-speaking Los Angeles woman
who applied for a QHP

Experiences using CECs or insurance agents were positive.

Many consumers who worked with CECs and insurance agents were satisfied with that experience. They appreciated the ability to ask questions and to learn that they were completing the application correctly. Non-English-proficient consumers were particularly appreciative of the hands-on help, saying that they were nervous about the application process and that working with a CEC or agent in their own language was reassuring. None reported long waits or delays when using a CEC or agent — at worst, they had to make an appointment and were seen a few days later. All felt their CECs and agents were knowledgeable and helpful. The only negative comment made about CECs and agents was that some consumers — mainly those who enrolled online — did not know about them and would have liked to have this option.

A Los Angeles Latina said she "actually was motivated to [enroll]" because a CEC reached out to her, provided her with information, and said she would help.

Regardless of how consumers enrolled, many found answering income questions to be difficult.

There were parts of the application process that posed more difficulty for consumers than others. One of those was income information. People with fluctuating income — who work on commission, are self-employed, are involved in seasonal work, or are paid in cash — seemed to struggle the most. They found it hard to project future earnings or figure out an average income. Those paid in cash wondered how they would be able to show proof of income (this was a particular concern for Latino consumers). A few admitted that they had guessed at their incomes when applying for a plan through Covered California and others revealed that they had put in different figures in order to see which income amount gave them the best insurance price. Some of these consumers were unaware that they might have to pay back part of their tax credits if they underreported their income.

Documentation requirements were challenging.

A few consumers said they were surprised that they needed to provide proof of income or tax returns — they thought this information could be gathered online. Many during the study complained about the sheer amount of paperwork they needed to provide and some said they had not been prepared to provide so much documentation when they started the application. Some who enrolled in QHPs and thought they had successfully completed the process received a letter from Covered California telling them their enrollment was conditional until they provided additional documentation. This unsettled consumers who thought they had completed the enrollment process.

Those who were found likely eligible for Medi-Cal reported they had to supply much more documentation than those applying for QHPs reported supplying. Often these Medi-Cal applicants said they needed to provide proof of income, tax returns, immigration documentation, proof of residence, and more.

Qualified Health Plans

The following were enrollment challenges specific to consumers who applied for QHPs.

Choosing a plan was hard, and those less experienced with health insurance faced the most problems.

Consumers found the part of the application where they chose a health plan to be daunting. Some admitted that they were not prepared at that moment to make a choice and so just chose a plan "for now," thinking they could change plans at a later point. A few felt they were given too many health plan choices and were overwhelmed, or found the various costs they were presented with to be confusing. This was particularly true of those who had less experience with health insurance. While most understood the monthly premium, some were confused by cost-sharing components such as deductible, copays, and out-of-pocket limits.

Some consumers wanted to base their plan choice on their current doctors — i.e., choose a plan that would allow them to continue to see their same doctors. But when they tried the doctor search function, it did not work or they could not find their doctor. A few prepared in advance by calling their physicians and asking which plans they accepted, but others did not and chose plans without knowing if they would be able to continue with their same doctor.

Premium cost was the main driver for many.

Even though some were confused by the different cost components, they all understood the monthly premium amount and for many this was the deciding factor in their plan choice. Seeking an affordable monthly premium meant that a few consumers opted for high-deductible Bronze plans because of the low monthly costs. But the majority of those in the study chose Silver plans because they found the monthly premium reasonable and these plans had a lower deductible and more comprehensive coverage than the Bronze offerings.

PREMIUM COST

"Cost was the main thing."

— Oakland man who applied for a QHP

A few reported that the initial costs they were quoted were lower than the actual costs they saw once they moved further into the application.

In a few instances, consumers were surprised and frustrated when their initial cost estimates from the Shop and Compare tool or calculator on the Covered California website were lower than the actual costs that appeared later in the full application. A handful of consumers felt this was done purposely to encourage them to enroll. Others looked at the initial cost figures as just rough estimates and the later costs as based on the real income and household size information they provided.

Consumers were mixed on whether their new plan was affordable.

Unsurprisingly, the lower the premium, the more likely consumers were to find it affordable. Some consumers found premiums up to about $200 per month to be a "good deal." Past experience paying a monthly premium was a big factor in this discussion. Those not used to paying for insurance seemed to struggle more with the cost. This was especially true of those who were healthy and younger. Those who had previously looked at the price of insurance on the private market or had been paying for COBRA were more likely to see QHP costs as reasonable.

PLAN AFFORDABILITY

"I do not know anybody who would make $2,000 a month, have taxes taken out of the $2,000 a month, and be able to pay $182 a month in health care — and pay rent and eat and transportation and whatever else. So how they are saying it is affordable, I do not know."

— Los Angeles man who applied for a QHP

There was confusion about how to use insurance once enrolled.

For some first-time health insurance consumers, the Covered California enrollment process left them unsure how to use their insurance once they were enrolled. They did not know how to find a doctor, they were not clear about what kind of costs they could incur, or they did not know what medications were covered or what hospitals were in their network.

Medi-Cal

The following were enrollment issues specific to those consumers who were found likely eligible for Medi-Cal.

Many were surprised to learn they qualified for Medi-Cal, and while pleased about free and low-cost coverage, some worried about lower quality care.

Some consumers went into the enrollment process suspecting they would be eligible for Medi-Cal, and a few had been enrolled in Medi-Cal before and hoped to enroll again. But others in the study had no experience with Medi-Cal and were surprised when they were told they might be eligible. Most were happy about this news, especially due to the $0 premium. Others, though, had mixed feelings. These consumers believed that Medi-Cal has a stigma. They worried that they would have difficulty accessing quality doctors. Some of these consumers said they would have preferred to pay a premium for a private plan rather than have free Medi-Cal. These responses were in the minority, however, and overall the response to Medi-Cal eligibility was positive.

The enrollment process for Medi-Cal was confusing and slow.

Most of the consumers in this study found enrolling in Medi-Cal through Covered California to be difficult. Those applying online through Covered California explained that after inputting their personal and financial information, they were informed they might qualify for Medi-Cal and were told that they would be contacted by Medi-Cal.

MEDI-CAL CONFUSION

"They sent me the letter saying that I did not qualify for [a QHP], but that I could qualify for Medi-Cal... but to wait and that they would contact me. And then I got another letter telling me the same thing. Just last week I got a letter that I should contact the [CEC] that helped me and that is where I am at — that I have to talk to her."

— Bakersfield woman found likely eligible for Medi-Cal

Consumers were frustrated and surprised that they could not proceed any further with the online application. They could not choose a plan or get a real-time confirmation of their enrollment, and they were not told how and when they would be contacted about their Medi-Cal eligibility. Such delays and uncertainties were not what they had expected when they started the enrollment process.

Many said they had to wait weeks — and some were still waiting — to hear back from Medi-Cal, and did not know how to follow-up or whom to call.

Waiting to hear back from Medi-Cal was frustrating for many consumers. Some did not know how to track their application or push it forward. Additionally, they did not know when they were supposed to be contacted. They were unclear whom to follow-up with or who was in control of their application, Medi-Cal or Covered California. A few reached out to their CEC to ask about their application but were told to sit tight and wait. Others reached out to a Medi-Cal county office and were also told to wait to receive information in the mail. This frustrated consumers who disliked feeling powerless and passive. They felt bounced around between Covered California and Medi-Cal and found the process baffling.

A letter from Covered California confused matters.

During the waiting period to hear from Medi-Cal, some consumers said they received a letter telling them they "did not qualify for Covered California" and this confused them. A number of CECs confirmed that this letter, sent from Covered California, caused confusion. These CECs explained that they received calls from many of their clients who asked for an explanation after receiving this letter. CECs said that part of the problem was that clients had not read the whole letter — they had not seen that the letter also indicated that they "may qualify for Medi-Cal." For example, a Bakersfield CEC who works with the Latino community (mainly Medi-Cal-eligible consumers) explained that some of her clients became angry with her when they received this letter, saying "You told me I qualified!" She had to calm them down and tell them to read further down the letter to see that they might qualify for Medi-Cal. CECs said letters such as these should be more clearly written.

Some Latino consumers, in particular, worried about losing their home if they enrolled in Medi-Cal.

Many Latino consumers in this study were confused about asset repossession and Medi-Cal. While estate recovery can be a real issue for some individuals 55 and older, concerns about "losing their homes" seemed more widespread among the participants in this study. A few CECs believe that this anxiety about losing their home could be causing some Latinos to avoid applying for Medi-Cal or even from considering Covered California.

FEAR OF HOME FORFEIT

"(Some Latinos) think that the government is going to come, because they gave you Medi-Cal, they are going to come in and pick up your house."

— Bakersfield CEC who works primarily with Latinos

Post-Enrollment

This section looks at where consumers stood following the enrollment process: whether they had received confirmation that they had enrolled successfully; whether they still needed to take additional enrollment steps; whether they had their new insurance card; and whether they had started to use their health insurance.

Many of those who successfully enrolled in health coverage through Covered California felt relief, "in control."

Most enrolled consumers were thankful for their coverage and the peace of mind it brought. They had entered the process wanting insurance and they got it. Some had previously given up hope of finding affordable health insurance, especially those with long-term medical conditions, but now were insured. "I definitely have more peace of mind you know… I do not want to be broke the rest of my life because of some unfortunate accident. And so I feel like now I have a little bit of a safety net," said a woman from Oakland who enrolled in a QHP.

A few consumers who were uninsured before enrolling noted that they now felt more in control of their health. Even if they did not immediately schedule an appointment with a doctor or use their insurance in some other way, they felt good knowing they were "in the driver's seat."

For some, there was still uncertainty about health insurance status.

Some consumers felt in limbo even after the enrollment process. They were still waiting to hear back from Medi-Cal or receive final confirmation that they were enrolled in a QHP. They wondered if they would need to provide additional documentation, were unsure if they had submitted their application correctly, or worried that their application was lost.

Some had started to use their coverage.

At the time of this study, a few consumers had already used their insurance to pay for a prescription medication or schedule a physical. Others had already seen a doctor. "I actually have already used the plan. I went to a dermatologist. I have been procrastinating for years and I just had biopsies done and so I personally think it is great [that I have insurance]," said an Irvine QHP enrollee.

No one had encountered any access problems. A Spanish-speaking Los Angeles woman who enrolled in a QHP had no issues. "I was getting really bad headaches and I went to the doctor. I gave them my insurance card and in 10 minutes I was attended to."

SENSE OF SECURITY

"It is there if you need it... You may never need to use but you have to have it."

— Los Angeles woman who enrolled in a QHP

Not all were in a rush to use their insurance.

At the time of their interview or focus group, a few consumers still needed to find a provider. Others had no immediate health care needs and had enrolled in insurance simply to have it in case of an emergency or to comply with the mandate and did not feel compelled to get preventive care. One consumer who had a high-deductible plan reported that she would continue to go to a low-cost health clinic in order to avoid the higher costs she would have to pay if she used her insurance.

Some planned to see a doctor as soon as they received their insurance card, to address ongoing medical needs or to get a long-overdue check-up.

Some of the consumers were anxious to start using their insurance and were just waiting for their insurance card. Specific health issues had been weighing on them and could now be addressed. Some in the study had not had a check-up in years and were looking forward to preventive care. "I will probably schedule an appointment with my doctor... I usually go get an annual physical and I have not been for a little while," said an Oakland woman who enrolled in a QHP.

Consumers want more follow-up once they complete the enrollment process and a resource to answer questions about their insurance.

Even after they had insurance or would have it soon, questions lingered in the minds of some consumers about their plans and how to use them. While they knew they could turn to their health insurance company, some still wanted other unbiased resources and thought Covered California should provide these.

Feedback from Counselors

This section provides feedback from 32 CECs about the Covered California enrollment experience. These individuals offered insight into their own experiences as enrollment assisters, including their thoughts about the diverse consumers they serve.

Most CECs did not feel well-trained.

Many CECs were critical of their training process. They felt the trainers were poorly informed, constantly needing to refer to the training manual. Most CECs did not receive training with the actual Covered California website — the first time some used it was when they tried to enroll their first client. Most said they did not discuss real-life scenarios during the training or work through difficult cases to prepare them for what enrollment was really going to be like. "We were given a binder... I felt like it was a read-along... I felt like maybe if they had the actual computer there and we could actually work hands-on... we would have encountered all these problems or questions we have now," explained a female CEC from Los Angeles.

CECs felt they had to learn on the job once they started enrolling clients. Most acknowledged they initially made a lot of mistakes and had to rely on their own creativity or help from other CECs to find solutions. Some CECs said they still felt on their own without support from Covered California.

The new CEC helpline was making a difference.

The first CEC focus group was held on Feb. 4th and at that time there was no dedicated helpline for CECs to call if they had a question about a client's application. The CECs in that focus group spent a lot of time describing how they had to use the same call center phone line as consumers and had long waits in the same queue while clients waited restlessly next to them. Some acknowledged that rather than wait, they just figured out answers themselves. The CECs strongly urged that Covered California create a helpline just for them to get answers in a more timely way.

Covered California did create a dedicated helpline for CECs soon after that focus group and, according to CECs, it made a difference. Some CECs in the three following focus groups said that they had started to use the helpline and that through it they were able to get the backup and support they had wanted since the start of open enrollment.

CEC MEDI-CAL ASSISTANCE

"If one of our clients qualifies for Medi-Cal, that case gets sent to DHS. What we do is assist them with, when they get contacted by DHS...when they get contacted they get paperwork, they ask them for things. That is when we come in and we help, we help them turn in all their paperwork."

— Bakersfield CEC who works primarily with Latinos

Medi-Cal enrollment presented problems for many CECs.

While some of the CECs in this study had prior Medi-Cal or Healthy Families enrollment experience, others did not and lacked information about Medi-Cal. Even those reporting substantial Medi-Cal knowledge felt limited in what they could do to help a Medi-Cal applicant through the process. They said this is because once a consumer is identified as likely to be eligible for Medi-Cal, the case goes to the applicant's county social services department to be processed for final determination. At that point, CECs felt they had limited ability to help the client. A few said they could not even track the application online once it left their office.

A letter from Covered California designating CECs as the main contact for Medi-Cal clients frustrated some CECs.

CECs said that a standardized letter informing Medi-Cal enrollees they did not qualify for a QHP under Covered California also designated the CEC as the main contact for the client. CECs' frustration with this letter was that they were not forewarned about it. Many said they had clients calling them out of the blue asking about the status of their Medi-Cal application. CECs said they were not comfortable being the main contact for Medi-Cal applicants because they could not access information about consumers' Medi-Cal cases.

Some CECs struggled with the documentation requirements of enrollment.

Obtaining the right documentation was sometimes difficult and confusing for CECs. Some said they were not always sure what was required. Asking for and obtaining income verification and proof of immigration and residency were the biggest roadblocks, according to these CECs. They said many of their clients had difficulty finding this documentation, particularly proof of income.

Certified Insurance Agents

The study also included interviews with two Certified Insurance Agents. They reported having many of the same concerns as CECs, including:

- Facing challenges with helping Medi-Cal clients, reporting unfamiliarity with the program; they also revealed that many of their peers do not help people apply for Medi-Cal because they do not receive any commission for such help but are financially incentivized to focus on QHP applicants
- Being frustrated with the documentation requirements and the lack of effective training
- Wanting a dedicated helpline just for agents, to reduce their wait times at the call center, like the CEC helpline

Key Populations

Of the 71 consumers in this study, 24 were Latino (18 of whom primarily speak Spanish), eight were Chinese American (all of whom primarily speak Mandarin), and four were Vietnamese American (three of whom primarily speak Vietnamese). This section offers insights into the Covered California enrollment experiences of these diverse consumers, many of whom speak a primary language other than English.

Latino Consumers

Many Latinos heard about Covered California from Spanish-language advertising, as well as from news reports and word of mouth.

Television and radio advertising was the main way in which many Latino consumers in this study said they initially heard about Covered California. They saw both English- and Spanish-language advertising about the new marketplace. The news and word of mouth from family members and friends in their community also played a significant role in raising awareness. Despite this, knowledge of Covered California and new coverage options was not deep for most of the Latino consumers in this study. Like other consumers in the study, they lacked knowledge about the various ways to enroll, about financial help, about the Medi-Cal expansion, and about how insurance works.

The Spanish-language version of Covered California's website, though not perfect, was an important resource.

A functional Spanish-language version of the Covered California website was a marked advantage Latinos had when compared with others in this study whose primary language was not English. A few found the terminology and Spanish translation to be confusing, in some cases, but liked the site overall. Latino consumers liked entering the application process through the online portal, and while some of them finished the enrollment process another way, the online application was a useful educational resource. They were grateful to have the online option, to shop and compare beforehand and to see their choices before enrolling.

Many Latino consumers had existing relationships with community centers and medical clinics that put them in touch with CECs.

Many Latinos in the study worked with CECs to enroll, in large part because of their existing relationships with local health clinics. Latinos who applied this way found the CECs extremely helpful. Most seemed to prefer to enroll in person, to ask questions, to hear reassurances, and to feel confident they were applying correctly. None reported difficulties finding a CEC who spoke Spanish and they appreciated being able to work with a Spanish-speaking CEC.

CECs also helped alleviate the anxiety around income verification and immigration status that some Latinos had. Some CECs mentioned that their Latino clients feared their application information would be shared with other government agencies and could lead to immigration problems for their family members. The trust that Latino consumers had with their CECs, in some cases built through long-standing relationships with clinics, made the process less daunting.

A Latina QHP enrollee in Los Angeles found in-person assistance made the process easy. She said she was old-fashioned and "came from a time from before [you could] pay bills on computers." She preferred to speak with people in person; she believed it made asking questions easier. The woman was able to find an enrollment assister who spoke both English and Spanish. Although she decided to speak in English during the meeting, it made her feel better knowing the assister could speak both languages. She was grateful that in-person help was so accessible and she successfully chose a Bronze plan.

Immigration status, income information, and concerns about losing their home if they enroll in Medi-Cal were barriers for some Latinos.

Latinos whose families have mixed immigration status reported more worries during the enrollment process than others did. They found it difficult to answer immigration questions and supply Social Security numbers for all immediate family members, even those who were not applying for coverage. They worried about who would be seeing this information and if it could get family members in trouble. "I think it might be a trap to get illegal immigrants to apply," said a Latina from Bakersfield,

recalling her initial worries about completing the Covered California application.

A few Latino consumers also had trouble with providing reliable income information. Some were paid in cash and others had fluctuating income, so projecting their future earnings and supplying acceptable income verification was difficult. And as discussed earlier in this report, there were concerns among Latino consumers about Medi-Cal's ability to reclaim assets such as a house, which made many nervous about applying.

Mandarin-speaking Consumers

Some Mandarin-speaking consumers had been putting off getting insurance.

Most of the eight Mandarin-speaking participants in the study had been uninsured for extended periods of time. Those who immigrated in recent years explained that they purposely stayed out of the health care market, mostly due to high costs. Health insurance is something they did not know much about and figured they could do without for a while. Some also mentioned being "their own doctor" and self-treating illnesses with home remedies and over-the-counter medications during this period without insurance. But they saw Covered California as a good opportunity to finally have health coverage. They particularly wanted preventive care and they had a sense that coverage might now be affordable.

Awareness about Covered California lagged, in part, because of language barriers.

Mandarin-speaking consumers in this study said they learned about Covered California through the news and word of mouth from friends, family, and others in their community. Some had also seen Chinese-language print materials and thought they had heard radio ads in their primary language. But these consumers felt that others in their community had little understanding of Covered California and Obamacare beyond the name recognition.

These consumers believed the knowledge gaps were due to language barriers. They did not think there was enough in-language outreach to their community. "You could have some Chinese pamphlets... At least you could have some basic information on there," suggested a Mandarin-speaking woman in Oakland who was a Medi-Cal applicant. Others recommended placing more Chinese-focused materials at local supermarkets, neighborhood restaurants, and local activity centers that serve their community.

LANGUAGE BARRIER

"They told me that I can go online, I can make a phone call, but I do not speak the language too well...If I were to go online, if I fill out the application incorrectly I was too afraid to do that...I called my friend to see if she can fill it out for me."

— Mandarin-speaking woman in Oakland who applied for QHP

Some Mandarin-speaking participants were frustrated they could not apply online in their primary language.

Unlike English- and Spanish-speakers, Mandarin-speaking consumers in this study were unable to apply online in their primary language. This was frustrating and made enrolling more difficult. Without an online option, some turned to a friend or family member who was proficient in English to help them enroll. Others worked with CECs in their local community health centers, or had an insurance agent from their community help them with the application.

A Mandarin-speaking woman in Oakland who applied for a QHP explained that she learned about Covered California – and that she would qualify for health insurance — from her sister-in-law. She went to her local clinic to learn more about it, then her husband went to the website to look for insurance. However, it was difficult for them because they are not proficient in English. Her sister-in-law had to walk them through the website, translating along the way. The woman also had an agent come to the house for further assistance. Even after enrollment, though, she felt she did not understand her plan. Without an interpreter, she could not read about her own insurance; she had to rely on her sister-in-law for help. She also said that she had received letters in English from Covered California and her health plan, which she could not understand without translation assistance.

Vietnamese-speaking Consumers

Awareness of Covered California was low, and word of mouth was key.

The Vietnamese-speaking consumers in this study said they heard about Covered California through a combination of word of mouth, the news, and Vietnamese-language radio ads. Still, at the time of this study awareness and understanding of Covered California was low in this community. There was name recognition, these consumers reported, and knowledge that there might be new health coverage available, but beyond this, these consumers felt their community had large awareness gaps.

These consumers tended to be uninsured for long periods before applying for coverage through Covered California and there was a lack of familiarity with health insurance. However, these consumers considered Covered California an opportunity to finally have affordable health care coverage.

Language was a barrier to enrollment.

The inability to apply online in their primary language was a barrier to some Vietnamese-speaking consumers. They wanted the option of online enrollment, or at least the ability to shop and compare their options online in their primary language before applying.

Some used a family member or friend to apply for them in English. Others worked with a CEC who spoke their primary language. However, they faced a continuing language challenge — the consumers were unable to go back into their accounts once they were created because they could not read English proficiently.

A 50-year old Vietnamese-speaking man in Irvine had heard about Covered California from Vietnamese newspapers, and also had spoken with friends and co-workers about it. He would have preferred a Vietnamese-language website, but still tried to enroll online. He encountered many problems — glitches, webpage freezes — but was successful after multiple attempts. The application was finished in November, and he was identified as likely Medi-Cal-eligible. However, as of February he had yet to get his health insurance. He was asked to provide additional documentation, such as his California identification and proof of citizenship, but had not heard back. Three months after applying, he still did not know when he would be enrolled in Medi-Cal.

Improvement Ideas

The following are ideas to improve the Covered California enrollment process that either come directly from the participants in this study or are inspired by the comments they made.

Open the Door Wider

Consumers and CECs suggested changes that would improve access to enrollment by "opening the door wider," which would address some of the biggest causes of consumer frustration. In this regard, they suggested Covered California:

- Reduce wait times for the customer service call center, give callers a sense of the wait times so they know what to expect, and extend the hours of the call center so that it is accessible 24/7.
- Raise awareness about CECs and Certified Insurance Agents; this would entail more public education about CECs and agents and making this information more prominent on the Covered California website.
- Give non-English-proficient populations access to online enrollment by translating the online application into multiple languages.
- Shorten the Medi-Cal processing time — most felt four to six weeks processing time was too long, and many would like Medi-Cal enrollment to happen in real time, just like with the QHP enrollees.

Improve Communications with Applicants

Many consumer and CEC criticisms of the Covered California enrollment process focused on communications. These study participants suggested that Covered California improve how it communicates with consumers to reduce confusion and to set expectations. Specifically, they recommended that Covered California:

- Clearly inform consumers about documentation requirements before they start the application; CECs also wanted clearer guidelines about documentation
- Send follow-up letters in appropriate languages
- Simplify language in all communications and put the most vital information first, to avoid confusion

- For those identified as likely eligible for Medi-Cal, clearly explain the enrollment process, the wait times, the appropriate contact people, and how individuals can track the status of their applications.

Improve Website Usability

Many consumers and CECs wanted enhancements to the Covered California website. They wanted Covered California to:

- Improve the online chat function; some preferred this to telephone or in-person assistance
- Improve the provider search function, making sure it is up-to-date, as an important way for consumers to select health plans
- Give clearer instructions about how to calculate income, which is especially important for those whose income fluctuates

Address Knowledge Gaps and Misperceptions

Many consumers felt that awareness of the details of Covered California was still low. They suggested more effort be made to educate consumers, particularly those who face language or cultural barriers to enrollment. In particular, they suggested that Covered California:

- Address immigration status concerns and asset repossession worries (as expressed particularly by Latinos in this study)
- Conduct more in-language outreach to Mandarin- and Vietnamese-speaking communities
- Create resources for consumers that explain the different costs consumers incur with health coverage

Support CECs and Agents

The CECs and Certified Insurance Agents wanted more training and support to do their jobs better. Specifically, they recommended that Covered California:

- Provide refresher training for CECs and agents that would address real-life scenarios and offer problem-solving exercises
- Create a feedback loop for CECs to share experiences and lessons from the field
- Create an agent-specific hotline, like that created for CECs

Making Progress

Since this research was conducted, Covered California has reported a number of improvement efforts underway:

- Hiring 350 additional Covered California service center employees
- Increasing bilingual Spanish speaking staff
- Increasing online chat resources, including adding Spanish chat
- Expanding telephone line capacity for the service center
- Posting the Qualified Health Plan application in Spanish, Chinese, Vietnamese, and Korean on the Covered California website
- Adding consumer information on Covered California website including searchable Frequently Asked Question page
- Requiring agents and CECs to complete annual re-certification training
- Creating a dedicated help line for Certified Insurance Agents

Measuring Marketplace Enrollment Relative to Projections

April 2014

Linda J. Blumberg, John Holahan, Genevieve M. Kenney, Matthew Buettgens,
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Robert Wood Johnson Foundation

Urban Institute

AT A GLANCE:

- As of March 1, 2014, the Affordable Care Act's (ACA) Health Insurance Marketplaces had enrolled 61 percent of 2014 projected nationwide enrollment of subsidized and unsubsidized individuals, as derived from the Urban Institute's Health Insurance Policy Simulation Model. On March 27, the Department of Health and Human Services announced that enrollment had surpassed 6 million nationally, more than 86 percent of projections for the year. Our estimates rely upon the March 1 enrollment numbers, however, the most recent to include state specific figures.
- State-Based Marketplaces (SBMs) have been more successful in reaching projected enrollment levels than have the Federally Facilitated Marketplaces (FFMs): by March 1, SBMs had enrolled 76 percent of the enrollment projected to occur by December 31, 2014, compared to 54 percent for FFMs.
- Within SBM and FFM categories, enrollment relative to projections varies tremendously.
- Similarly, Marketplaces had enrolled 63 percent of the subsidized population expected to enroll in 2014; again, SBMs had significantly higher enrollment rates than FFMs (82 percent versus 55 percent).
- As of March 1, Marketplaces had enrolled 24 percent of projected 2016 enrollment and 13 percent of their target population (pre-reform nongroup insurance enrollees and uninsured individuals ineligible for public insurance or affordable employer-based coverage). All states will likely see substantial increases in enrollment in the coming years.

INTRODUCTION

As the first open-enrollment period for the new Health Insurance Marketplaces (HIMs) draws to a close, it is important to measure each state's progress. In this brief we compare the enrollment numbers as of March 1, 2014 (the most recent release to include state specific figures), to projected enrollment in 2014 and 2016 and estimates of the number of people eligible for HIM subsidies.[1] The comparisons to projected enrollment complement recently released comparisons to eligibility from the Kaiser Family Foundation by adjusting for expectations about the share of eligibles who would enroll.[2] The enrollment projections reflect the fact that different members of the potential HIM population (those with pre-ACA nongroup insurance and the uninsured without access to public insurance or affordable employer-based insurance) are likely to enroll at different rates. For example, those with health problems and those eligible for more financial assistance are more likely to enroll than the healthy and those eligible for little or no subsidies.

We also separate those eligible for subsidized coverage in the Marketplaces and compute their enrollment rates by state. Those eligible for subsidies will make up most HIM enrollees, and subsidies are available only with the purchase of a Marketplace plan. Enrollment of those receiving subsidies as a share of all those eligible for subsidies is an important measure of Marketplace success, since similar unsubsidized plans are also available outside the Marketplace for higher-income purchasers.[3]

The end of the first open-enrollment period on March 31 was not the end of 2014 Marketplace enrollment. Some states as well as the federal government have expanded enrollment periods to accommodate those reporting difficulties using the new online enrollment systems. In addition, many people will experience a qualifying event—such as the birth of a child, divorce, significant change in income, or the loss of insurance through an employer—during the course of the year and will therefore be allowed a special open-enrollment period. Thus, HIM enrollment numbers are likely to continue to increase throughout the year. Therefore, we will regularly update and compare actual enrollment numbers with our projected 2014 and 2016 enrollment estimates, as well as our estimates of the subsidy eligible population.

The brief relies upon analysis of the Health Insurance Policy Simulation Model-American Community Survey version (HIPSM-ACS). The model is based upon ACS data from 2009, 2010, and 2011 to obtain representative samples of state populations and their pre-ACA implementation insurance coverage. We identify the target population for Marketplace enrollment—the population that the Marketplaces are designed to cover—as (1) those who

would be covered by a nongroup plan even in the absence of the ACA; and (2) those who would be uninsured in the absence of the ACA, are not eligible for public coverage, and do not have affordable access to coverage through their own or a family member's employer. Undocumented immigrants are excluded from the target population as the ACA prohibits their enrollment in Marketplace coverage.

HIPSM simulates individual and family health insurance enrollment under the ACA based upon eligibility for programs and subsidies, health insurance coverage and options in the family, health status, socio-demographic characteristics, any applicable penalties for remaining uninsured, and other factors.[4] Subsidy eligibility is determined taking into account state decisions to expand Medicaid under the law and access to employer-based coverage. State-level estimates of target populations, subsidy-eligible individuals, and projected enrollment result from aggregated individual- and family-level estimates for those residing in each state.

In the results described below, we compare the latest state specific enrollment data released by the US Department of Health and Human Services with HIPSM-ACS projected enrollment for 2014 and 2016 as well as estimates of the target population. We also compare federal data on enrollment of individuals (not available for all states) to HIPSM-ACS estimates of the number eligible for subsidies in each state. The 2016 estimates represent expected levels of enrollment once the Marketplaces have been operational for three years and all early enrollment problems have been overcome, and once knowledge and understanding of the law's coverage options and financial assistance have spread more widely than can be expected at the start of a new program.

We project 2014 enrollment by scaling down the 2016 estimates by the same proportional amount for each state, reaching a total Marketplace enrollment of 7 million, consistent with the initial estimate released by the Congressional Budget Office (CBO). While CBO subsequently revised its projection of 2014 enrollment downward after problems with the launch of the Marketplaces, our aggregate 2014 projections remain at 7 million; so, our estimates of state progress in actual enrollment relative to expected enrollment reflect their differential challenges with the new IT systems. Had we scaled back the 2016 projected enrollment levels to 6 million, as CBO did, the progress toward 2014 expected enrollment would have been greater nationally and in each state. Preliminary indications on March 31 suggest that the original estimate of 7 million may have been reached by the end of the open enrollment period, although an official tally was unavailable at the time of this brief's production.

WHAT WE FOUND

As of March 1, 2014, the ACA's Health Insurance Marketplaces had enrolled 61 percent of projected 2014 nationwide enrollment of subsidized and unsubsidized individuals, as derived from the Urban Institute's Health Insurance Policy Simulation Model (Table 1). On March 27, the Department of Health and Human Services announced that enrollment had surpassed 6 million nationally, more than 86 percent of projections for the year. Our estimates rely upon the March 1 enrollment numbers, however, the most recent to include state specific figures. Projected enrollment for 2014 is about one-third of projected equilibrium enrollment levels, which are anticipated to be achieved by the end of 2016. The most recent state-specific data indicate that 4.2 million people had chosen Marketplace-based plans by March 1, 2014. However, some of these individuals will not pay their premiums and, as such, will not be covered by Marketplace plans during 2014.[5] Enrollment numbers have increased markedly through the end of March and will still increase throughout the year because of special enrollment periods.

State-Based Marketplaces have been more successful in reaching projected enrollment levels than have the Federally Facilitated Marketplaces: by March 1, SBMs had enrolled 76 percent of enrollment projected to occur by December 31, 2014, compared to 54 percent for FFMs. The 17 states that developed their own Marketplaces have together enrolled 1.7 million people in their plans. Another 2.6 million people have enrolled in federally run Marketplaces. New Mexico and Idaho are administering their own Marketplaces but are currently relying on the federal IT system for eligibility determination and enrollment.

Within SBM and FFM categories, enrollment relative to projections varies tremendously. Three of the 17 SBMs—Vermont, Connecticut, and the District of Columbia—have already exceeded projected 2014 enrollment figures; Rhode Island and California have reached 98 and 96 percent, respectively, of their projected first-year enrollment. Other SBMs have had slower enrollment starts; Hawaii and Massachusetts, for example, have enrolled 25 percent or

less of their first-year projections because of significant IT system challenges. However, these two states have the lowest shares of uninsured nonelderly residents in the country, owing to state implemented reforms before the ACA, and they will rely on their prior systems to maintain high levels of coverage during their challenging transitions to ACA-compliant IT environments.

In contrast, none of the 34 FFM states had met 2014 enrollment projections by March 1, and only four had enrolled more than 70 percent of the state-specific projections (North Carolina, Michigan, Florida, and Maine). Twenty FFMs had enrollment rates below 50 percent of projections.

Similarly, Marketplaces had enrolled 63 percent of the subsidized population expected to enroll in 2014; again, SBMs had significantly higher enrollment rates than FFMs (82 percent versus 55 percent). Vermont, California, Rhode Island, and Connecticut all enrolled more than the projected 2014 enrollment of subsidized individuals by March 1, 2014 (Table 2). Among FFMs, subsidized enrollment relative to expectations for 2014 have been highest thus far in North Carolina, Michigan, Florida, Maine, and Wisconsin, all of which have enrolled upwards of 70 percent of first year projections.

As of March 1, Marketplaces had enrolled 24 percent of projected 2016 enrollment and 13 percent of their target population (pre-reform nongroup insurance enrollees and uninsured individuals ineligible for public insurance or affordable employer-based coverage). All states will likely see substantial increases in enrollment in the coming years. In 2016—by which knowledge of the ACA, its requirements, and coverage options is expected to be similar to the long-run equilibrium situation—projected Marketplace enrollment was estimated to be 2.5 times that in 2014. Vermont has already enrolled 70 percent of its projected 2016 enrollment, the leader among all the Marketplaces by a wide margin. Vermont also leads the states in Marketplace enrollment of subsidized individuals, having enrolled more than 65 percent of the subsidized population projected to enroll by the end of 2016. The vast majority of the states, including 12 of the 17 SBMs and all the FFMs, have yet to enroll one-third of their projected 2016 numbers, providing considerable evidence for the ongoing need for continued education, outreach, and enrollment assistance efforts over the coming years.

ENDNOTES

1. This brief does not address Medicaid enrollment.
2. Levitt L, G Claxton and A Damico, "How Much Financial Assistance Are People Receiving Under the Affordable Care Act?" KaiserFamily Foundation, March 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8569-how-much-financial-assistance-are-people-receiving-under-the-affordable-care-act1.pdf
3. Vermont and the District of Columbia are exceptions since their Marketplaces will be the exclusive markets for nongroup insurance there.
4. See "The Urban Institute's Health Microsimulation Capactilities," available at http://www.urban.org/publications/412154.html for an overview of HIPSM. For a more detailed description of the model, see "Health Insurance Policy Simulation Model (HIPSM) Methodology Documentation: 2011 National Version," available at http://www.urban.org/publications/412471.html.
5. Secretary of Health and Human Services Kathleen Sebelius has been quoted indicating that insurers report that 80 to 90 percent of enrollees are paying their first month's premiums. See Robert Pear, "Health Care Signups Reach Frenzy in Final Day to Enroll," *New York Times*, March 31, 2014.

Table 1: Marketplace Enrollment Progress, by Marketplace Type

Enrollment as of March 1, 2014 in State Based Marketplaces							
State	(1) Projected 2014 Marketplace Enrollment	(2) Total Marketplace Target Population for 2016	(3) Projected 2016 Marketplace Enrollment	(4) March 1, 2014 Marketplace Enrollment Data	(5 = 4/1) March 1, 2014 Enrollment as a Percent of Projected 2014 Enrollment	(6 = 4/2) March 1, 2014 Enrollment as a Percent of the Total Target Population	(7 = 4/3) March 1, 2014 Enrollment as a Percent of Projected 2016 Enrollment
Vermont	14,000	52,000	35,000	24,326	**178.9%**	**47.0%**	**70.2%**
District of Columbia	6,000	31,000	19,000	6,249	**108.8%**	**20.0%**	**33.1%**
Connecticut	57,000	241,000	162,000	57,465	**101.0%**	**23.8%**	**35.5%**
Rhode Island	19,000	75,000	48,000	18,902	**97.9%**	**25.3%**	**39.1%**
California	906,000	3,332,000	2,357,000	868,936	**95.9%**	**26.1%**	**36.9%**
Idaho	57,000	267,000	142,000	43,861	**77.3%**	**16.5%**	**31.0%**
New York	321,000	1,295,000	811,000	244,618	**76.3%**	**18.9%**	**30.2%**
Washington	147,000	572,000	373,000	107,262	**73.1%**	**18.8%**	**28.7%**
Kentucky	81,000	307,000	196,000	54,945	**68.0%**	**17.9%**	**28.1%**
Colorado	130,000	497,000	351,000	83,469	**64.2%**	**16.8%**	**23.8%**
Nevada	65,000	242,000	156,000	28,353	**43.8%**	**11.7%**	**18.2%**
Minnesota	75,000	331,000	223,000	32,030	**42.6%**	**9.7%**	**14.4%**
Maryland	91,000	397,000	250,000	38,070	**41.8%**	**9.6%**	**15.3%**
Oregon	94,000	350,000	232,000	38,806	**41.5%**	**11.1%**	**16.7%**
New Mexico	46,000	171,000	112,000	15,012	**32.7%**	**8.8%**	**13.4%**
Hawaii	19,000	86,000	47,000	4,661	**25.1%**	**5.4%**	**9.9%**
Massachusetts	88,000	396,000	255,000	12,965	**14.8%**	**3.3%**	**5.1%**
Total SBM	*2,213,000*	*8,640,000*	*5,769,000*	*1,680,000*	***75.9%***	***19.4%***	***29.1%***

continued on next page

Table 1: Marketplace Enrollment Progress, by Marketplace Type *continued*

Enrollment as of March 1, 2014 in Federally Facilitated Marketplaces							
State	(1) Projected 2014 Marketplace Enrollment	(2) Total Marketplace Target Population for 2016	(3) Projected 2016 Marketplace Enrollment	(4) March 1, 2014 Marketplace Enrollment Data	(5 = 4/1) March 1, 2014 Enrollment as a Percent of Projected 2014 Enrollment	(6 = 4/2) March 1, 2014 Enrollment as a Percent of the Total Target Population	(7 = 4/3) March 1, 2014 Enrollment as a Percent of Projected 2016 Enrollment
North Carolina	246,000	1,304,000	615,000	200,546	**81.5%**	**15.4%**	**32.6%**
Michigan	189,000	781,000	467,000	144,587	**76.7%**	**18.5%**	**31.0%**
Florida	594,000	3,177,000	1,437,000	442,087	**74.5%**	**13.9%**	**30.8%**
Maine	35,000	157,000	82,000	25,412	**73.6%**	**16.2%**	**31.0%**
New Hampshire	31,000	157,000	79,000	21,578	**69.0%**	**13.7%**	**27.2%**
Wisconsin	107,000	444,000	269,000	71,443	**66.6%**	**16.1%**	**26.6%**
Pennsylvania	267,000	1,439,000	677,000	159,821	**60.0%**	**11.1%**	**23.6%**
Virginia	175,000	941,000	451,000	102,815	**58.9%**	**10.9%**	**22.8%**
Montana	39,000	190,000	98,000	22,582	**57.6%**	**11.9%**	**23.1%**
Georgia	247,000	1,445,000	608,000	139,371	**56.3%**	**9.6%**	**22.9%**
Alabama	100,000	637,000	252,000	55,000	**54.7%**	**8.6%**	**21.8%**
Missouri	140,000	785,000	349,000	74,469	**53.2%**	**9.5%**	**21.4%**
Illinois	215,000	897,000	566,000	113,733	**52.8%**	**12.7%**	**20.1%**
Tennessee	149,000	832,000	378,000	77,867	**52.2%**	**9.4%**	**20.6%**
New Jersey	154,000	603,000	396,000	74,370	**48.4%**	**12.3%**	**18.8%**
Utah	83,000	384,000	208,000	39,902	**47.9%**	**10.4%**	**19.2%**
South Carolina	117,000	657,000	283,000	55,830	**47.8%**	**8.5%**	**19.7%**
Delaware	14,000	60,000	34,000	6,538	**47.0%**	**10.9%**	**19.0%**
Arkansas	61,000	218,000	147,000	27,395	**45.1%**	**12.6%**	**18.6%**
Kansas	66,000	352,000	169,000	29,309	**44.6%**	**8.3%**	**17.4%**
Indiana	150,000	856,000	369,000	64,972	**43.4%**	**7.6%**	**17.6%**
Nebraska	50,000	244,000	136,000	21,578	**43.1%**	**8.8%**	**15.8%**
Texas	696,000	3,831,000	1,683,000	295,025	**42.4%**	**7.7%**	**17.5%**
Wyoming	18,000	84,000	45,000	6,838	**38.6%**	**8.1%**	**15.1%**
Ohio	205,000	796,000	498,000	78,925	**38.4%**	**9.9%**	**15.9%**
Mississippi	68,000	417,000	162,000	25,554	**37.9%**	**6.1%**	**15.8%**
Louisiana	122,000	735,000	305,000	45,561	**37.3%**	**6.2%**	**14.9%**
Arizona	160,000	559,000	391,000	57,611	**36.0%**	**10.3%**	**14.7%**
West Virginia	30,000	118,000	68,000	10,599	**35.9%**	**9.0%**	**15.5%**
Oklahoma	97,000	520,000	235,000	32,882	**33.9%**	**6.3%**	**14.0%**
Alaska	22,000	105,000	51,000	6,666	**30.1%**	**6.4%**	**13.2%**
Iowa	54,000	218,000	145,000	15,346	**28.3%**	**7.1%**	**10.6%**
South Dakota	25,000	125,000	66,000	6,765	**26.8%**	**5.4%**	**10.2%**
North Dakota	20,000	73,000	54,000	5,238	**26.2%**	**7.2%**	**9.8%**
Total FFM	*4,745,000*	*24,142,000*	*11,773,000*	*2,558,000*	***53.9%***	***10.6%***	***21.7%***
National	6,958,000	32,781,000	17,542,000	4,238,000	**60.9%**	**12.9%**	**24.2%**

Source: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Enrollment data is as of Mar 1, 2014 from HHS (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf).

Note: The Marketplace target population for 2016 consists of three groups: those eligible for subsidies, those currently with nongroup coverage but who are ineligible for subsidies or Medicaid/CHIP, and those currently uninsured who do not have access to employer coverage and who are ineligible for subsidies or Medicaid/CHIP; SBM=State-Based Marketplace; FFM=Federally Facilitated Marketplace.

Table 2: Marketplace Subsidized Enrollment Progress, by Marketplace Type

Enrollment as of March 1, 2014 in State Based Marketplaces							
State	(1) Projected 2014 Subsidized Enrollment	(2) Total Eligible for Subsidies for 2016	(3) Projected 2016 Subsidized Marketplace Enrollment	(4) March 1, 2014 Subsidized Marketplace Enrollment Data	(5 = 4/1) March 1, 2014 Subsidized Enrollment as a Percent of Projected 2014 Subsidized Enrollment	(6 = 4/2) March 1, 2014 Subsidized Enrollment as a Percent of Population Eligible for Subsidies	(7 = 4/3) March 1, 2014 Subsidized Enrollment as a Percent of Projected 2016 Subsidized Enrollment
Vermont	11,000	35,000	20,000	13,379	**121.3%**	**37.8%**	**65.5%**
California	723,000	2,097,000	1,338,000	764,664	**105.8%**	**36.5%**	**57.1%**
Rhode Island	16,000	52,000	29,000	16,634	**104.5%**	**32.1%**	**56.4%**
Connecticut	42,000	142,000	77,000	41,949	**100.7%**	**29.6%**	**54.4%**
Idaho	47,000	143,000	87,000	39,914	**85.2%**	**27.8%**	**46.0%**
Washington	119,000	381,000	221,000	86,882	**72.9%**	**22.8%**	**39.4%**
New York	262,000	900,000	485,000	176,125	**67.3%**	**19.6%**	**36.3%**
Kentucky	68,000	225,000	127,000	38,462	**56.2%**	**17.1%**	**30.4%**
Colorado	100,000	297,000	186,000	47,577	**47.5%**	**16.0%**	**25.6%**
Nevada	55,000	173,000	102,000	22,399	**40.7%**	**13.0%**	**22.0%**
Oregon	78,000	241,000	144,000	30,657	**39.5%**	**12.7%**	**21.3%**
New Mexico	39,000	121,000	72,000	11,709	**30.2%**	**9.7%**	**16.3%**
District of Columbia	4,000	15,000	7,000	812	**23.1%**	**5.4%**	**12.5%**
Hawaii	15,000	62,000	28,000	1,631	**10.8%**	**2.6%**	**5.8%**
Maryland	69,000	246,000	128,000	-	**-**	**-**	**-**
Massachusetts	63,000	237,000	116,000	-	**-**	**-**	**-**
Minnesota	53,000	180,000	98,000	-	**-**	**-**	**-**
Total SBM	*1,762,000*	*5,547,000*	*3,264,000*	*1,293,000*	***81.9%***	***26.5%***	***44.2%***

continued on next page

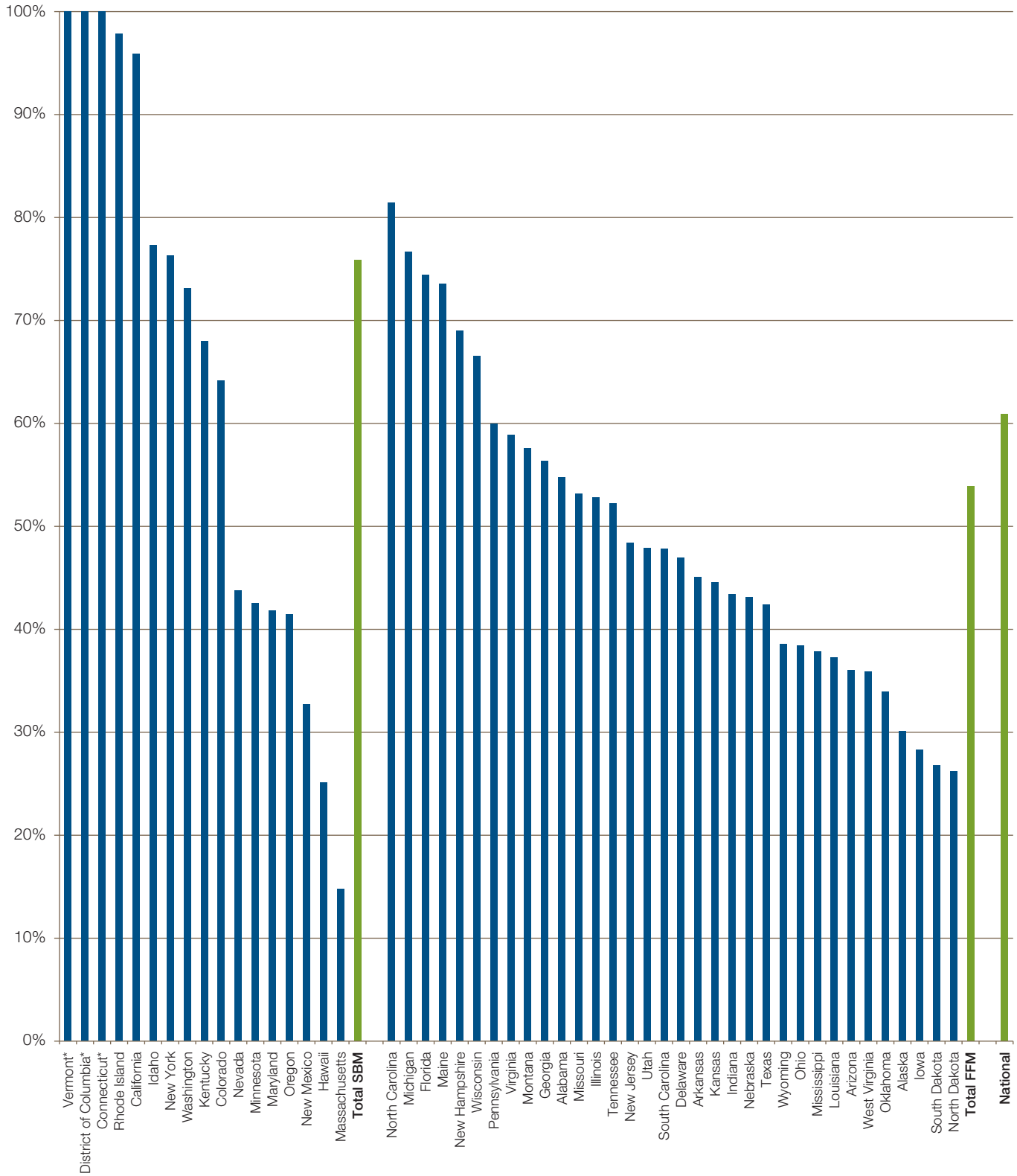
Table 2: Marketplace Subsidized Enrollment Progress, by Marketplace Type *continued*

Enrollment as of March 1, 2014 in Federally Facilitated Marketplaces							
State	(1) Projected 2014 Subsidized Enrollment	(2) Total Eligible for Subsidies for 2016	(3) Projected 2016 Subsidized Marketplace Enrollment	(4) March 1, 2014 Subsidized Marketplace Enrollment Data	(5 = 4/1) March 1, 2014 Subsidized Enrollment as a Percent of Projected 2014 Subsidized Enrollment	(6 = 4/2) March 1, 2014 Subsidized Enrollment as a Percent of Population Eligible for Subsidies	(7 = 4/3) March 1, 2014 Subsidized Enrollment as a Percent of Projected 2016 Subsidized Enrollment
North Carolina	203,000	700,000	376,000	182,497	**89.8%**	**26.1%**	**48.5%**
Michigan	157,000	567,000	290,000	125,791	**80.2%**	**22.2%**	**43.3%**
Florida	503,000	1,714,000	931,000	397,878	**79.2%**	**23.2%**	**42.7%**
Maine	30,000	102,000	55,000	22,871	**77.1%**	**22.4%**	**41.7%**
Wisconsin	88,000	321,000	164,000	64,299	**72.8%**	**20.0%**	**39.3%**
New Hampshire	25,000	92,000	47,000	15,968	**62.6%**	**17.4%**	**33.8%**
Montana	32,000	105,000	60,000	19,421	**59.9%**	**18.5%**	**32.4%**
Pennsylvania	217,000	813,000	402,000	127,857	**58.9%**	**15.7%**	**31.8%**
Virginia	140,000	511,000	260,000	82,252	**58.7%**	**16.1%**	**31.7%**
Georgia	207,000	738,000	383,000	118,465	**57.2%**	**16.0%**	**30.9%**
Alabama	83,000	320,000	153,000	47,300	**57.2%**	**14.8%**	**30.9%**
Missouri	116,000	411,000	215,000	63,299	**54.6%**	**15.4%**	**29.5%**
Illinois	170,000	582,000	315,000	87,574	**51.5%**	**15.0%**	**27.8%**
Tennessee	121,000	452,000	225,000	61,515	**50.7%**	**13.6%**	**27.4%**
Utah	69,000	216,000	127,000	34,316	**49.9%**	**15.9%**	**27.0%**
New Jersey	124,000	407,000	229,000	61,727	**49.9%**	**15.2%**	**27.0%**
Nebraska	38,000	122,000	71,000	18,773	**49.1%**	**15.3%**	**26.5%**
South Carolina	99,000	360,000	183,000	48,014	**48.6%**	**13.3%**	**26.2%**
Arkansas	51,000	152,000	95,000	24,929	**48.6%**	**16.4%**	**26.2%**
Indiana	125,000	465,000	231,000	57,175	**45.8%**	**12.3%**	**24.8%**
Delaware	12,000	44,000	21,000	5,165	**44.6%**	**11.8%**	**24.1%**
Wyoming	14,000	45,000	27,000	6,291	**43.7%**	**13.9%**	**23.6%**
Kansas	53,000	184,000	98,000	22,861	**43.1%**	**12.4%**	**23.3%**
Mississippi	57,000	201,000	106,000	23,765	**41.3%**	**11.8%**	**22.3%**
Texas	589,000	1,952,000	1,092,000	241,921	**41.0%**	**12.4%**	**22.2%**
Louisiana	101,000	361,000	187,000	39,638	**39.3%**	**11.0%**	**21.2%**
Ohio	174,000	584,000	322,000	67,086	**38.6%**	**11.5%**	**20.8%**
West Virginia	26,000	93,000	48,000	9,115	**35.3%**	**9.8%**	**19.1%**
Arizona	134,000	386,000	249,000	42,632	**31.7%**	**11.1%**	**17.1%**
Oklahoma	82,000	284,000	152,000	25,648	**31.3%**	**9.0%**	**16.9%**
Iowa	42,000	136,000	78,000	12,891	**30.6%**	**9.5%**	**16.5%**
South Dakota	20,000	63,000	37,000	6,021	**30.1%**	**9.6%**	**16.3%**
Alaska	20,000	66,000	36,000	5,799	**29.6%**	**8.7%**	**16.0%**
North Dakota	15,000	44,000	29,000	4,400	**28.4%**	**10.0%**	**15.4%**
Total FFM	*3,938,000*	*13,595,000*	*7,293,000*	*2,175,000*	***55.2%***	***16.0%***	***29.8%***
National	5,701,000	19,142,000	10,557,000	3,468,000	**62.9%**	**18.8%**	**33.9%**

Source: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Enrollment data is as of Mar 1, 2014 from HHS (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf).

Note: SBM=State-Based Marketplace; FFM=Federally Facilitated Marketplace; "-" indicates data is not available; SBM and National totals and rates omit states with unavailable data for columns 4, 5, 6, and 7.

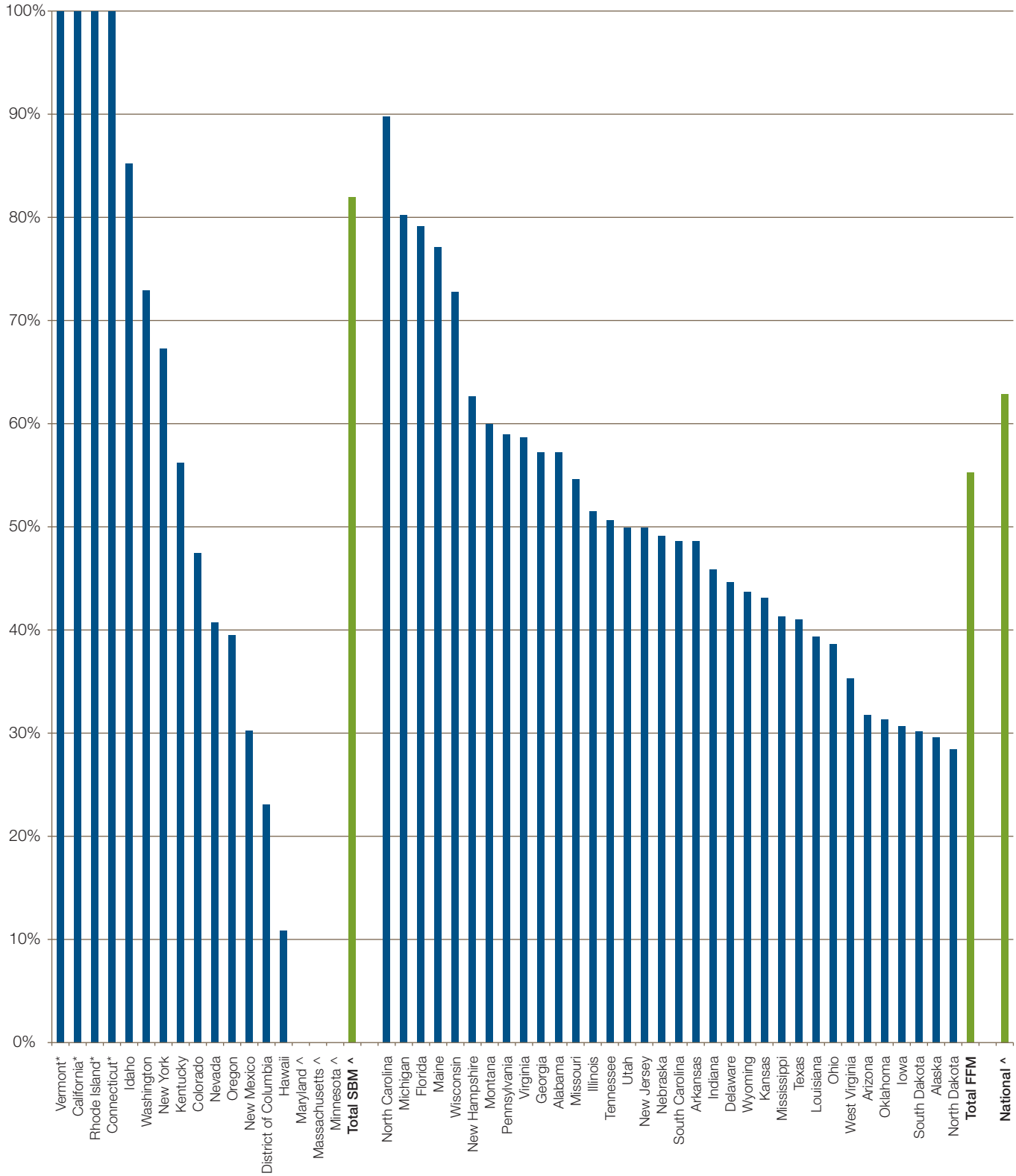
Figure 1: March 1, 2014 Enrollment as a Percent of Projected 2014 Enrollment



Source: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Enrollment data is as of Mar 1, 2014 from HHS (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf).

*Notes: *denotes states with current enrollment greater than projected 2014 enrollment; CT (101.0%), DC (108.8%), and VT (178.9%); SBM=State-Based Marketplace; FFM=Federally Facilitated Marketplace.*

Figure 2: March 1, 2014 Subsidized Enrollment as a Percent of Projected 2014 Subsidized Enrollment



Source: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Enrollment data is as of Mar 1, 2014 from HHS (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf).

*Notes: *denotes states with current enrollment greater than projected 2014 enrollment; CA (105.8%), CT (100.7%), RI (104.5%), and VT (121.3%); SBM=State-Based Marketplace; FFM=Federally Facilitated Marketplace; ^Data is not available in MA, MD, and MN and SBM and National rates omit these states.*

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By Benjamin D. Sommers, John A. Graves, Katherine Swartz, and Sara Rosenbaum

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Medicaid And Marketplace Eligibility Changes Will Occur Often In All States; Policy Options Can Ease Impact

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ABSTRACT Under the Affordable Care Act (ACA), changes in income and family circumstances are likely to produce frequent transitions in eligibility for Medicaid and health insurance Marketplace coverage for low- and middle-income adults. We provide state-by-state estimates of potential eligibility changes ("churning") if all states expanded Medicaid under health reform, and we identify predictors of rates of churning within states. Combining longitudinal survey data with state-specific weighting and small-area estimation techniques, we found that eligibility changes occurred frequently in all fifty states. Higher-income states and states that had more generous Medicaid eligibility criteria for nonelderly adults before the ACA experienced more churning, although the differences were small. Even in states with the least churning, we estimated that more than 40 percent of adults likely to enroll in Medicaid or subsidized Marketplace coverage would experience a change in eligibility within twelve months. Policy options for states to reduce the frequency and impact of coverage changes include adopting twelve-month continuous eligibility for adults in Medicaid, creating a Basic Health Program, using Medicaid funds to subsidize Marketplace coverage for low-income adults, and encouraging the same health insurers to offer plans in Medicaid and the Marketplaces.

Beginning January 1, 2014, the Affordable Care Act (ACA) established two pathways to health insurance for nonelderly US citizens and legal residents. The first was an expansion of Medicaid coverage for people with annual incomes of up to 138 percent of the federal poverty level in states that elected to expand their programs. The second pathway was subsidizing private coverage purchased via health insurance Marketplaces for people with incomes of 138–400 percent of poverty who do not have an offer of affordable coverage through an employer. The pathways are designed to work in tandem, but a major challenge is how to promote continuity of coverage and health care for people when their incomes and life circumstances cause them to transition between Medicaid and subsidized private coverage.

In states that opt out of the ACA's Medicaid expansion, changes in income or family circumstance will lead many people to lose coverage entirely unless they qualify for coverage under one of the traditional categories of Medicaid eligibility: pregnancy, disability, or being the impoverished parent of a minor child. A less stark problem that presents a different set of challenges will occur in states that do expand Medicaid: the potential for moving between Medicaid and Marketplace coverage.

Both of these types of "churning"—loss of coverage and frequent transitions in the source of

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coverage—can cause difficulties. The total loss of coverage raises the most serious problems in terms of access to care, but frequent transitions across coverage pathways also raise important issues for beneficiaries, health plans, providers, and policy makers. From one year to the next or during any given year, many individuals and families will experience changes in eligibility either for Medicaid or for Marketplace coverage. These eligibility changes could lead to both gaps in coverage and disruptions in the continuity of care, because people might have to find new providers or change their existing health treatments if their new insurance plan uses a different provider network or covers different services than their old plan did.

Previous research has estimated that approximately half of low-income adults might experience a change in income or family circumstances leading them to transition from Medicaid to Marketplace coverage (or vice versa) each year.[1] Policy makers continue to explore various options to reduce the frequency of churning or at least mitigate its adverse impact on the continuity of health care.

Because churning is the result of many factors, it may be a larger issue in some states than in others. To date, there is little evidence about which states are most likely to experience churning. In this context, state-level estimates of potential churning rates among people likely to participate in Medicaid and the Marketplaces would be extremely valuable.

A major limitation to analyzing state-specific churning is that the most commonly used source of data on changes in insurance coverage and income over time—the Census Bureau's Survey of Income and Program Participation (SIPP)—was not designed to provide samples of people that are representative of every state's population.[2] The survey's sample is relatively small and disproportionately includes lower-income people and people in particular localities.[3] We overcame these limitations by combining information on income and family changes from the SIPP with state-specific weights that we developed using a much larger survey, the American Community Survey (ACS).[4]

Our study objectives were to provide detailed estimates of the potential extent of churning between Medicaid and Marketplace coverage under health reform in each state and to identify state-level factors associated with higher rates of churning.

Study Data And Methods

DATA SOURCES We used data from two sources. First, information on changes in eligibility over time came from the 2008 SIPP. Following previous research,[1,5] we identified all adults ages 19–62 (thus excluding adults who would age into Medicare during the survey's follow-up period) who were likely to enroll in Medicaid or subsidized Marketplace coverage. We defined this sample as those adults with family incomes estimated to be up to 400 percent of poverty (incomes that made them eligible for Medicaid or tax credits for Marketplace coverage) who did not have Medicare, employer-sponsored insurance, or military health insurance. These criteria yielded a sample of 11,898 people.

For each month in the survey, we estimated family income as a percentage of poverty,[6] using the concept of the health insurance unit (see the online Appendix for details).[7] We tracked the number of adults experiencing a change in income that would result in a shift in eligibility (based on crossing the Medicaid expansion income threshold of 138 percent of poverty) during the subsequent twelve months.

Annual income is used to calculate the proper tax credit for people who have coverage in the Marketplace and has been studied previously in the context of reconciliation payments.[5] However, eligibility for Medicaid is based on monthly income, and eligibility for Marketplace subsidies is contingent on not being eligible for Medicaid. Therefore, monthly income was the relevant measure for this analysis.

We were also more interested in coverage changes than in the receipt or extent of tax credits. Therefore, we did not analyze how often people had income changes that crossed alternative thresholds, such as 250 percent of poverty (the ACA threshold for receiving cost-sharing subsidies) or 400 percent of poverty.

Our second data source was a three-year sample of 9,204,447 people in the 2009–11 ACS. These data were used to construct state-specific weights for the SIPP sample, following the method developed by Allen Schirm and Alan Zaslavsky.[8] Specifically, state weights were developed using a Poisson regression model that calibrated SIPP state population totals to match a set of forty-three control totals from the ACS. If, for example, based on the ACS there were 35,000 people working in the manufacturing industry in North Dakota, then our SIPP estimate also yielded an estimate of 35,000. State-level control totals included demographic characteristics, income, family composition, insurance coverage type, and employment measures (both status in the labor force and industry).

Using the approach employed by John Graves and Katherine Swartz,[9] we restricted the construction of state weights so that only people in contiguous states and states with similar eli-

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gibility policies for public programs could contribute information to an estimate for a given state (see the online Appendix for details).[7] The information for each person in the expanded state sample was then weighted by the appropriate state-specific weight to yield representative estimates for each state.

ANALYSIS Using the methods outlined above, we estimated rates of churning for each state. Our two primary outcomes were the percentages of adults with continuous eligibility for the same insurance program over a six-month period and over a twelve-month period. We limited our sample to people for whom we had complete income data for the first twelve months in the survey.

After producing state-specific estimates of rates of continuous eligibility over time, we analyzed whether churning rates varied by states' poverty rates or the generosity of each state's pre-ACA Medicaid eligibility criteria for nonelderly adults.

For the state poverty rate analysis, the sample was divided into three groups based on the rate in each state (as derived from the Census Bureau's 2009 Current Population Survey), using natural breaks in the distribution to produce similar-size groups (people whose incomes were less than 11.0 percent, 11.0–14.5 percent, and greater than 14.5 of poverty). We also tested the impact of categorizing states by per capita income or median household income.

For the analysis of the generosity of each state's pre-ACA Medicaid eligibility criteria for nonelderly adults, the sample was divided into three groups based on the share of a standardized national population that would be eligible for Medicaid under each state's laws (see the online Appendix for details).[7] This approach was similar to methods used in previous research.[10]

We used *t* tests to identify differences in churning rates across these classifications for all fifty states and the District of Columbia. We also ran bivariate linear regression models in which each state's percentage of adults with twelve months of uninterrupted eligibility was the outcome and the state poverty rate, per capita income, and Medicaid eligibility measure were separately used as continuous predictor variables.

Our goal in these analyses was not to present an exhaustive model of predictors of coverage stability. Instead, we sought to identify simple state-level measures that offer a straightforward way to conceptualize what kinds of states experience more or less churning. For this purpose, we selected measures that vary widely across states and might plausibly affect income mobility, program eligibility, or both over time.

LIMITATIONS Our study has several important limitations. First, we used self-reported income data, which might correspond imperfectly with income as it will actually be assessed by state Medicaid programs and the Marketplaces. The impact of this imprecision on state-level churning rates is unclear.

Second, our sample underrepresented people who dropped out of the SIPP sample. Such people are likely to have less stable circumstances than those who remain in the survey, so our approach could underestimate the extent of churning.

Third, our sample contained all adults who were potentially eligible for Medicaid or subsidized Marketplace coverage. Many eligible people have not enrolled in public coverage programs in the past,[11] but our sample design implicitly assumed full participation rates. However, it is unclear whether people who do not enroll are more or less likely to experience income changes than those who do sign up for coverage.

Fourth, some people in this income range may have declined an offer of affordable employer-sponsored insurance (that is, insurance costing less than 9.5 percent of the employee's income), which would have precluded their receiving Marketplace tax credits.[12] SIPP does not supply information on employees' potential premium obligations, which prevented us from accurately identifying such people in the data set.

Consistent with the ACA, our approach assumed that people could lose eligibility for Medicaid or subsidized Marketplace coverage in any given month based on changed economic or family circumstances. Whether interruptions will be as frequent as the law contemplates is unclear, since families might fail to report changed circumstances each time they occur. Moreover, the Centers for Medicare and Medicaid Services (CMS) has used Section 1115 waivers under the Social Security Act to enable states to apply to adults a policy of twelve-month continuous eligibility for Medicaid—an option that already exists for children.[13] State Medicaid agencies and the Marketplaces also may vary in how quickly they respond to reported changes in eligibility.

For the purpose of estimating rates of churning, we assumed that all states would expand Medicaid eligibility to 138 percent of poverty. As of January 2014, however, only twenty-five states and the District of Columbia had elected to do so.[14] Furthermore, the landscape of the Medicaid expansion is changing rapidly, and it is possible that some states will scale back higher-income (above 138 percent of poverty) eligibility for Medicaid once Marketplace subsidies become available. Therefore, we felt that a simplifying assumption using the same income

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cutoff for all states would produce the most plausible comparisons across states.

The state-based weighting approach also has limitations. Our reweighting method was designed to strike a balance between the biased and imprecise direct state estimates yielded by small samples and the also potentially biased but more reliable indirect state estimates produced by appropriately weighted larger samples. As noted above, we also limited out-of-state "borrowing" to respondents in contiguous states and states with similar public program eligibility policies. This might result in less statistically reliable estimates for states with few neighbors.

Study Results

Exhibit 1 shows eligibility continuity curves for selected states representing the upper and lower bounds, the median, and selected percentiles of adults experiencing continuous eligibility for Medicaid or Marketplace coverage. Appendix Exhibit 2 lists the specific values for each state and 95% confidence intervals for the estimates.[7] The curves are clustered in a fairly narrow band. Across all states (not including the District of Columbia), an estimated 63–72 percent of adults did not experience any changes in eligibility through the first six months, and in all but two states, 40–55 percent of adults did not experience any changes during the full twelve-month period.

Two states' estimates were outliers, with little churning at six months but marked churning at twelve months; thus, we did not include those states in Exhibit 1. Hawaii and Maine experienced more churning at twelve months than any other state—with only 40 percent and 42 percent of adults, respectively, having stable eligibility. However, those states' estimates at six months were fairly high, at 70 percent and 67 percent, respectively. As discussed above, our weighting approach may be less reliable in states with few or no neighboring states, such as these two outliers.

Appendix Exhibit 3 shows the values by state for people whose incomes were initially below 138 percent of poverty versus those with incomes between 139–400 percent of poverty.[7] Although the precise pattern varied across states, the median rate of continuous eligibility at twelve months was slightly higher for those with initial incomes in the range of 139–400 percent of poverty than for those whose incomes were initially below 138 percent of poverty (53 percent and 47 percent, respectively).

We found that eligibility continuity was lowest (that is, churning rates were highest) at twelve months in states with the lowest poverty rates (Exhibit 2). Each percentage-point decrease in a state's poverty rate was associated with a 0.29 percent increase in churning at twelve months (Exhibit 3). However, it is important to note that this relationship is not exactly linear: Churning rates were quite similar across states with low and medium levels of poverty, in contrast to high-poverty states.

We found a similar pattern—higher-income states having more churning—when we used alternative groupings of states by their poverty rates and when we used per capita income or median household income instead of poverty rates (Appendix Exhibit 4).[7] Continuity of eligibility was also lower in states that had more generous Medicaid programs before the ACA (Exhibit 2).

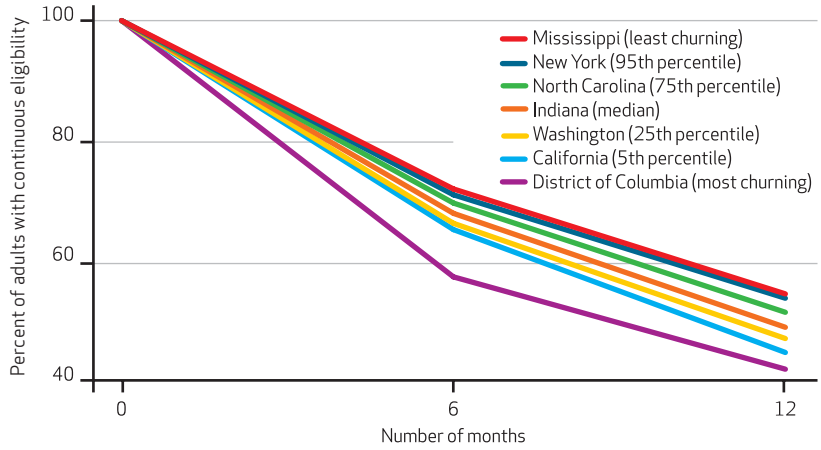
Discussion

Beginning in January 2014, the pathways to affordable insurance expanded significantly in all states as a result of the ACA's insurance Marketplaces, especially in states that have expanded their Medicaid programs. The ACA was designed to ensure coverage continuity for US citizens and qualifying residents, with a pathway available to everyone—regardless of income or life circumstances.

In states that fully implement the ACA with expanded Medicaid programs, this vision will

EXHIBIT 1

Estimated Percentages Of Adults In Selected States Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage



SOURCE Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text) using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text). **NOTES** The sample contained adults ages 19–62 with family incomes of less than 400 percent of poverty who did not have Medicare, military health insurance, or employer-sponsored health insurance during the study period and for whom we had income data for their first twelve months in the survey ($N = 11,898$). A change in eligibility was based on a change in the family's monthly income as a percentage of poverty that moved the income across the threshold of 138 percent of poverty. Family income was defined using the health insurance unit.

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EXHIBIT 2

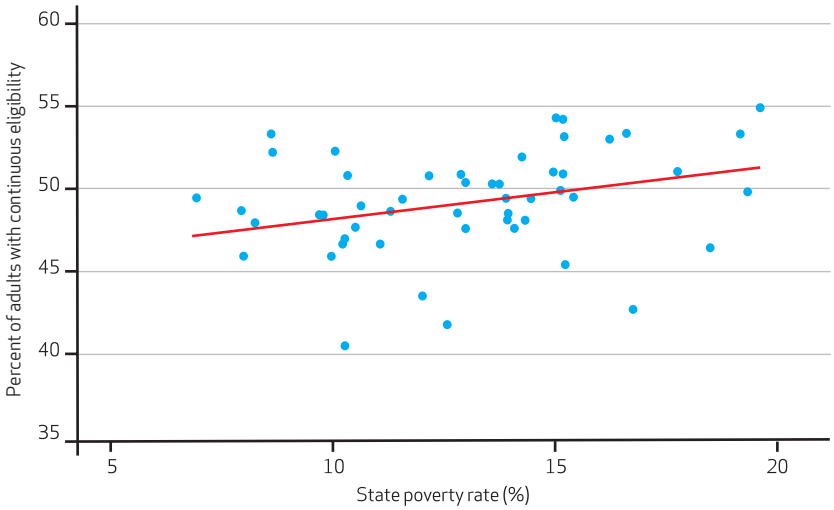
Estimated Percentages Of Adults Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage, By State Characteristic

State characteristic	Percentage of adults with continuous eligibility at: 0 months	6 months	12 months	*p* value[a]
POVERTY RATE				
Low ($n = 16$)	100.0	67.9	48.4	0.03
Medium ($n = 19$)	100.0	67.6	48.5	0.03
High ($n = 16$)	100.0	68.9	50.8	Ref
MEDICAID ELIGIBILITY CRITERIA BEFORE THE AFFORDABLE CARE ACT				
Most generous ($n = 17$)	100.0	68.0	48.1	0.005
Moderately generous ($n = 17$)	100.0	67.2	48.4	0.01
Least generous ($n = 17$)	100.0	69.1	51.1	Ref

SOURCE Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text), using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text); and, for state characteristics, of data from the 2009 Current Population Survey and of eligibility data from the Kaiser Family Foundation. **NOTES** The sample contained fifty-one state-level estimates (for the fifty states and the District of Columbia), based on an analysis of adults ages 19–62 with family incomes less than 400 percent of poverty who did not have Medicare, military health insurance, or employer-sponsored health insurance during the study period and for whom we had income data for their first twelve months in the survey ($N = 11,898$). A change in eligibility was based on a change in the family's monthly income as a percentage of poverty that moved the family's income across the threshold of 138 percent of poverty. Family income was defined using the health insurance unit. [a]*p* values for difference at twelve months were based on a *t* test comparing the twelve-month estimate across the groups as indicated.

EXHIBIT 3

Estimated Percentages Of Adults Experiencing Continuous Eligibility For Medicaid Or Marketplace Coverage At Twelve Months, By State Poverty Rate



SOURCE Authors' analysis of data from the 2008–09 Survey of Income and Program Participation (see Note 3 in text) using state-specific weights from the 2009–11 American Community Survey (see Note 4 in text); and, for state poverty rates, of data from the 2009 Current Population Survey. **NOTES** The red line shows the following regression equation: twelve-month continuous coverage = 45.4% + 0.29% × state poverty rate ($p = 0.04$). See Exhibit 2 Notes for additional information.

be realized. There, the challenges become how to ensure that eligibility translates into actual enrollment, and how to make transitions in coverage as smooth as possible. In states that do not expand Medicaid, these transitions will be starker and more painful.

Previous research[1,12] has demonstrated that millions of Americans will face circumstances that cause them to transition among coverage pathways during a year. Our study estimated how such churning might vary across states. Our results have three primary implications.

First and most important, transitioning among pathways to coverage has the potential to be a major issue in every state. Medicaid—and state health policy more generally—is typically characterized by differences across states in numerous domains.[11,15–17] However, we found that if all states were to expand Medicaid, most would experience relatively similar rates of changes in eligibility for Medicaid and premium subsidies over six or twelve months.

We estimated that approximately half (plus or minus 5 percentage points) of adults likely to be eligible for Medicaid or subsidized Marketplace coverage will experience an eligibility change within twelve months. Our estimated churning rates are slightly higher than those in one previous analysis of four large states.[5] However, our approach used more robust state-level weighting than the previous study and measured income based on the health insurance unit, instead of the family.

Second, although churning rates were likely to be high everywhere, we found some small differences in the rates across states. States with lower poverty rates and higher per capita incomes were likely to experience higher rates of churning between eligibility for Medicaid and eligibility for premium subsidies.

To see why this might be the case, consider two states, one with a poverty rate of 10 percent (and a relatively high median household income) and the other with a poverty rate of 15 percent (and a relatively low median household income). The richer state has a larger share of its population with incomes of 100–250 percent of poverty, while the poorer state has a larger share of its population with incomes of below 50 percent of poverty. The richer state has more people close enough to the eligibility cutoff that they are likely to transition between Medicaid and Marketplace coverage as their incomes rise. Fewer people in the poorer state will be able to raise their incomes above 138 percent of poverty.

Third, states with more-generous eligibility criteria for their Medicaid programs before the ACA also had higher churning rates. In part, this is a result of the fact that these states tended to

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Most adults who lose Marketplace subsidies in nonexpanding states will become uninsured.

have lower poverty rates. But, in addition, states whose pre-ACA Medicaid enrollment included people at higher income levels were likely to have a larger population in Medicaid with incomes at or near the threshold of 138 percent of poverty. That increases the likelihood that many of them would transition between Medicaid and the Marketplace during a year. In contrast, in states without generous Medicaid eligibility, some of the people in this income group likely have employer-sponsored insurance instead of Medicaid, which makes them less likely to have Medicaid or Marketplace coverage in 2014.

It is important to recognize that the eligibility changes we have analyzed are the result of an effort to expand pathways to affordable coverage for all Americans. Churning has often been used to describe the negative outcome of moving into and out of insurance coverage and becoming uninsured. In contrast, we are discussing changes that are a by-product of a system that allows for transitions among insurance pathways. These transitions increase the risks of disrupting care continuity and of having short gaps in coverage. But they represent a different (and less problematic) form of churning than that between having Medicaid or Marketplace coverage and being uninsured.

However, when low-income adults in states that opt not to expand their Medicaid programs experience a loss of income that drops them below 100 percent of poverty, most will not be eligible for subsidized coverage in the Marketplace or for Medicaid. Most nonexpansion states restrict Medicaid eligibility for adults to pregnant women, certain low-income adults with disabilities, and parents of minor children with incomes of no more than 35 percent of poverty on average.[18] In other words, most adults who lose Marketplace subsidies in nonexpanding states will become uninsured, as has traditionally happened to adults who lose Medicaid eligibility.[19]

Policy Implications

Our findings indicate that every state is likely to experience significant rates of eligibility changes over time. A number of policies have recently been proposed to mitigate the effects of churning between Medicaid and Marketplace coverage, and state policy makers should consider them in the light of our findings.[12]

One option is for states to adopt twelve-month continuous eligibility periods in Medicaid as a means of overcoming the churning effects of periodic income fluctuations. As noted above, CMS has offered states a fast-track option to adopt this approach, using Section 1115 waivers.[13] In addition, legislation that would enable states to choose such an option without a waiver is now pending in Congress.

A second, more incremental option offered in CMS's 2012 regulations allows states to assess people's ongoing eligibility for Medicaid using projected annual income instead of current monthly income. This option could reduce rates of eligibility changes, particularly for workers whose earnings vary seasonally.[20]

A third option for states is to use Medicaid funds to purchase coverage in qualified health plans in the Marketplace for people with incomes below 138 percent of poverty. This is similar to what Arkansas proposed in its waiver application, which was approved by CMS.[21] Previous estimates have suggested that such premium support could reduce churning by as much as two-thirds in those states whose pre-ACA eligibility standards were very restrictive.[22] In effect, people covered through premium support arrangements could maintain their enrollment in the same health plan regardless of the source of subsidy. However, people whose income rose above 138 percent of poverty would face monthly premiums and additional cost sharing that could lead some to drop coverage entirely. Thus, even a premium support model is unlikely to eliminate churning entirely.

A fourth approach is the Basic Health Program, an option under the ACA that enables states to combine their Medicaid expansions with Marketplace subsidies into a single program for individuals and families with incomes of up to 200 percent of poverty. This option has been estimated to reduce churning by 4–5 percentage points per year and to push the churning point to a higher income level, where employer-sponsored coverage is more likely to be an option.[5] However, the impact of the Basic Health Program on churning depends on the population affected and assumptions made about who will sign up for coverage.[5,12,23] In any case, the option will not be available until at least 2015: CMS has not yet issued regulations on

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how the Basic Health Program will work.

A fifth option relates to how and when income changes are verified. Previous research has found that some Medicaid churning is the result of administrative errors or misunderstandings of the application process by beneficiaries when they attempt to reenroll.[24,25] This suggests that using state administrative data to verify eligibility might produce errors. Safeguards such as automatically continuing eligibility for an extra three months or until the next period of open enrollment for the Marketplace could help minimize inappropriate changes in coverage and reduce unnecessary reenrollments.[26] Similarly, integrating Marketplace and Medicaid eligibility determination could help eliminate the possibility of gaps in coverage associated with changes in eligibility. Unfortunately, many states using the federal Marketplace do not plan to allow it to determine people's eligibility for Medicaid, which will increase the risk of bureaucratic delays.

Finally, a state option that combines enrollment and marketing strategies is to encourage certified Medicaid managed care plans to enter state Marketplaces. In recent months it has become clear that a number of companies with historic roots in Medicaid managed care have decided to pursue such certification because they realize that their members will experience income fluctuations and thus might have disruptions in coverage and care. The use of multimarket plans could promote continuity of coverage. However, states will need to ensure that Medicaid managed care plans have adequate financial reserves before allowing them to sell coverage in the Marketplace.

The "bridge plan" option created by CMS in 2012 is essentially a partial version of the multimarket plan strategy.[27] It allows plans to operate in both markets under limited circumstances, such as covering only people who have experienced a change in eligibility in the previous year.

Conclusion

Our findings add to a growing body of literature that documents the potential for changes in eligibility for health insurance coverage among low-income families under the ACA. In particular, our study demonstrates that if all fifty states and the District of Columbia were to expand Medicaid under the ACA, a substantial number of people in every state would experience income changes over the course of a year that would change their eligibility for Medicaid or the subsidized health plans sold in the Marketplaces.

Eligibility changes are likely to be a major challenge for every state as implementation of the ACA continues.

We found that higher-income states might be particularly prone to churning between Medicaid and plans sold in the Marketplaces, but the differences between higher- and lower-income states were small. The implication is that eligibility changes are likely to be a major challenge for every state as implementation of the ACA continues. Of course, the disruptions in care resulting from churning are even more serious in states that are not expanding Medicaid in 2014: Those states will have large gaps in eligibility for many low-income adults whose incomes will be too high for Medicaid but too low for tax credits.

Large government programs such as Social Security, Medicare, Medicaid, and the Children's Health Insurance Program typically do not start operating with all of their policies already perfectly tuned. The transition issues raised here will require attention in the coming years, and our key conclusion is that every state will need to address them.

Fortunately, during the past two years an increasing number of feasible policy options have emerged that could mitigate the effects of such changes in eligibility. State officials should consider using these options to reduce inefficient transitions that are a by-product of multiple pathways to insurance and fluctuating incomes. Reducing such churning will greatly increase the likelihood of stable coverage and improved quality of care under the Affordable Care Act. ■

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State Health Reform Assistance Network
Charting the Road to Coverage

TOOLKIT
April 2014

Network Adequacy Planning Tool for States

Prepared by the ***Center on Health Insurance Reforms, Georgetown University Health Policy Institute***

The Affordable Care Act (ACA) includes certain requirements relating to the adequacy of provider networks developed by health insurers to deliver covered services to their enrollees. The requirements provide broad parameters within which insurance regulators and other state officials responsible for network adequacy must evaluate the networks of Qualified Health Plans (QHPs) operating in their markets. A U.S. Department of Health and Human Services (HHS) regulation on minimum network adequacy standards requires QHPs to establish networks that:

- Include essential community providers (340B providers and other providers serving medically underserved populations);
- Are sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and
- Are consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act (PHS), a provision that allows network plans to limit coverage to its eligible enrollees and to limit enrollment to the network's maximum capacity.[1]

Despite these parameters, once the federal and state marketplaces became operational, complaints started to surface about narrow networks that offered consumers little choice among providers. In some states, a limited number of plan offerings, combined with the narrow networks offered by the plans, leave entire delivery systems (hospitals and related primary and specialty care providers) out of the marketplace offerings, a frustrating development for those consumers who prefer receiving care from the eliminated providers. In response to these and other network-related complaints, HHS has proposed a new rule[2] that imposes a more rigorous review of network adequacy in the Federally Facilitated Marketplace, an approach that was outlined in the 2015 Letter to Issuers in the Federally Facilitated Marketplaces.[3]

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

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The Health Policy Institute is a multidisciplinary group of faculty and staff dedicated to conducting research on key issues in health policy and health services research. A team of research professors at the institute (supported by the RWJF State Network) are working with states, providing technical assistance focused on implementation of the private market reforms and exchanges under the Affordable Care Act. For more information on the Health Policy Institute, visit *http://ihcrp.georgetown.edu/*.

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For more information, please contact David Cusano at dc1025@georgetown.edu or 202.687.4940.

[1] 45 CFR 156.230(a)
[2] CMS-9949-P Patient Protection and Affordable Care Act, *Exchange and Insurance Market Standards for 2015 and Beyond,* http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf
[3] Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *2015 Letter to Issuers in the Federally Facilitated Marketplaces*, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

Another response to the ACA requirements and the marketplace developments is the heightened attention state regulators are paying to their current network adequacy standards and their plans to revise them to address the new requirements and related problems. To assist with that effort, the *State Health Reform Assistance Network* team at Georgetown has developed a planning tool for states to use when analyzing and updating their network adequacy standards.

The Network Adequacy Planning Tool below is divided into 10 sections; each section represents a category of considerations to be addressed when developing network adequacy standards. The categories are:

- Reasonable access;
- Choice;
- Availability;
- Continuity of care;
- Essential Community Providers (ECPs);
- Multi-tiered plans;
- Narrow network plans;
- Nondiscrimination;
- Transparency; and
- Filing requirements.

An eleventh section is reserved for any formulae that states may want to include in their network adequacy standards, and includes a link to the Medicare Advantage network adequacy formula.

Within each category, three columns provide a planning structure. In the first column are lists of considerations for each category. For example, considerations in the "Transparency" category are provider directory standards, disclosure standards, and balance billing standards (to address issues related to billing by out-of-network providers). The "Narrow Networks" category prompts regulators to consider how they will identify narrow networks and whether they will regulate them differently.

In the next column is a menu of regulatory options for states to consider when formulating standards within a particular category. The list is not intended to be exhaustive and the planning tool will be updated periodically as new ideas and information become available. State officials may also want to add regulatory options that might meet their state's specific needs.

As regulatory options are considered and selected for each category, they can be listed in the last column, titled "Selections." States can then convert their regulatory option selections to a network adequacy checklist for use when reviewing insurer network submissions.

As noted, the Network Adequacy Planning Tool is not intended to be all-inclusive or to present every regulatory option available to regulators who are revisiting their network adequacy standards. It is, however, designed to present an overview of the task and frame the critical thinking and discussion that will result in comprehensive standards that meet the needs of today's health insurance issuers and consumers.

Network Adequacy Planning Tool for States

	Considerations	Regulatory Options	Selections
Reasonable Access	Standard for assuring that the following are available within issuer's service area: • Sufficient in total number of practitioners and facilities • Sufficient in types of practitioners and facilities	1) Minimum # of providers a) Based on population density b) Based on a formula (See "Formula") 2) Maximum mileage standard for each provider type a) ___% of network must meet standard b) Entire network must meet standard or rural and urban standards 3) Required minimum number *or* percentage of hospitals 4) Define and require inclusion of Centers of Excellence for certain conditions (e.g., transplants) 5) Define and require inclusion of certain specialty facilities (e.g., advanced trauma units) 6) Explore regulation of insurer formularies to assure patient access to certain pharmaceuticals 7) Require issuers to demonstrate that all network providers are actively accepting new patients at the time of open enrollment a) Require issuers to include a provision in provider contracts requiring providers to give issuer ____ weeks' notice before discontinuing accepting new patients	*[EXAMPLE: 1)a), 3), 4)]*
	MONITORING OPTIONS: Self report, GeoAccess or alternative software, test formula		
Choice	Standard for assuring that the following are available within issuer's service area: • A comprehensive range of primary, specialty, institutional, and ancillary services are readily available at reasonable times to all enrollees • Each enrollee has adequate choice among each type of health care provider	1) Minimum numbers of providers by type a) Based on population density b) Based on a formula (See "Formula") 2) Minimum ratio of providers to insured - by specialty 3) Minimum percentage of each specialty available in service area 4) Minimum number *or* percentage of hospitals	
	MONITORING OPTIONS: Self-report, review of provider lists against enrollee numbers by specialty and service area		

Availability	Standard for assuring: • Services are accessible in a timely manner appropriate for enrollee's condition • Services are accessible with no unreasonable delay	1) Require 24/7 call availability 2) Prescribe maximum mileage standards (See "Reasonable Access") 3) For routine and urgent care a) Require minimum number of hours open for appointments b) Require maximum timeframe until next available appointment, specific to provider type c) Require maximum waiting room times, specific to provider type 4) Provide a special enrollment for enrollees who a) Choose a plan based on a provider who is listed as accepting new patients b) Later learns provider is not accepting new patients	
	Standard to assure availability of emergency care	1) Require emergency services to be accessible 24/7 without unreasonable delay 2) Prescribe maximum mileage standards (See "Reasonable Access") 3) Require 24/7 call availability 4) Require a minimum number of emergency facilities a) By mileage standards b) By % of available facilities 5) Prescribe maximum wait times 6) Require a process for transitioning from out-of-network emergency care to in-network emergency care	
	MONITORING OPTIONS: Self-report**,** secret shopper, consumer complaints		
Continuity of Care	Standards for assuring: • Accommodation of individuals who are in an active course of treatment for a serious disease by a non-network provider • Accommodation of individuals who are in an active course of treatment for a serious disease by a network provider who has been terminated • Accommodation of individuals with specific complex chronic conditions needing secondary or tertiary specialty care not included in the network	1) Define diseases or conditions to which strategy applies 2) Define length of time for which standard applies, e.g., 30, 60, 90 days 3) Require in-network (or lowest cost tier) coverage level while the individual is in the course of treatment 4) Require issuer to enter into limited benefit agreements at in-network coverage levels for those with specific complex chronic diseases	

	MONITORING OPTIONS: Self-report (filing of continuity of care policies and processes), consumer complaints, market conduct examinations		
Essential Community Providers (ECPs)	Standard to assure sufficient number and geographic distribution of ECPs	1) Providers defined as 340B providers 2) Prescribe % of ECPs required to be contracted with: a) 30% new CMS proposed guidance (current guidance is 20%, or 10% with narrative justification) 3) Prescribed minimum % of ECPs in the service area 4) Prescribe minimum % of ECPs in each ECP category 5) Based on number of available ECP providers a) Minimum ratio of ECP primary care providers (PCPs)/specialty care providers (SCPs)/Facilities to: i) Anticipated/actual low-income and/or medically underserved individuals; or ii) Minimum % of Medicaid/CHIP, uninsured, and/or low-income (below 250% FPL) individuals in patient mix	
	MONITORING OPTIONS: Self-reports that compare ECPs in area with provider list, consumer complaints, market conduct examinations		
Multi-Tiered Plans	Standard specific to multi-tiered plans	1) Require the lowest price tier to meet standards 2) Require the combined tiers to meet standards 3) Require each tier to meet standards	
	MONITORING OPTIONS: Self-report, consumer complaints, market conduct examinations, filing of network criteria for various tiers (see "Transparency – narrow networks")		
Narrow Network Plans	Standard for identifying and regulating narrow networks	1) Determine a definition for "narrow networks" 2) For networks that meet definition a) Require *full* disclosure of *all* criteria used to select network providers b) Require *full* disclosure of selection process 3) Require issuer to establish and disclose an appeals procedure for providers who were not selected for the network 4) Require issuers offering narrow networks to offer alternative plans a) Offer a broad network program at each metal level b) Offer a plan with less out-of-network cost-sharing at each metal level 5) Require the issuer to disclose whether the narrow network is tied to quality improvement and care management; and to submit an annual certification that the two types of activities were completed 6) Require issuers offering a plan that meets the definition of a narrow network to also offer a plan that either: 1) has a broader network (to be defined by state); or 2) has less out-of-network cost-sharing at each metal level at which a narrow network plan is offered	
	MONITORING OPTIONS: Require the filing and review of disclosures in #2 and #5 with forms for review. As part of form review, comparison of criteria with provider network, consumer complaints.		

Nondiscrimination	Standards to assure that networks do not discriminate in design: • Based on gender, gender preference, national origin, sex, family structure, ethnicity, race, employment status, or socioeconomic status • Based on health or disability status	1) Review specialist lists for inclusion (or absence) of appropriate number of specialists and facilities treating expensive conditions (e.g., oncologists, hematologists, federally designated hemophilia treatment centers) 2) Explore utilization of software to test for discrimination	
	MONITORING OPTIONS: Conduct review in #1 as part form review, market conduct examinations		
Transparency	Standard for assuring provider directory transparency	1) Require provider directory to be available electronically on website and in hard copy, by request a) Primary and specialty care physicians i) Location and contact information ii) Education/board certification iii) Languages spoken iv) New patient acceptance status b) Hospitals and other facilities c) Interactive map on website with provider locations by type 2) Service area map on website showing network a) Click on provider location to see: i) Location and contact information ii) Education/board Certification iii) Languages spoken iv) New patient acceptance status 3) Require updates monthly, weekly… 4) Require updates in real time 5) Provide a special enrollment for enrollees who choose a provider listed as accepting new patients and later learn he/she is not accepting (See “Availability”)	
	Standard for disclosures	1) Clear, concise disclosures stating the limits of the network, e.g., # or name of hospitals and out-of-network cost-sharing and balance billing possibilities a) Prominently displayed on web page where provider list appears, or at top of each page of hard copy 2) Narrow network disclosures (See “Narrow Networks”) 3) Require providers to notify members and the insurer of any change in ownership, affiliation, or contractual arrangement that may result in increased financial liability to members of the insurer as a result of such change a) Require providers to use disclosure template provided by issuers when issuing the notification to members	

	Standards for balance billing	1) Prohibit balance billing from institutional providers (anesthesia, lab, ER physicians, etc.) not listed in the provider directory 2) Require insurers to hold consumers harmless for all services provided in in-network hospitals 3) If not prohibited, require clear, concise disclosures of the possibility of balance billing by institutional providers with the provider directory hospital listing	
	MONITORING OPTIONS: Self-report, secret shopper, consumer complaints**,** form review filing of disclosures		
Filing Requirements	Documentation issuers are required to file to ensure their networks meet the network adequacy standards	1) Access plan 2) Alternative plan with justification, if standards are not met 3) Quarterly reports 4) Complete provider lists, including a) Location and contact information b) Education/board certification c) Languages spoken d) New patient acceptance status e) Provider quality metrics 5) Provider maps (See "Transparency") 6) Narrow network disclosures (See "Narrow Networks") 7) Items listed in "Monitoring Options" sections	
Formula	EXAMPLE: Medicare Advantage Formula - Used to establish criteria for: • Minimum number of providers • Maximum travel distance to providers • Maximum travel time to providers	Medicare Advantage Network Adequacy Formula	

UC BERKELEY LABOR CENTER

Policy Brief

UC Berkeley Center for Labor Research and Education

April 2014

POLICY BRIEF

The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal

by Miranda Dietz, Dave Graham-Squire, and Ken Jacobs

Funding for this brief was provided by The California Endowment

Introduction

Projections for enrollment in the new insurance options created under the Affordable Care Act (ACA) are often point-in-time estimates. But just as people frequently move in and out of being uninsured, insurance coverage through Covered California (California's health insurance marketplace) or through Medi-Cal is dynamic and can change for an individual over the course of a year.

This churn in enrollment is important to understand and predict. In order to maximize the number of insured Californians, Covered California will need to reach individuals who become eligible for coverage between open enrollment periods. Understanding the extent and nature of churn can help in planning for ongoing enrollment, ensuring smooth health coverage transitions and continuity of care, and reducing uninsurance.

Methodology

The California Simulation of Insurance Markets (CalSIM) model version 1.7 provides a demographic profile of the California non-elderly population with household income at or below 138 percent of the Federal Poverty Level (FPL) projected to be enrolled in Medi-Cal in 2019,[1] and the non-elderly population with household income between 139 and 400 percent of FPL projected to be enrolled with subsidies through Covered California in 2019. This analysis uses the longitudinal Survey of Income and Program Participation (SIPP) and calibrates the population in the 2004-05 and 2008-09 panels to match the demographics of the two groups predicted by CalSIM. Following each cohort across 12 months and observing changes in income, take up of employer sponsored insurance (ESI), and loss of insurance recorded in the SIPP, the analysis predicts the share of those originally enrolled who will remain in the same type of coverage at the end of the 12 months. The odds of becoming uninsured are adjusted to account for policy changes under the ACA.[2] In this analysis, we assume that the chance of Covered California enrollees becoming uninsured is

[1] Children in households with income at or below 266 percent of FPL are eligible for Medi-Cal, but only those in households with income at or below 138 percent were included in this analysis.

[2] These policy changes include the minimum essential coverage requirement (the individual mandate), the provision of advanced premium tax credits (subsidies) and cost-sharing subsidies to make individual coverage more affordable, and streamlined enrollment and renewal processes.

reduced by 90 percent (from chance of becoming uninsured without the ACA) under a stronger retention scenario and 50 percent under a weaker retention scenario. We further assume that no Medi-Cal enrollees who continue to be eligible will drop their coverage to become uninsured.

Results

Table 1 shows how many of those initially eligible for and enrolled in Medi-Cal will remain eligible over the course of the year, how many will become eligible for coverage with subsidies through Covered California, and how many will leave for employer-sponsored insurance (ESI).

These estimates assume that Medi-Cal enrollees become eligible for Covered California only if their incomes fall within 139-400 percent FPL for two consecutive months and final annual income exceeds 138 percent FPL. As mentioned above, they also assume "perfect re-enrollment" where no one eligible for benefits leaves Medi-Cal to become uninsured. This assumption is unlikely to hold in reality; despite the fact that Medi-Cal does not require premium payments, there will no doubt be people who remain eligible but for various reasons will not be re-enrolled. This analysis does not estimate the extent of those re-enrollment challenges and can therefore be considered a best-case scenario for churn in Medi-Cal.

Table 1: For individuals enrolled in Medi-Cal, share staying in Medi-Cal, becoming eligible for subsidies through Covered CA, or leaving for job-based coverage within 12 months[i]

Enrollees with household income at or below 138 percent FPL

Stay in Medi-Cal	74.5%
Income increases, eligible for Covered California	16.5%
Leave for job-based coverage	9.1%
Total	100%

Table 2 shows how many of those initially eligible for and enrolled with subsidies through Covered California will take up Medi-Cal or other public coverage over the course of the year, how many will leave for ESI, and how many become uninsured.

These estimates are calculated using two scenarios: stronger retention and weaker retention (see methodology for more details). The results under both scenarios are similar and do not appear to be very sensitive to these retention assumptions.

Table 2. For individuals enrolled in Covered California receiving subsidies, share staying in Covered California, leaving for other coverage, or becoming uninsured within 12 months[ii]

	Stronger retention scenario	Weaker retention scenario
Stay in Covered California	57.5%	53.3%
Take Up Medi-Cal / Public Coverage	21.3%	20.5%
Leave for job-based coverage	19.0%	18.3%
Become Uninsured	2.2%	7.9%
Total	100%	100%

This analysis focuses on a given *cohort* of enrollees—those who are enrolled at a given point in time—and follows them throughout 12 months. We predict that a significant portion of any given cohort of Medi-Cal (25.5 percent) or subsidized Covered California (42.5 to 46.7 percent) enrollees will have a short period of enrollment (lasting less than 12 months). People who are short-term enrollees will leave and join throughout the year. If we were to look at those who were *ever* enrolled in one of these programs over the course of the year (instead of focusing on a particular cohort that is enrolled at a point in time), we would see that an even higher share are short-term enrollees.[3]

[3] To see why, imagine the following simplified scenario: 100 people are enrolled in Covered California in January, and 57 of those original 100 are still enrolled in January of the following year. Imagine that the population enrolled stays steady at 100 because take up in the population generally is not changing. Imagine further that all short-term enrollees stay for exactly 4 months. Thus, in May 43 people leave and 43 new people join. The same thing happens in September. Looking over the course of the year 100+43+43=186 people were ever enrolled; 57 of them (31 percent) were enrolled for the whole year, and 129 (69 percent) were short-term enrollees.

Discussion

For a given cohort of enrollees in Medi-Cal with household income at or below 138 percent FPL, about three-quarters (74.5 percent) are expected to remain enrolled in Medi-Cal after 12 months, while one in six (16.5 percent) are expected to experience income increases that will make them eligible for Covered California. Because Medi-Cal is such a significant program in California, the percentage who become eligible for Covered California amounts to a relatively large number of individuals.

Administrative redetermination hurdles were a significant source of churn in Medi-Cal before the ACA.[iii] Because redetermination will happen every 12 months instead of every 6 months and will be more automated under the ACA, we should expect a somewhat more stable Medi-Cal population. National SIPP analysis from 2001 suggests that prior to the ACA, 55 percent of a cohort of Medicaid enrollees were enrolled for the entire year,[iv] a smaller share than we predict in California in 2019 under the ACA. California administrative data indicate that churn prior to the ACA varied by eligibility category. Of the approximately 1.4 million Californians enrolled in Medi-Cal as CalWORKS recipients, 77 percent were continuously enrolled for a year or more; 52 percent of the low-income families not enrolled in CalWORKs remained for at least a year.[v] Administrative data also reveal that a significant share of Medi-Cal enrollees—6 percent of those ever enrolled throughout the year—currently experience a gap in coverage of less than a year.[4] This short-term loss of coverage is more likely to be the result of an administrative glitch than a true change in eligibility, and is thus a good target for increasing coverage stability in the population. *Effective implementation of the changes aimed at streamlining the redetermination processes is required for the stability of the Medi-Cal population to actually increase.*

For a given cohort of enrollees with subsidies in Covered California, a little over half (53.3 to 57.5 percent) are expected to remain in that coverage for the entire year. This is roughly similar to the share remaining in the nongroup market nationally without the ACA. According to Kaiser Family Foundation analysis of the national SIPP in 2010-2011, of those who had only nongroup coverage in January 2010, 56 percent still had only nongroup coverage in December of 2010.[vi] Prior to the ACA, purchasers on the nongroup market could be rejected for pre-existing conditions and did not have a centralized online marketplace to compare plans. The ACA provides subsidies to some consumers to increase plan affordability, and mandates that individuals have health insurance coverage for at least nine months of the year or face a tax penalty. All these changes should encourage enrollment both among those who expect to be in the marketplace for long periods of time as well as people who expect to have a different form of coverage within 12 months.

Enrollment in Medi-Cal and Covered California will be dynamic as Californians move in and out of coverage and change coverage sources. This policy brief predicts a significant level of churn out of Medi-Cal and Covered California each year. Approximately one-fifth of the cohort of Covered California enrollees are expected to transition to public coverage such as Medi-Cal, and another fifth are expected to transition to employer-sponsored coverage.

At the same time, Californians will be newly enrolling in Medi-Cal during the year. Many individuals will enroll in Covered California during special enrollment periods,[vii] as they experience certain triggering events which make them eligible for enrollment outside of the regular enrollment periods. Triggering events are often but not always changes in life circumstances including losing job-based coverage, getting married or having a child, or moving into a new service area.[viii] *Consequently, it will be vital for the enrollment infrastructure—from outreach, to the website, to in-person and call-center assistance—to be available and active even outside of open enrollment periods.*

Changes in eligibility do not guarantee enrollment. The risk of becoming uninsured during the kinds of life transitions that precipitate such changes in eligibility are well documented. Job loss or change, divorce or widowhood, aging out, disability, and moving are all associated with loss of insurance.[ix] *Making sure that people successfully transition from one type of insurance to another will depend not only on the ease of enrollment, but also the extent to which Covered California and Medi-Cal take advantage of*

[4] Note that this estimate is not a cohort analysis, but is a share of those ever enrolled over the course of a year. This analysis used only select aid codes in Medi-Cal, meant to approximate those who will be eligible under Modified Adjusted Gross Income (MAGI) rules under the ACA. DHCS Research and Analytical Studies Division, "Continuity in Medi-Cal Eligibility (Churn in Population) Pivot Table." Fiscal Year 2010-2011. Available online at www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Medi-Cal_Enrollment_Trends.aspx.

existing institutional points of connection to people undergoing these life transitions, e.g., COBRA notices or government services like unemployment, CalFresh (food stamps), or the Department of Motor Vehicles.

Bouts of uninsurance are known to have negative health consequences. The uninsured have higher mortality overall,[x] and are more likely to go without care.[xi] Those who are not continuously insured underutilize preventive care, and have been found to use more care when they do become insured.[xii] *It will be important that outreach, enrollment assistance, and effective sign up processes are available throughout the year for Medi-Cal and for those who experience life transitions that qualify them for mid-year enrollment in Covered California.*

ENDNOTES

[i] Analysis performed by Elise Gould, Economic Policy Institute and Dave Graham-Squire, UC Berkeley Labor Center.

[ii] *Ibid.*

[iii] Benjamin D. Sommers, "Loss of Health Insurance Among Non-elderly Adults in Medicaid." *Journal of General Internal Medicine*. Volume 24, Number 1 (2009): p. 1-7.

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[v] California HealthCare Foundation, "Medi-Cal Facts and Figures: A Program Transforms." May 2013. California Health Care Almanac.

[vi] Gary Claxton, Larry Levitt, Anthony Damico, and Matthew Rae, "How Many People Have Nongroup Health Insurance?" December 2013. Kaiser Family Foundation.

[vii] For more on this issue, see Rick Curtis and John Graves, "Open Enrollment Season Marks the Beginning (Not the End) of Exchange Enrollment." November 26, 2013. *Health Affairs* Blog.

[viii] For a partial list of triggering events see: https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/. California state law goes beyond federal regulations to include additional triggering events that make individuals eligible for a special enrollment period in Covered California or the individual market. California Insurance Code 10965.3 (d) and Health and Safety Code 1399.849(d).

[ix] Ken Jacobs, Laurel Lucia, Ann O'Leary, and Ann Marie Marciarille, "Maximizing Health Care Enrollment through Seamless Coverage for Families in Transition: Current Trends and Policy Implications." March 2011. University of California, Berkeley Center for Labor Research and Education and Center for Health, Economic and Family Security.

[x] Andrew P. Wilper, S. Woolhandler, K.E. Lasser, D. McCormick, D.H. Bor, and D.U. Himmelstein, "Health Insurance and Mortality in U.S. Adults," *American Journal of Public Health*, Volume 99, Number 12 (2009): p. 2289-2295.

[xi] Michelle M. Doty, S.D. Rustgi, C. Schoen, and S.R. Collins, "Maintaining Health Insurance During a Recession: Likely COBRA Eligibility," The Commonwealth Fund Issue Brief, January 2009.

[xii] Joseph Sudano and David Baker, "Intermittent Lack of Health Insurance Coverage and Use of Preventive Services," *American Journal of Public Health*, Volume 93, Number 1 (2003): p. 130-137; and J. Michael McWilliams, E. Meara, A.M. Zaslavsky, and J.Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *The New England Journal of Medicine*, Volume 357 (2007): p. 143-53.

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Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

A children's health policy blog
CCF - Center For Children and Families / All / Recommendations to Strengthen Navigator and Assister Programs
Welcome to Say Ahhh! a health care policy blog by Georgetown University's Center for Children and Families. Our policy experts have their fingers on the pulse of what's happening on health care coverage for children and families. Our experience is diverse, our perspectives unique, our mission united.

Recommendations to Strengthen Navigator and Assister Programs

April 07, 2014
Tricia Brooks
Affordable Care Act : Outreach and Enrollment / All

Hats off to navigators and certified application counselors (CACs) across the country who persevered through the rocky rollout of the marketplaces and helped create the late surge that put enrollment over the top. There is much yet to be learned as we reflect back on open enrollment, but we already know there is much that can be done to strengthen and enhance the navigator and CAC programs.

As a starting point, CMS recently proposed a set of regulations that would provide relief from over-reaching state navigator laws that prevent navigators and assisters from fulfilling their duties as required by the Affordable Care Act. Comments on these regulations are due April 21.

Recently, my colleagues at the Asian Pacific Islander American Health Forum, Center on Budget and Policy Priorities, Community Catalyst, Enroll America, Families USA, National Health Law Program and I put our heads together to identify strategies and priorities to enhance the work of navigators and other assisters. We summarized these in a letter to Secretary Sebelius and CCIIO administrators with detailed recommendations to:

1. Refine the navigator federal grant application and award process.
2. Strengthen the infrastructure that supports assisters.
3. Enhance training and continuing education.

The big ask, of course, is for more funding to boost consumer assistance. The grants awarded to navigators and community health centers in 34 states where the federal government runs the marketplace was barely more than twice the combined total that California and New York allocated for consumer assistance funding. In all states that operate a state-based or partnership marketplace, considerably more resources were available for outreach

and consumer assistance than in states served by the federal marketplace (FFM). Notably, none of the 12 states showing Medicaid/CHIP enrollment gains of between 10% and 35% were FFM states.

Regardless of how much funding is allotted to support navigator grantees over the next year, there are a number of strategies that would enable navigators and assisters to maximize the number of consumers who can be helped effectively with limited federal dollars:

- Grants should be awarded to organizations that can coordinate the consumer assistance effort in a state or region to ensure that resources are directed at the places and populations most in need. Investing in this level of coordination and oversight minimizes duplication and ensures a holistic approach to assistance across the state or region.
- Navigators should be allowed to provide assistance over the phone, after obtaining written authorization from the consumer. Phone assistance will save time and help ensure that more individuals complete the enrollment or renewal process.
- A unit of system and policy experts should be dedicated to support navigators and assisters. Assisters often have more experience and expertise than call center personnel. Dedicating an expert unit to support them will advance problem resolution and troubleshooting of systemic issues.
- A dedicated assister web portal will enable Navigators and CACs to efficiently provide application assistance, while enabling the marketplace to track enrollment by assister and more readily manage its oversight responsibilities.

The letter to Secretary Sebelius dives more deeply into these priorities and other recommendations, and suggests additional training that would broaden the knowledge of assisters.

The next open enrollment period will likely be much smoother, but marketplaces will also be processing the first round of renewals for more than 7 million people. And if enrollees didn't like the plan they picked, they will be looking for more help in comparing plans. Equally important, long-time uninsured consumers need help in using their insurance because the ultimate test of the ACA will be whether people are able to access the health care they need and find value in their coverage.

Throughout open enrollment, focus groups and surveys of applicants and the uninsured highlight the direct connection between consumer assistance and enrollment success. Just as marketing and customer service are critical to the ongoing success of a business, so is consumer assistance to achieving the vision of health reform.

Categories: Outreach and Enrollment , All
Tags: navigators

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America's Underinsured

A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions

Cathy Schoen, Susan L. Hayes, Sara R. Collins, Jacob A. Lippa, and David C. Radley

March 2014

THE COMMONWEALTH FUND

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

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The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

America's Underinsured

A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions

Cathy Schoen, Susan L. Hayes, Sara R. Collins,
Jacob A. Lippa, and David C. Radley

March 2014

ABSTRACT

The Affordable Care Act insurance reforms seek to expand coverage and to improve the affordability of care and premiums. Before the implementation of the major reforms, data from U.S. census surveys indicated nearly 32 million insured people under age 65 were in households spending a high share of their income on medical care. Adding these "underinsured" people to the estimated 47.3 million uninsured, the state share of the population at risk for not being able to afford care ranged from 14 percent in Massachusetts to 36 percent to 38 percent in Idaho, Florida, Nevada, New Mexico, and Texas. Nationally, more than half of people with low incomes and 20 percent of those with middle incomes were either underinsured or uninsured in 2012. The report provides state baselines to assess changes in coverage and affordability and compare states as insurance expansions and market reforms are implemented.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new Fund publications when they become available, visit the Fund's website and register to receive email alerts. Commonwealth Fund pub. no. 1736.

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EXECUTIVE SUMMARY

The United States is in the midst of the most significant health insurance expansion and market reforms since Medicare and Medicaid were enacted in 1965. The Affordable Care Act aims to insure millions of people without health care coverage and make medical care and premiums more affordable with coverage. Enrollment began in October 2013; major coverage reforms started in January 2014.

The twin goals of health insurance are to enable affordable access to health care and to alleviate financial burdens when injured or sick. It is well known that the uninsured are at high risk of forgoing needed care and of struggling to pay medical bills when they cannot postpone care. Studies further find that insured people who are poorly protected based on their households' out-of-pocket costs for medical care are also at risk of not being able to afford to be sick.

Using newly available data from census surveys, this report provides national and state-level estimates of the number of people and share of the population that were insured but living in households that spent a high share of annual income on medical care in 2011–12. In the analysis, we refer to these people as "underinsured." However, this group is only one subset of the underinsured. Our estimates do not include insured people who needed care but went without it because of the out-of-pocket costs they would incur, or the insured who stayed healthy during the year but whose health insurance would have exposed them to high medical costs had they needed and sought care.

The analysis finds that in 2012, there were 31.7 million insured people under age 65 who were underinsured. Together with the 47.3 million who were uninsured, this means at least 79 million people were at risk for not being able to afford needed care before the major reforms of the Affordable Care Act took hold.

At the state level, the percentage of the under-65 population who were either uninsured or underinsured ranged from 14 percent in Massachusetts to 36 percent to 38 percent in the five highest-rate states—Idaho, Florida, Nevada, New Mexico and Texas (Exhibit ES-1).

In all states, people with low incomes are at greatest risk for being underinsured or uninsured. Nationally, in 2012, nearly two-thirds (63%) of those with incomes below the federal poverty level were either underinsured or uninsured. Among those with incomes between 100 percent and 199 percent of poverty, nearly half (47%) were underinsured or uninsured.

A decade or more of people losing health coverage and a steady erosion in the financial protection of insurance has also put middle-income families at risk. In 2012, one of five people (20%) under age 65 with middle incomes (between 200% and 399% of poverty)—an estimated 15.6 million people—were either underinsured or had no health insurance. The share of middle-income people who were underinsured or uninsured reached highs of 28 percent to 31 percent in Texas, Alaska, and Wyoming.

Historically, states with high uninsured rates have had lower rates of job-based insurance and more restrictive Medicaid eligibility and often high rates of poverty, making it more difficult to expand coverage from state resources alone. To overcome these historic barriers, insurance reforms provide for federal subsidies to reduce premium costs and out-of-pocket medical costs for eligible low- and middle-income families who buy plans through the new state-based insurance marketplaces. Federal resources also support expanding state Medicaid programs to

Exhibit ES-1. Summary Highlights: National and State-Level Estimates, Under-65 Population

	PEOPLE	PERCENT OF POPULATION		
	Millions 2012	National 2012	Lowest state	Highest state
Total: Insured but underinsured* or uninsured	**79.0**	**29.5%**	**14%**	**38%**
Insured but underinsured	31.7	11.8%	8%	17%
Uninsured	47.3	17.7%	4%	27%
Premiums exceed ACA thresholds**	29.2	10.9%	7%	14%

* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
** Affordable Care Act (ACA) thresholds refers to the maximum premium contribution as a share of income in marketplaces or Medicaid.
Data source: March 2012 and 2013 Current Population Surveys.

citizens and legal residents with incomes near or below poverty.

For those eligible to participate, income-related tax credits for premiums and Medicaid will limit the share of income individuals and families are required to contribute toward their premiums. Using newly available census data on out-of-pocket premium costs compared with incomes, we estimate that 29 million insured people were in households that spent more on premiums as a share of income in 2012 than the new premium contribution limits set by the Affordable Care Act for those eligible for subsidized coverage. Across states, the share of the population paying high premiums relative to their incomes ranged from 8 percent to 17 percent of the insured. Although only a portion of those with high-premiums compared to income (an estimated 11 million) will be eligible to participate in expanded Medicaid or to receive premium assistance for plans purchased in the marketplaces, the state level estimates provide a baseline to assess changes in premiums affordability relative to income over time.

The impact of insurance expansions on coverage, premium, and out-of-pocket costs for medical care will depend critically on state decisions regarding Medicaid. Income eligibility levels for premium tax credits start at 100 percent of poverty, with the law designed to expand Medicaid to cover people with incomes up to 138 percent of poverty. As of yet, 24 states have opted not to expand their Medicaid programs to 138 percent of poverty. Of these states, only Wisconsin will cover adults up to the federal poverty level. An estimated 15.2 million people who are either uninsured or underinsured who have incomes below poverty live in the 23 states where Medicaid eligibility for adults is well below poverty. Although some may be ineligible based on immigration status and others may be eligible under current Medicaid but not yet signed up, unless these states participate in the Medicaid expansion, there will be no new subsidized coverage option for these people since their income is too low to qualify for premium assistance.

State-level data indicate the law's income-related reforms are well-targeted to help people with incomes in ranges that put them at greatest risk for being either uninsured or underinsured. The Affordable Care Act thus has the potential to reduce high medical care cost burdens while also covering the uninsured. However, the extent of improvement

will critically depend on state decisions and the plans people select.

To the extent the law's coverage provisions reach low- and middle-income families who are uninsured or underinsured, we may change the access and affordability map of the country. However, this will depend on states seizing the opportunity to invest and use new federal resources well, combined with effective oversight of private insurance plans.

The number of uninsured declined by nearly 2 million from 2010 to 2012 following implementation of early Affordable Care Act reforms, including expansion of coverage to young adults. National surveys in 2013 and early 2014 indicate further decline in the number of uninsured, providing continuing positive news. As of March 2014, 5 million people had selected a plan through the new marketplaces and 10.3 million adults and children had been determined eligible for Medicaid and the Children's Health Insurance Program (CHIP). With reforms to ensure more comprehensive benefits, there is the potential to improve affordability across states.

For the first time, the nation has committed resources with the goal of achieving near-universal coverage with financial protection to ensure care as well as insurance is affordable. These are ambitious goals given the wide geographic gaps in coverage and affordability evident before reforms took hold. This report provides state-by-state baseline data to assess changes in coverage and affordability and compare states as reforms are implemented.

INTRODUCTION

The United States is in the midst of the most significant health insurance expansion and market reforms since Medicare and Medicaid were enacted in 1965. Aiming to expand coverage and make medical care and premiums more affordable, the Affordable Care Act major coverage expansions and market reforms commenced in January 2014.

The twin goals of health insurance are to enable affordable access to health care and to alleviate financial burdens when injured or sick. It is well known that the uninsured are at high risk of forgoing needed care and of struggling to pay medical bills when they cannot postpone care. Studies further find that insured people who are poorly protected based on their households' out-of-pocket costs for medical care are also at risk of not being able to afford to be sick.

Using newly available data from census surveys on out-of-pocket costs for medical care, this report provides national and state-level estimates of the number of people and share of the population that were insured but living in households that spent a high share of annual income on medical care in 2011–12. In the analysis, we refer to these people as "underinsured." Adding the underinsured to people uninsured, this report provides estimates of the share of each state's population at risk of not being able to afford care before major insurance expansions and reforms

We also analyze the share of each state's under-65 population that were paying a high share of their family income on premiums before major reforms. The report thus provides state baseline data to assess changes in coverage and affordability and to compare states as reforms are implemented.

HOW THIS STUDY WAS CONDUCTED

The report draws on data from the U.S. Census Bureau's Current Population Surveys (CPS) for 2012 and 2013. Historically, the CPS has tracked health insurance coverage to allow for estimates of the uninsured in all states. Starting in 2010, the survey added questions about out-of-pocket spending for medical care and premiums. In the analysis we used this newly available data to estimate the number of insured people under age 65 who were in families (including single-person households) that paid a high share of their annual income on medical care, indicating they were "underinsured."

Building on earlier studies,[1] we used two thresholds to identify people who were insured with high medical-cost burden: people with insurance in households that spent 10 percent or more of total income on medical care (not including premiums); or 5 percent or more, if annual income was less than 200 percent of poverty. We refer to these people as "underinsured."[2] Our earlier work also included insured people with deductibles that were high relative to family incomes, since they had great potential financial risk even if they did not incur high medical costs during the year. This information is not available in the CPS survey: thus the estimate of people who are insured yet underinsured is a more conservative estimate and a subset of the at-risk population.

We also estimated the number of insured people who paid a relatively high share of their incomes on premiums. To do this, we compare the amount spent on premiums relative to incomes to threshold limits for premium tax credits or Medicaid set by the Affordable Care Act. This provides an estimate of the number of people who spent more on premiums as a share of incomes than

they might have if they were eligible for subsidized coverage or Medicaid.[3]

We profile national and state-level estimates for four income groups using poverty thresholds:

- below poverty: annual income of less than $11,490 if single; less than $23,550 for a family of four in 2013;
- low income: 100 percent to 199 percent of poverty—annual income of $11,490 to less than $22,980 if single; $23,550 to less than $47,100 for a family of four in 2013;
- middle income: 200 percent to 399 percent of poverty—annual income of $22,980 to less than $45,960 if single; $47,100 to less than $94,200 for a family of four in 2013;
- higher income: 400 percent of poverty or more—annual income at or above $45,960 if single and at or above $94,200 for a family of four in 2013.

Nationally, and in many states, these groups represent the bottom (poor and low income), middle and top one-third of the income distribution for the under-65 population. Tables 1 and 2 provide national and state total populations and income distributions.

In the analysis, we report national-level estimates for 2012, which are the most recent CPS data available. To ensure adequate sample size, state-level estimates use an average of two years, 2011–2012 (March 2012 and 2013 CPS). The tables at the end of the report provide details by state for the estimated number of people (and percent of the state population) who are uninsured, underinsured, or paying premiums that are high relative to their income.

FINDINGS

Nearly 32 Million People Underinsured: Insured but Spent High Share of Income on Medical Care

In 2012, 42.5 million people under age 65 spent a high share of their income on medical costs, not including insurance premiums.[4] Of these, 31.7 million were insured yet underinsured, based on the costs they or their families incurred for medical care relative to their incomes.[5] Overall, about one of eight (12%) of the under-65 population were underinsured, putting them at risk of going without needed care or for incurring medical bill problems and debt (Exhibit 1 and Table 1).

From 2010 to 2012, following early Affordable Care Act reforms that expanded coverage to young adults, the number of uninsured declined by nearly 2 million (Exhibit 1). However, during this same time period, the estimated number of people who were insured but underinsured grew from 29.9 million to 31.7 million, nearly offsetting the gain in coverage. As a result, in 2012, before the launch of major insurance reforms, 79 million

Exhibit 1. Uninsured or Underinsured: National Trends, Under-65 Population

	MILLIONS 2010	MILLIONS 2011	MILLIONS 2012	PERCENT OF POPULATION
Uninsured	49.2	47.9	47.3	17.7%
Insured but underinsured	29.9	30.6	31.7	11.8%
Total: Insured but underinsured* or uninsured	79.1	78.5	79.0	29.5%

* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2011, 2012, and 2013 Current Population Surveys.

people were either underinsured (31.7 million) or uninsured (47.3 million)—nearly 30 percent of the under-65 population.

Nationally, half of the estimated 32 million underinsured people had incomes below 100 percent of poverty; nearly one-third (9.7 million people) had incomes between 100 percent and 199 percent of poverty. Another 13 percent—4.2 million—were in middle-income families with incomes between 200 percent and 399 percent of poverty (Exhibit 2 and Table 4).

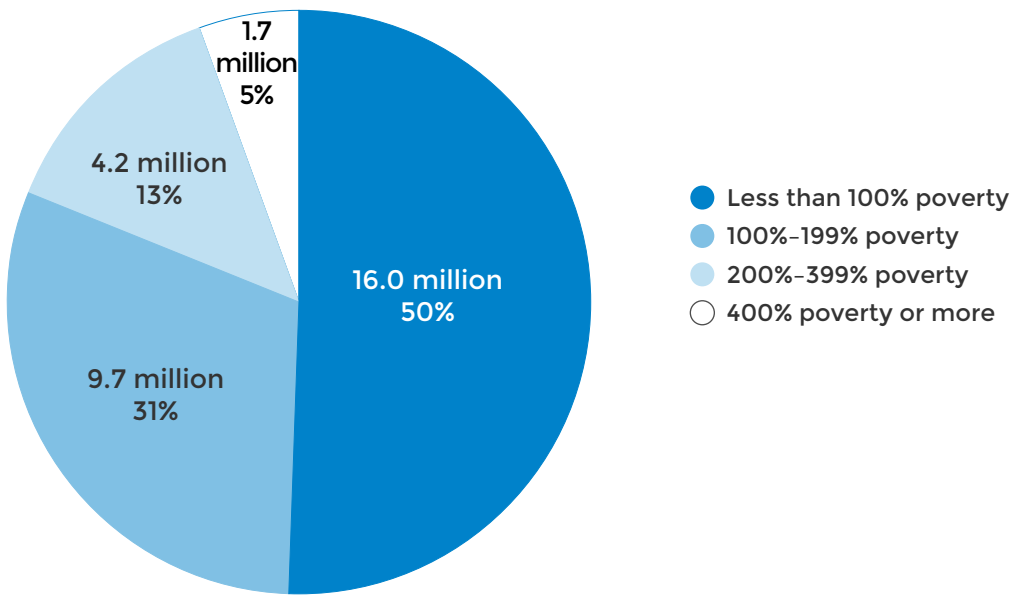
Wide State Differences in the Share of Population Underinsured or Uninsured

The percent of states' under-65 population who were insured but underinsured ranged more than two-fold across states: from a low of 8 percent in New Hampshire to highs of 16 percent to 17 percent in Tennessee, Mississippi, Utah, and Idaho (Exhibit 3 and Table 3).

Nationally, nearly one of five people under age 65—47.3 million—were uninsured in 2012. The share of states' nonelderly population who were uninsured ranged from a low of 4 percent in Massachusetts to a high of 27 percent in Texas (Table 3). Combining estimates of the underinsured and uninsured, the share of people at risk of not being able to afford care before the launch of the Affordable Care Act's major coverage reforms ranged from a low of 14 percent in Massachusetts to highs of 36 percent to 38 percent in Idaho, Florida, Nevada, New Mexico, and Texas (Exhibit 4 and Table 3).

There is a distinct regional pattern: several of the states with the lowest rates of uninsured or underinsured were in the Northeast (Massachusetts, Connecticut, Vermont, and New Hampshire) or upper Midwest (Minnesota, North Dakota). States with the highest rates were in the South and West

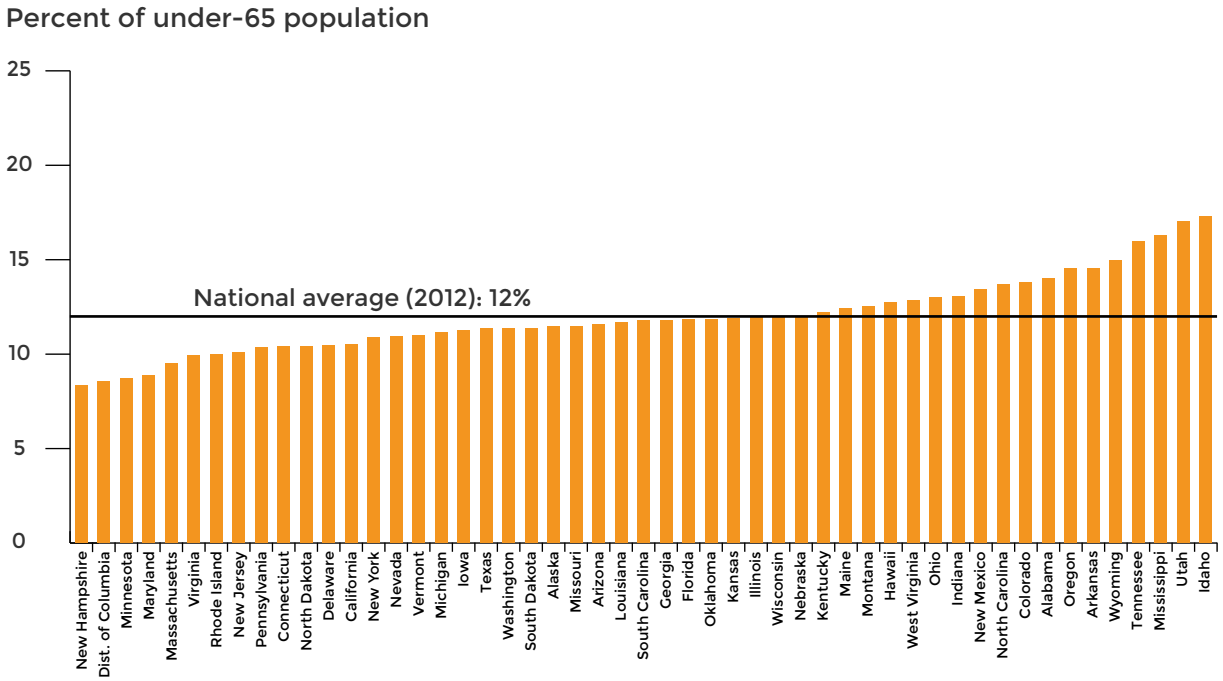
Exhibit 2. Distribution of Underinsured by Poverty, Under-65 Population, 2012



Note: Sum of percentages or people may not equal total because of rounding.
* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2013 Current Population Survey.

Exhibit 3. Underinsured by State, 2011–2012

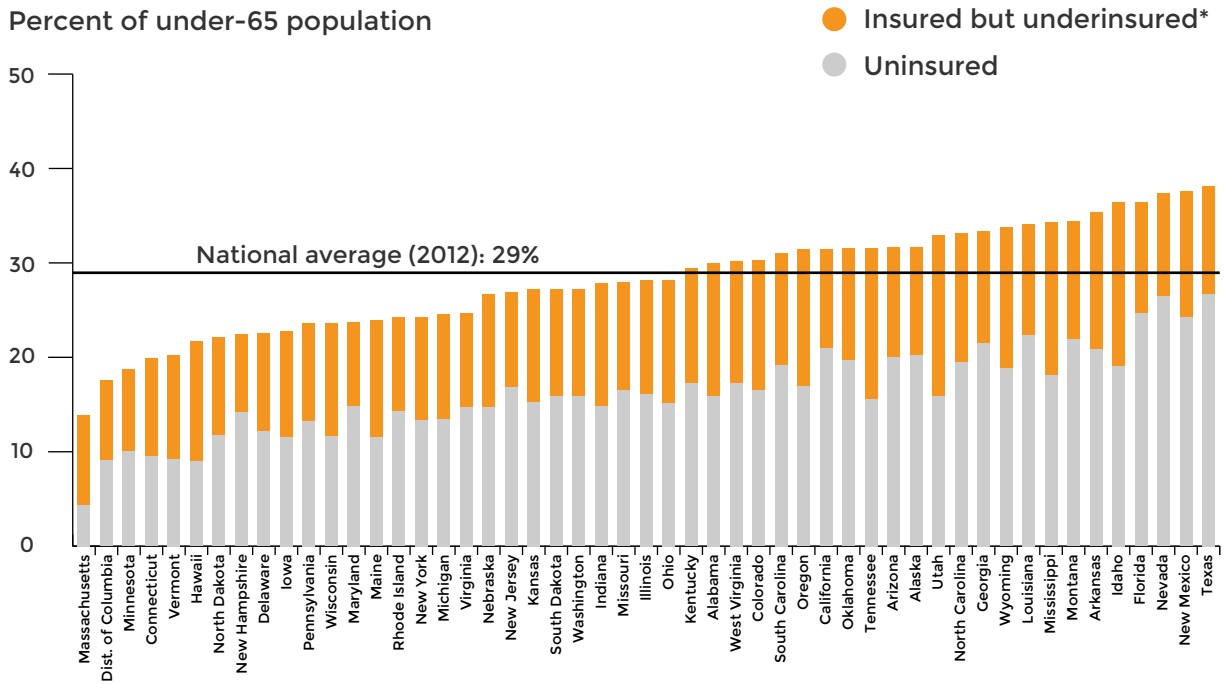
Ranges from 8 percent to 17 percent of population



Note: Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2012–2013 Current Population Survey (states: two-year average).

Exhibit 4. Underinsured or Uninsured by State, 2011–2012

Ranges from 14 percent to 38 percent of population



* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2012–2013 Current Population Survey (states: two-year average).

(Montana, Arkansas, Idaho, Florida, Nevada, New Mexico and Texas). Four states (Massachusetts, Minnesota, Connecticut, North Dakota) and the District of Columbia stand out for having uninsured and underinsured rates that were relatively low compared with other states (Table 3).

Low- and Middle-Income Households Most at Risk

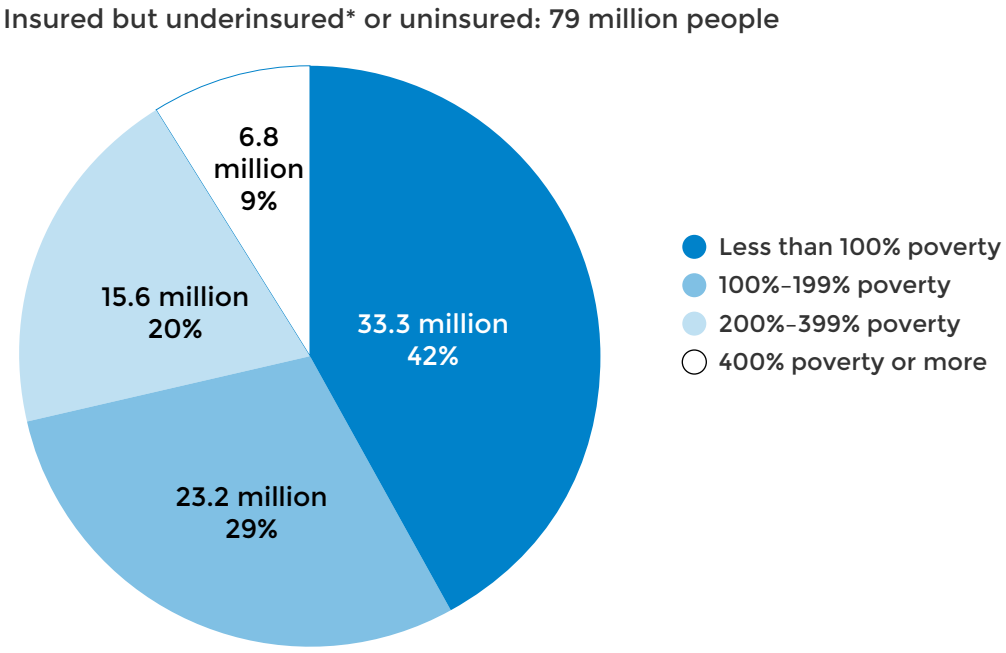
The vast majority of the 79 million uninsured or underinsured—more than nine of 10—had incomes below 400 percent of poverty (Exhibit 5 and Table 6). More than two of five (33.3 million) had incomes below poverty.

People living in low- or middle-income households are most at risk of being either uninsured or insured but poorly protected. Nationally, nearly two-thirds (63%) of those with incomes below poverty were either underinsured or uninsured in 2012 (Exhibit 6). At the state level, with the exception of Massachusetts, Delaware, and the District of Columbia, at least half of the poorest residents of states either had no health insurance or were underinsured (Table 6). In Nevada and Utah, at least three-quarters of residents with incomes below poverty were uninsured or underinsured.

Among people with incomes near poverty (100% to 199% of poverty), nearly half (47%) were uninsured or underinsured. Across states, this ranged from a low of 30 percent or less in Massachusetts, Hawaii, and the District of Columbia to highs of 55 percent to 56 percent in Idaho and Texas (Table 6).

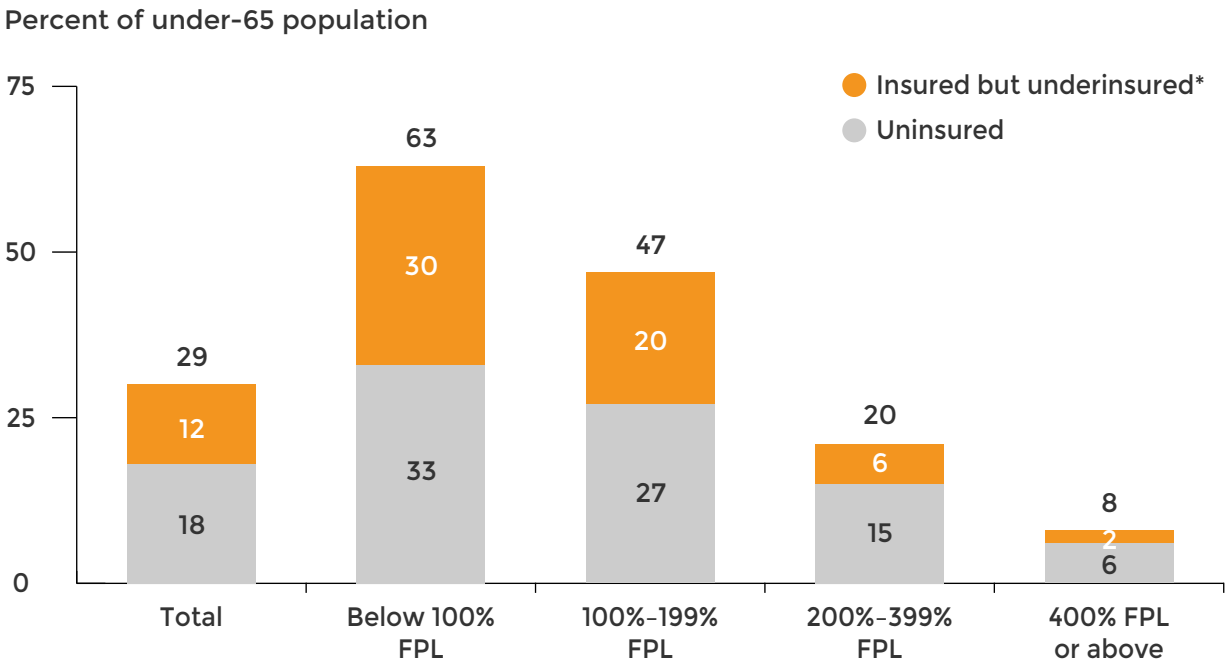
Reflecting the ongoing erosion of coverage, 20 percent of people with middle-class incomes (200% to 399% of poverty) were also uninsured or underinsured in 2012. This amounts to an estimated 15.6 million people with incomes well above

Exhibit 5. Distribution of Underinsured or Uninsured by Poverty, Under-65 Population, 2012



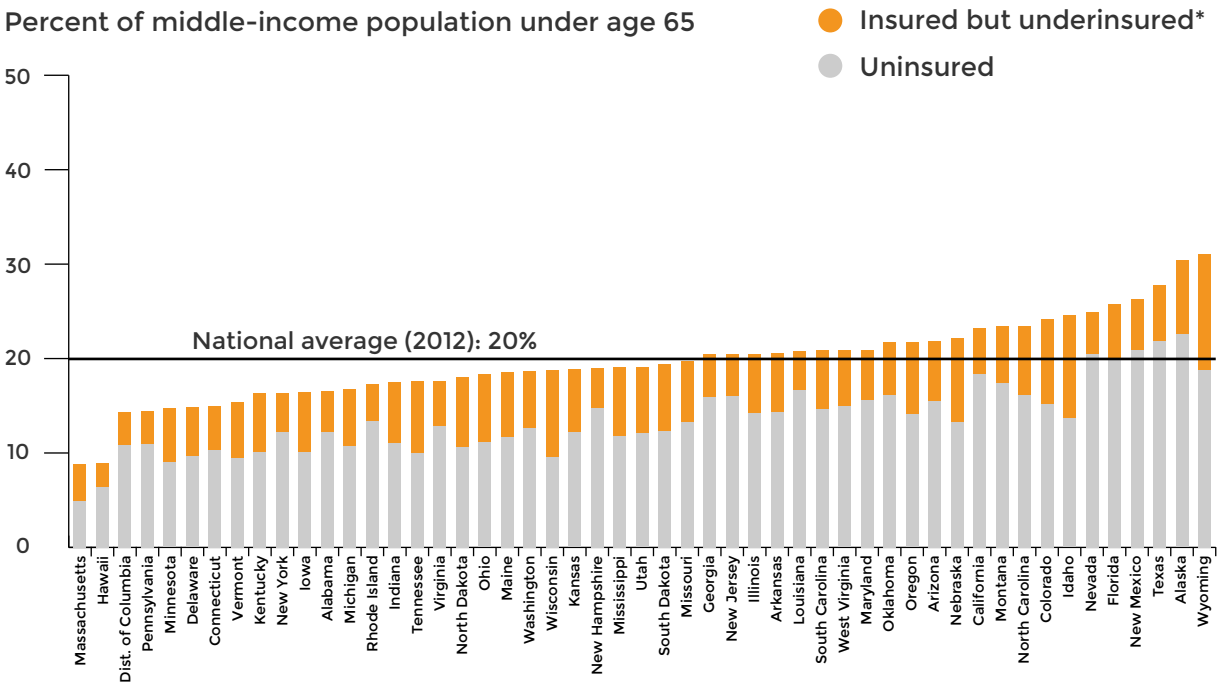
* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2013 Current Population Survey.

Exhibit 6. At Risk: 79 Million Uninsured or Underinsured, 2012



Notes: FPL = federal poverty level. Percentages may not sum to total because of rounding.
* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2013 Current Population Survey.

Exhibit 7. Middle-Income Uninsured or Underinsured by State, 2011-2012



Note: Middle income = 200% to 399% of poverty.
* Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2012–2013 Current Population Survey (states: two-year average).

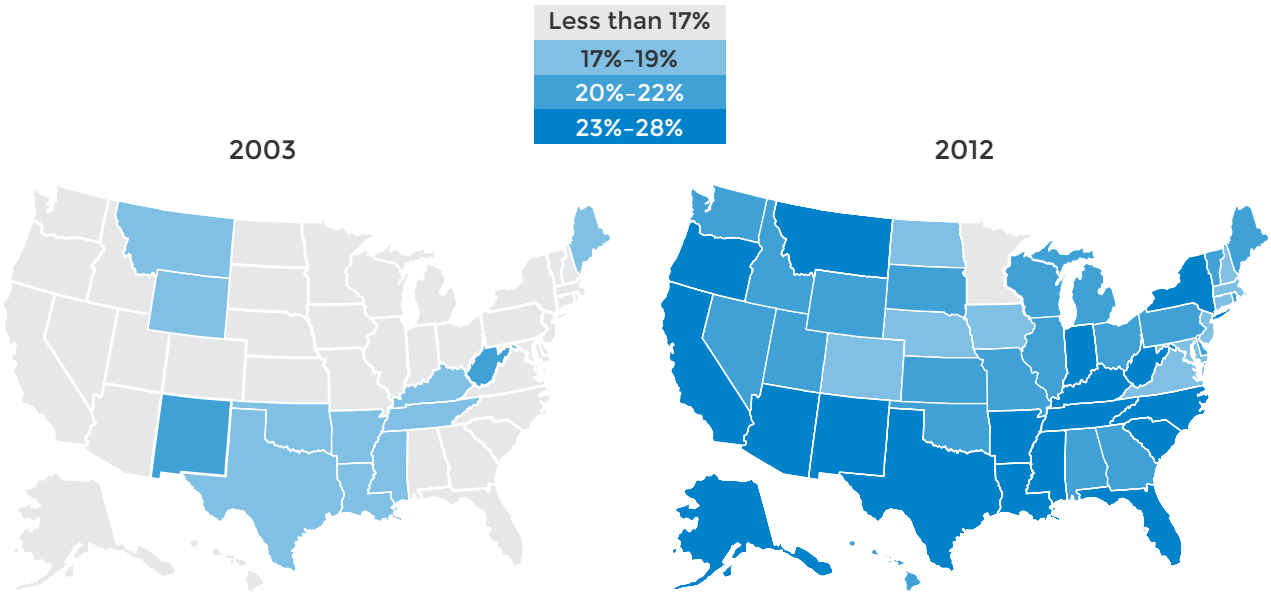
poverty who were either uninsured or insured but incurring medical bills that were high relative to their incomes.

Combining the numbers of uninsured and underinsured, the percent of states' middle-income population at risk of not being able to afford care ranged from 9 percent in Hawaii and Massachusetts to highs of 28 percent to 31 percent in Texas, Alaska and Wyoming. In seven states—Idaho, Nevada, Florida, New Mexico, Texas, Alaska, and Wyoming—at least one of four middle-income residents were uninsured or insured but poorly protected (Exhibit 7 and Table 6).

The exposure to high out-of-pocket medical care costs even when people have insurance reflects insurance trends—including higher deductibles and cost-sharing, as well as gaps in benefits or limits on coverage—in both the employer and individual insurance markets.[6] This puts insured families at risk in terms of access to health care and financial well-being. Studies indicate that low- and middle-income insured individuals and families who face high out-of-pocket costs for medical care relative to their incomes are nearly as likely as the uninsured population to go without care because of costs, forgo care when sick, struggle to pay medical bills, or incur medical debt.[7] Both population groups—underinsured and uninsured—are at far higher risk of access or medical bill concerns than those with more protective coverage.

In all states, people with higher incomes—at or above 400 percent of poverty—have more protective coverage. The combined share of the states' higher-income population who were uninsured or underinsured before reforms ranged from 3 percent in Massachusetts to 13 percent in Alaska and Wyoming (Table 6).

Exhibit 8. Total Premiums for Employer-Sponsored Insurance Rise Sharply as Share of Median Income for Under-65 Population, 2003 and 2012



Note: Premiums include employer and employee shares.
Data sources: 2003, 2012 Medical Expenditure Panel Survey–Insurance Component; March 2004 and March 2013 Current Population Surveys for median income.

Premiums for Employer-Sponsored Insurance Have Risen More Rapidly Than Incomes, Value of Benefits Declined

Over the past decade, the cost of health insurance has risen far faster than incomes for middle- and low-income working-age families. Nationally by 2012, average annual premiums for employer-sponsored health insurance (including the employer and employee share) equaled about 22 percent of median household income for the under-65 population, up from 15 percent in 2003. In each state, average premiums were a greater share of median income in 2012 than they were in 2003 (Exhibit 8 and Table 7).

Maps detailing these changes reveal the starkly altered landscape. In 2003, in three-fourths of the states, the average premiums for employer-sponsored health insurance amounted to less than 17 percent of state median incomes. In all but two states, premiums as a share of median state incomes were below 20 percent. By 2012, average premiums were at least 17 percent of median incomes in all but one state, Minnesota, and 23 percent to 28 percent of median income in 18 states, including the four most populous: California, Texas, New York, and Florida.

At the same time that premiums have risen, the value of benefits has declined. Deductibles more than doubled for plans provided by larger and small employers.[8] This increase—plus other cost-sharing or limits on benefits—has left insured patients paying a higher share of medical bills. With little or no growth in incomes over a decade, insurance and care have become less affordable.

MAJOR INSURANCE AND MARKET REFORMS

Responding to widespread concerns about access to care and affordability, the Affordable Care Act seeks to expand and improve insurance coverage with subsidies aimed to reach those with low or middle incomes. In October 2013, enrollment opened for the Affordable Care Act's new coverage options that commenced in 2014 with the joint goals of expanding coverage and making insurance and care more affordable. The law's major insurance reforms include three main provisions: 1) expansion of Medicaid eligibility to people with incomes up to 138 percent of poverty; 2) income-related tax credits to reduce the cost of premiums for people with incomes between 100 percent and 399 percent of poverty who are eligible to purchase plans through state-based insurance marketplaces; and 3) lower cost-sharing for people with low or modest incomes who are eligible for Medicaid or to participate in the new insurance marketplaces. In addition, insurance market reforms effective in January 2014 set new standards for insurance and established new market rules that prohibit turning people away or charging them more because of health status or gender. Market reforms also limit the amount insurers can charge based on enrollees' age, limit annual out-of-pocket costs, and require plans to include essential benefits.[9]

Medicaid and Income-Related Premium Assistance

The Affordable Care Act provides federal support to expand Medicaid for all citizens and legal residents with incomes up to 138 percent of the federal poverty level. This represents a significant expansion of the program for adults. Before reform, in most states, nondisabled adults without children were not eligible for Medicaid regardless of income level, and

the income eligibility thresholds for parents were well below poverty.[10] The expansion is fully funded by the federal government through 2016 with the federal share declining to 90 percent by 2020.[11]

People with incomes between 100 percent and 400 percent of poverty can receive tax credits to help pay insurance premiums if they do not have access to public insurance or an affordable employer-based plan.[12] For those eligible, tax credits will cap premium costs at 2 percent to 9.5 percent of annual income, relative to various thresholds of the federal poverty level (Exhibit 9).

The premium assistance and Medicaid expansion have the potential to lower costs for many low- and middle-income individuals and families who have insurance and expand coverage to people who do not. Using newly available information on out-of-pocket payments for premiums, we estimate that 29 million insured people—11 percent of the total under-age-65 population and 13 percent of the insured population under age 65—paid premiums that exceeded the Affordable Care Act premium contribution thresholds for those at their household income level before reforms (Table 8). In other words, they had high premium out-of-pocket costs compared with incomes, with "high" defined as in excess of Affordable Care Act contribution thresholds.

Across states, the share of the insured population paying high premiums relative to income in 2011–12 ranged from an estimated 8 percent to 17 percent (Exhibit 10). Table 8 provides baseline estimates by state for the number of insured people in households paying a high share of their incomes on premiums before the implementation of reforms. In the larger states, this amounts to millions of people. For example, an estimated 3.1 million insured in California, 2.3 million in Texas, 1.9 million in

Exhibit 9. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

FPL	INCOME	PREMIUM CONTRIBUTION AS A SHARE OF INCOME	OUT-OF-POCKET LIMITS	ACTUARIAL VALUE: IF IN SILVER PLAN
<100%	S: <$11,490 F: <$23,550	0% (Medicaid)	$0 (Medicaid)	100% (Medicaid)
100%–137%	S: $11,490 – <$15,856 F: $23,550 – <$32,499	2%, or 0% if Medicaid		94%
138%–149%	S: $15,856 – <$17,235 F: $32,499 – <$35,325	3.0%–4.0%	S: $2,250 F: $4,500	94%
150%–199%	S: $17,235 – <$22,980 F: $35,325 – <$47,100	4.0%–6.3%		87%
200%–249%	S: $22,980 – <$28,725 F: $47,100 – <$58,875	6.3%–8.05%	S: $5,200 F: $10,400	73%
250%–299%	S: $28,725 – <$34,470 F: $58,875 – <$70,650	8.05%–9.5%		70%
300%–399%	S: $34,470 – <$45,960 F: $70,650 – <$94,200	9.5%	S: $6,350 F: $12,700	70%
400%+	S: $45,960+ F: $94,200+	—		—

Four levels of cost-sharing: Bronze: actuarial value 60% Silver: actuarial value 70%
Gold: actuarial value 80% Platinum: actuarial value 90%

Note: FPL refers to federal poverty level as of 2013. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan. Out-of-pocket limits for 2014.
Source: Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

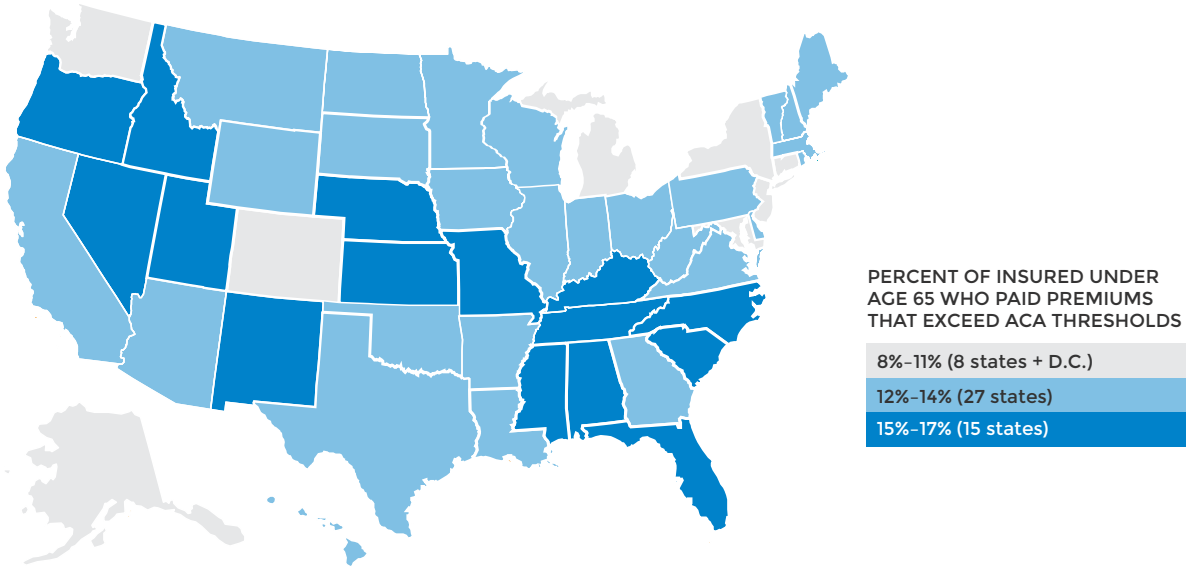
Florida, and 1.6 million in New York paid a high share of income on premiums.

However, not everyone who pays high premiums relative to income will be eligible for help. The 29 million insured people includes 13.7 million with incomes below 138 percent of poverty who are paying premiums above the Affordable CareAct thresholds for this group. Of these, 8.8 million had private insurance they bought on their own or through employers (Table 9). Based on their income alone, they would likely be eligible for expanded Medicaid if their state decides to participate in Medicaid expansions.

For those with incomes above Medicaid eligibility, the law restricts eligibility for premium assistance in marketplaces to people buying insurance on their own and to workers who have employer coverage where the employee's premium costs for self-only coverage exceeds 9.5 percent of income. Among the 29 million insured with high premium costs in 2012, 11.7 million had employer-sponsored coverage and incomes that would be too high to qualify for expanded Medicaid.[13] Only a portion of this group will be eligible for premium assistance. In addition, those who are employed by small employers may benefit from insurance market reforms and the small business marketplaces that may yield more affordable options for some of those businesses. Another 2.2 million with high-premium costs and incomes above Medicaid levels bought insurance on their own.[14] All would likely be eligible for premium assistance (Table 9).

The baseline data on premiums relative to incomes indicate that if all states participate in Medicaid expansions, at least 11 million insured people with high premiums compared with incomes could receive premium help based on their income alone.[15]

Exhibit 10. Twenty-Nine Million Insured Paid Premiums in Excess of Affordable Care Act Thresholds, 2011–2012



Note: Affordable Care Act thresholds refers to the maximum premium contribution as a share of income in marketplaces or Medicaid if eligible to participate.
Data source: March 2012–2013 Current Population Survey (states: two-year average).

Medicaid Expansion Makes a Critical Difference

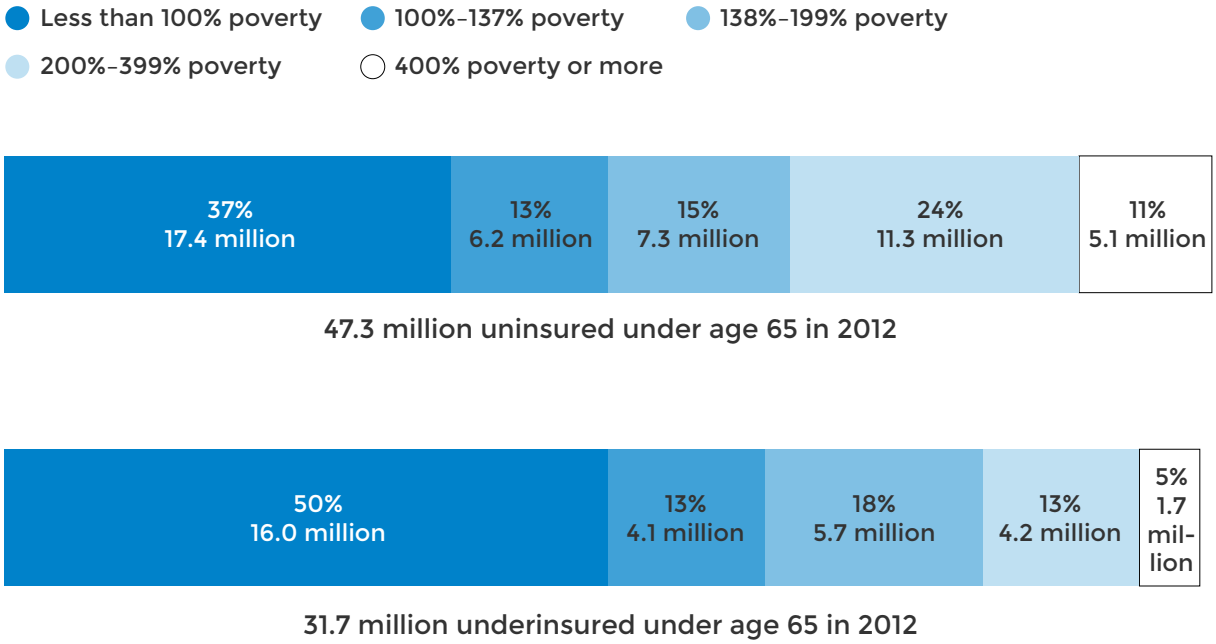
As originally enacted, the insurance reforms expanded Medicaid to people with incomes up to 138 percent of poverty in all states to ensure that low-income individuals and families would have access to comprehensive coverage with little or no premiums or cost-sharing.[16] As Exhibit 11 illustrates, a substantial share of the uninsured and underinsured have incomes within the range to qualify for expanded Medicaid. An estimated 23.6 million uninsured—half of the total 47.3 million uninsured—had incomes below 138 percent of poverty in 2012. Of the 31.7 million underinsured—nearly two-thirds, or 20.1 million—had incomes below the new Medicaid threshold.

In June 2012, the Supreme Court ruled that state participation in Medicaid is optional. As of March 2014, 26 states plus the District of Columbia have chosen to participate in the Medicaid expansion and 24 states have either said they are not expanding or had not yet decided to expand Medicaid to 138 percent of poverty (Exhibit 12).[17] Of the states that have not yet decided to participate, only Wisconsin will provide Medicaid up to the federal poverty level for childless, nondisabled adults.[18]

The law was written assuming that all states would participate in the Medicaid expansion. Therefore, premium assistance in the marketplaces will be available only to people with incomes of at least 100 percent of poverty. In states that do not expand Medicaid, those with income below poverty will have no new options available.

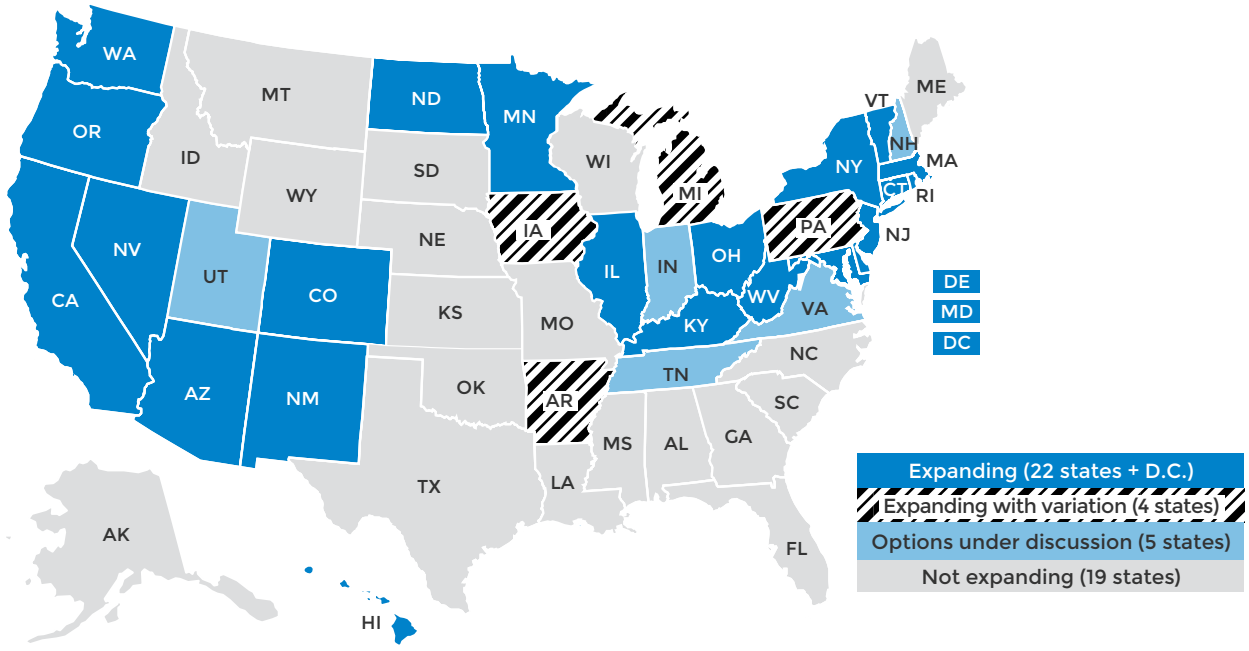
Based on the most recent census data, 15.2 million uninsured or underinsured people with incomes below poverty live in the 23 states (excluding Wisconsin) where existing Medicaid eligibility

Exhibit 11. Distribution of Uninsured or Underinsured by Poverty, 2012



Notes: Percentages may not add to 100% because of rounding. Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2013 Current Population Survey.

Exhibit 12. Status of State Participation in Medicaid Expansion, as of March 2014



Note: The Centers for Medicare and Medicaid Services (CMS) has approved waivers for expansion with variation in Arkansas, Iowa, and Michigan. Pennsylvania's waiver is currently under review by CMS.
Source: Avalere, *State Reform Insights;* Center on Budget and Policy Priorities; Politico.com; Commonwealth Fund analysis.

standards exclude childless, nondisabled adults and where income eligibility levels are often well below poverty for adults with dependent children. Only four of these states have Medicaid income eligibility for parents at or above the poverty level—Alaska, Maine, Tennessee, and Wisconsin.[19] Some of the uninsured or underinsured poor in these states may be ineligible for Medicaid based on immigration status and others may be eligible under current Medicaid or the Children's Health Insurance Program (CHIP) but not yet signed up.[20] However, unless these states decide to participate in the expansion, the poorest residents will have no new insurance options available to them.

Excluding Wisconsin, an estimated 3.5 million of the insured poor who paid premiums live in states that are not participating in the Medicaid expansion (Table 10). They will not be newly eligible for Medicaid nor premium assistance through tax credits.

Many of the states not participating in Medicaid expansion have among the highest rates of uninsured or underinsured people as a share of their total state populations. Without Medicaid expansion, this vulnerable group will remain at high risk for access, health, and financial problems.

Income-Related Reduced Cost-Sharing and New Market Standards

The health plans available in the new marketplaces are required to provide essential health benefits, including preventive care and other benefits typically covered in employer plans. Insurers must offer these benefits in four categories, or "metal tiers," based on the percentage of medical costs covered: bronze (covering an average of 60% of a person's

annual medical costs), silver (70% of costs), gold (80% of costs), and platinum (90% of costs).[21]

People with incomes below 250 percent of poverty who select silver plans are also eligible for cost-sharing subsidies that increase the amount of medical costs covered by their plan, thereby lowering the amount they have to spend out-of-pocket on deductibles, copayments, and coinsurance. However, people must enroll in silver plans in order to receive this benefit (Exhibit 9). These provisions could help reduce the number of underinsured people to the extent that those who were uninsured or underinsured before reforms are eligible to participate in the marketplaces and select silver plans.

The insurance market reforms also provide new protections against high out-of-pocket medical care costs. The law caps the amount people will pay out-of-pocket annually for covered medical and prescription drug benefits, with the lowest out-of-pocket limits for people with incomes below 200 percent of poverty. It also prohibits plans from imposing annual dollar limits on covered benefits. This latter provision protects the insured from simply running out of coverage. Effective this year, reforms prohibit insurers from denying or limiting coverage or charging higher premiums based on gender or poor health. These reforms potentially make premiums and health care more affordable across lifetimes.

Changing the Insurance Map of the Country

The Affordable Care Act insurance reforms were well-targeted to provide assistance to those currently uninsured or insured but poorly protected—that is, the underinsured. As Exhibit 11 illustrates, approximately two-thirds of the uninsured and four-fifths (81 percent) of the underinsured have incomes below 200 percent of poverty—the income range potentially eligible for substantial premium assistance and reduced cost-sharing. Many may also benefit from new insurance market rules that apply broadly across the country. There is the potential to reduce the number of uninsured and underinsured compared with the 2012 baseline.

Substantial gains, however, will depend on the plans people choose and state efforts to ensure high-value benefit designs and accessible networks. One concern is to what extent people with low or modest incomes will opt for "bronze" level plans. These plans may be attractive because they have the lowest premiums. For people with low incomes, tax credits may offset most or all of the out-of-pocket premium costs for these plans. However, people choosing bronze-level plans will pay 40 percent of medical care costs on average and thus remain at financial risk. Additionally, in choosing a bronze plan, people with low incomes forgo the cost-sharing subsidies that are tied to silver plans that substantially reduce out-of-pocket spending for medical care. As of February 2014, 62 percent of those enrolling in the new marketplaces selected silver plans, 19 percent had selected gold or platinum, and 19 percent had selected bronze.[22] It will be important to track the pattern of plan choices by income to assess the impact on affordability.

In addition, it is important to note that the Affordable Care Act's limits on out-of-pocket costs for covered benefits also apply only to in-network providers. As discussed in a recent report profiling insured people with medical debt, even with the new limits, the insured may encounter high medical care costs if they receive care from out-of-network clinicians.[23] This can happen even if the patient selects an in-network surgeon and hospital, if anesthesiologists or other clinicians involved in the hospital care are allowed to stay out-of-network.

CONCLUSION

If the Affordable Care Act's major coverage provisions, which went into effect in January 2014, perform near expectations, the United States will come closer to achieving near-universal coverage. By making affordable, comprehensive coverage available, the reforms have the potential to reduce the ranks of the uninsured and the insured with high cost burdens. To the extent insurance reforms achieve this potential, they will improve access to care, decrease the number of people who go without care because of costs, and reduce medical debt and struggles with unaffordable medical bills. More protective insurance could also allow for more equitable access to primary and preventive care.[24]

The major insurance reforms that began this year have the potential to change the insurance and access map of the country. The number of uninsured declined by nearly 2 million from 2010 to 2012 following implementation of early Affordable Care Act reforms, including expansion of coverage to young adults. National surveys in 2013 and early 2014 indicate further decline in the number of uninsured, providing continuing positive news. As of March 2014, 5 million people had selected a plan through the new marketplaces[25] and 10.3 million adults and children had been determined eligible for Medicaid and the Children's Health Insurance Program (CHIP).[26] With reforms to ensure more comprehensive benefits, there is the potential to improve affordability across states.

However, the new marketplaces offer plans that include substantial cost-sharing and annual caps on out-of-pocket patient costs that apply to in-network providers only. With these benefit designs, there is the risk that the nation could convert the uninsured into the underinsured and fail to stop the erosion in insurance protections for people with private insurance coverage.[27]

To assess the impact of reforms will require monitoring affordability of care for the insured as well as the number of people remaining uninsured. Preventing more people from becoming underinsured will depend on state action, oversight of insurance plans offered, and the individual choices consumers make when selecting coverage.

This report offers baseline data for states and the nation to track and assess changes over the next several years. Millions of people in low- and middle-income families stand to gain more affordable insurance and access to care if states use the new resources wisely and creatively.

NOTES

1 C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2011 30(9):1762–71. The 10 percent threshold dates back to early studies by Pamela Farley Short. The 5 percent threshold comes from the Child Health Insurance program standard for low-income families where some cost-sharing was allowed above 100 percent of poverty. We apply the 5 percent threshold to all below 200 percent—although one could argue for much lower for below poverty.

2 Analysis of the Current Population Survey data was conducted by Claudia Solis-Roman at New York University, working with Sherry Glied. Schoen and Collins developed the specifications for the high-cost burden and high premium variables.

3 Programmers at the New York University Robert F. Wagner Graduate School of Public Service conducted the analysis of Current Population Survey data using specifications provided by the authors.

4 We categorized insured individuals or insured families being underinsured if out-of-pocket costs relative to their income for medical expenses (excluding health insurance premiums) were 10 percent or more of their annual income, or 5 percent or more if their income was below 200 percent of poverty.

5 The other 10.8 million with high out-of-pocket medical care expenses compared with their incomes were uninsured.

6 C. Schoen, J. A. Lippa, S. R. Collins, and D. C. Radley, *State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore Need for Action* (New York: The Commonwealth Fund, Dec. 2012); and S. R. Collins, R. H. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013).

7 Schoen, Doty, Robertson, and Collins, "Affordable Care Act Reforms Could Reduce," 2011.

8 Schoen, Lippa, Collins, and Radley, *State Trends in Premiums and Deductibles,* 2012.

9 K. Davis, *A New Era in American Health Care: Realizing the Potential of Reform* (New York: The Commonwealth Fund, June 2010); and K. Pollitz, C. Cost, K. Lucia et al., *Medical Debt Among People with Health Insurance* (Washington, D.C.: Henry J. Kaiser Family Foundation, Jan. 2014).

10 C. Schoen, S. Hayes, and P. Riley, *The Affordable Care Act's New Tools and Resources to Improve Health and Care for Low-Income Families Across the Country* (New York: The Commonwealth Fund, Oct. 2013).

11 S. Glied and S. Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion* (New York: The Commonwealth Fund, Dec. 2013).

12 By regulations to implement the Affordable Care Act, an employer-sponsored plan is considered affordable if the portion of the annual premium an employee must pay for self-only coverage does not exceed 9.5% of the employee's household income and the plan covers at least 60 percent, on average, of medical costs. Plan affordability is based on the cost of self-only coverage regardless of whether employees have family coverage and may pay more than 9.5 percent of their income for that coverage.

13 Calculated from Table 9. The 11.7 million includes people with employer-sponsored insurance (ESI) with incomes from 138 percent to 399 percent of poverty. Only some of these people will be eligible for premium tax credits. Those with ESI with incomes below 138 percent of poverty will be eligible for Medicaid if their state takes part in the expansion.

14 The sum of those with individual coverage with incomes from 138 percent to 399 percent of poverty adds to 2.2 million when including the estimate to two decimal places; Table 9 adds to 2.1 million because of rounding.

15 See Table 9. The 11 million number includes those with employer-sponsored insurance or individual insurance under 138% poverty plus those with individual insurance with incomes from 138% poverty to 399% poverty.

[16] R. Rudowitz and L. Snyder, *Premiums and Cost-Sharing in Medicaid* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Feb. 2013); T. Jost, "Implementing Health Reform: Final Rule on Premium Tax Credit, Medicaid, and CHIP Eligibility Determinations (Part 2)," *Health Affairs Blog*, July 7, 2013; and U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment," Final Rule, *Federal Register*, July 15, 2013 (78)135:42279.

[17] Avalere, *State Reform Insights;* Center for Budget and Policy Priorities; Politico.com; and Commonwealth Fund analysis.

[18] Kaiser Commission of Medicaid and the Uninsured, *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of January 1, 2014* (Washington, D.C.: Henry J. Kaiser Family Foundation, Jan. 13, 2014); and Wisconsin Department of Health Services, "BadgerCare+ Demonstration Project Waiver," Jan. 9, 2014, www.dhs.wisconsin.gov/badgercareplus/waivers.htm.

[19] Kaiser Commission, *Where Are States Today?* 2014.

[20] Kaiser Commission on Medicaid and the Uninsured, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* (Washington, D.C.: Henry J. Kaiser Family Foundation, Oct. 23, 2013).

[21] Collins, Robertson, Garber, and Doty, *Insuring the Future*, 2013.

[22] U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Policy, *Health Insurance Marketplace: February Enrollment Report, For the Period: October 1, 2013–February 1, 2014, ASPE Issue Brief* (Washington, D.C.: ASPE, Feb. 12, 2014).

[23] Pollitz, Cost, Lucia et al., *Medical Debt Among People with Health Insurance,* 2014.

[24] S. R. Collins, R. H. Robertson, T. Garber, and M. M. Doty, *The Income Divide in Health Care: How the Affordable Care Act Will Help Restore Fairness to the U.S. Health System* (New York: The Commonwealth Fund, Feb. 2012); and C. Schoen, S. L. Hayes, J. A. Lippa, and D. C. Radley, *Insurance Matters: Primary and Preventive Care Access by State Before Major Insurance Expansions* (New York: The Commonwealth Fund, forthcoming 2014).

[25] M. Tavenner, "Marketplace Enrollment Hits 5 Million Milestone," *HHS.gov/Health Care Blog,* March 17, 2014; and U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Policy, *Health Insurance Marketplace: March Enrollment Report, For the Period: October 1, 2013–March 1, 2014, ASPE Issue Brief* (Washington, D.C.: ASPE, March 11, 2014).

[26] Centers for Medicare and Medicaid Services, *Medicaid and CHIP: January 2014 Monthly Applications and Eligibility Determinations Report* (Washington, D.C.: CMS, Feb. 28, 2014). The 10.3 million number includes the 8.9 million determined eligible through state agencies and another 1.4 million determined eligible through the federally facilitated exchanges.

[27] J. Gruber and I. Perry, *Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable?* (New York: The Commonwealth Fund, April 2011).

Table 1. National Distribution of U.S. Population Under Age 65 by Federal Poverty Level, 2012

	UNDER-65 POPULATION	
	POPULATION IN MILLIONS	PERCENT OF POPULATION GROUP
Total population under age 65	**267.7**	**100%**
<100% poverty	52.9	20%
100%–137% poverty	20.3	8%
138%–199% poverty	29.3	11%
200%–399% poverty	76.2	28%
400% poverty or more	89.1	33%
Uninsured population under age 65	**47.3**	**100%**
<100% poverty	17.4	37%
100%–137% poverty	6.2	13%
138%–199% poverty	7.3	15%
200%–399% poverty	11.3	24%
400% poverty or more	5.1	11%
Insured population under age 65 who are underinsured[a]	**31.7**	**100%**
<100% poverty	16.0	50%
100%–137% poverty	4.1	13%
138%–199% poverty	5.7	18%
200%–399% poverty	4.2	13%
400% poverty or more	1.7	5%
Insured population under age 65 with premiums that exceed ACA threshold or Medicaid[b]	**29.2**	**100%**
<100% poverty	8.1	28%
100%–137% poverty	5.6	19%
138%–199% poverty	6.5	22%
200%–399% poverty	9.0	31%
400% poverty or more	0	0%
Underinsured[a] or with premiums that exceed the ACA threshold or Medicaid[b] under age 65	**50.6**	**100%**
<100% poverty	19.3	38%
100%–137% poverty	7.7	15%
138%–199% poverty	9.7	19%
200%–399% poverty	12.1	24%
400% poverty or more	1.7	3%

Note: Sum of people and percentages in population subgroups may not equal total because of rounding.

[a] Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.

[b] Affordable Care Act (ACA) thresholds refers to the maximum premium contribution as a share of income in marketplaces or Medicaid if eligible to participate.

Data source: Analysis of March 2013 Current Population Survey (CPS).

Table 2. State Population Demographics by Federal Poverty Level, Under Age 65, 2011–2012

	UNDER-65 POPULATION								
	TOTAL	LESS THAN 100% POVERTY		100%–199% POVERTY		200%–399% POVERTY		400% POVERTY OR MORE	
State	People	People	Percent	People	Percent	People	Percent	People	Percent
United States (2012)	267,740,038	52,870,157	20%	49,599,636	19%	76,163,816	28%	89,106,429	33%
United States (2011–2012)	267,575,496	53,286,976	20%	49,448,659	18%	76,421,641	29%	88,418,220	33%
Alabama	4,150,585	865,456	21%	807,823	19%	1,242,164	30%	1,235,142	30%
Alaska	643,903	95,910	15%	105,539	16%	190,260	30%	252,194	39%
Arizona	5,689,270	1,337,661	24%	1,117,468	20%	1,582,745	28%	1,651,396	29%
Arkansas	2,451,343	590,794	24%	533,052	22%	747,682	31%	579,815	24%
California	33,389,710	7,760,875	23%	6,547,421	20%	8,543,102	26%	10,538,312	32%
Colorado	4,473,497	724,488	16%	671,523	15%	1,267,786	28%	1,809,700	40%
Connecticut	3,011,169	425,092	14%	413,529	14%	741,321	25%	1,431,227	48%
Delaware	760,994	148,053	19%	136,056	18%	216,849	28%	260,036	34%
District of Columbia	549,330	134,666	25%	70,774	13%	99,661	18%	244,229	44%
Florida	15,687,963	3,285,656	21%	3,096,387	20%	4,599,910	29%	4,706,010	30%
Georgia	8,598,462	1,990,122	23%	1,575,700	18%	2,546,942	30%	2,485,698	29%
Hawaii	1,143,348	246,812	22%	232,677	20%	327,325	29%	336,534	29%
Idaho	1,350,649	249,423	18%	327,601	24%	426,499	32%	347,126	26%
Illinois	10,984,776	2,035,642	19%	2,093,103	19%	3,014,759	27%	3,841,272	35%
Indiana	5,427,533	1,096,482	20%	1,040,346	19%	1,572,488	29%	1,718,217	32%
Iowa	2,609,741	346,733	13%	467,042	18%	893,099	34%	902,867	35%
Kansas	2,411,193	437,664	18%	448,672	19%	746,953	31%	777,904	32%
Kentucky	3,756,355	791,378	21%	776,419	21%	1,142,092	30%	1,046,466	28%
Louisiana	3,874,266	1,014,970	26%	743,493	19%	1,087,136	28%	1,028,667	27%
Maine	1,123,414	170,260	15%	197,208	18%	366,073	33%	389,873	35%
Maryland	5,094,796	722,262	14%	734,338	14%	1,338,707	26%	2,299,489	45%
Massachusetts	5,585,276	859,153	15%	752,301	13%	1,380,846	25%	2,592,976	46%
Michigan	8,258,807	1,549,186	19%	1,425,631	17%	2,308,308	28%	2,975,682	36%
Minnesota	4,598,136	566,426	12%	645,490	14%	1,387,942	30%	1,998,278	43%
Mississippi	2,512,432	650,764	26%	543,632	22%	743,450	30%	574,586	23%
Missouri	5,063,833	1,018,114	20%	872,743	17%	1,494,555	30%	1,678,421	33%
Montana	817,238	156,182	19%	167,441	20%	272,654	33%	220,961	27%
Nebraska	1,590,083	217,221	14%	271,872	17%	513,180	32%	587,810	37%
Nevada	2,349,645	498,649	21%	499,976	21%	727,119	31%	623,901	27%
New Hampshire	1,120,722	114,162	10%	136,324	12%	331,201	30%	539,035	48%
New Jersey	7,445,027	1,136,072	15%	1,165,245	16%	1,874,067	25%	3,269,643	44%
New Mexico	1,741,452	479,812	28%	336,644	19%	432,176	25%	492,820	28%
New York	16,608,850	3,702,305	22%	2,904,750	17%	4,519,562	27%	5,482,233	33%
North Carolina	8,170,616	1,651,823	20%	1,718,327	21%	2,366,414	29%	2,434,052	30%
North Dakota	598,390	72,059	12%	81,041	14%	200,124	33%	245,166	41%
Ohio	9,636,202	1,922,676	20%	1,747,696	18%	3,032,866	31%	2,932,964	30%
Oklahoma	3,216,702	654,515	20%	610,814	19%	981,237	31%	970,136	30%
Oregon	3,311,824	611,014	18%	678,195	20%	995,626	30%	1,026,989	31%
Pennsylvania	10,763,884	1,886,148	18%	1,735,473	16%	3,196,369	30%	3,945,894	37%
Rhode Island	875,455	168,541	19%	139,981	16%	224,096	26%	342,837	39%
South Carolina	3,986,837	853,635	21%	811,863	20%	1,280,171	32%	1,041,168	26%
South Dakota	703,440	113,226	16%	130,423	19%	253,647	36%	206,144	29%
Tennessee	5,457,678	1,180,358	22%	1,093,560	20%	1,718,875	31%	1,464,885	27%
Texas	23,090,586	5,181,634	22%	4,861,552	21%	6,441,780	28%	6,605,620	29%
Utah	2,560,747	378,933	15%	585,358	23%	888,436	35%	708,020	28%
Vermont	516,488	69,071	13%	85,524	17%	171,626	33%	190,267	37%
Virginia	6,927,932	1,022,906	15%	1,058,782	15%	1,964,650	28%	2,881,594	42%
Washington	5,971,672	958,359	16%	1,132,048	19%	1,716,827	29%	2,164,438	36%
West Virginia	1,542,410	321,374	21%	300,206	19%	505,004	33%	415,826	27%
Wisconsin	4,872,659	752,855	15%	721,453	15%	1,653,643	34%	1,744,708	36%
Wyoming	498,176	69,404	14%	98,143	20%	151,637	30%	178,992	36%

Data source: March 2012–13 Current Population Survey (CPS).

Table 3. Uninsured or Underinsured Under Age 65, Total, by State, 2011–2012

UNINSURED OR UNDERINSURED[a] UNDER AGE 65						
	UNINSURED		UNDERINSURED[a]		EITHER UNINSURED OR UNDERINSURED[a]	
State	People	Percent	People	Percent	People	Percent
United States (2012)	47,296,988	18%	31,653,855	12%	78,950,843	29%
United States (2011–2012)	47,617,535	18%	31,112,183	12%	78,729,718	29%
Alabama	660,730	16%	582,071	14%	1,242,801	30%
Alaska	129,873	20%	73,672	11%	203,545	32%
Arizona	1,140,186	20%	657,244	12%	1,797,430	32%
Arkansas	510,383	21%	357,034	15%	867,417	35%
California	6,992,371	21%	3,507,450	11%	10,499,821	31%
Colorado	736,879	16%	616,371	14%	1,353,250	30%
Connecticut	285,748	9%	313,463	10%	599,211	20%
Delaware	92,570	12%	79,411	10%	171,981	23%
District of Columbia	49,802	9%	46,898	9%	96,700	18%
Florida	3,866,688	25%	1,854,797	12%	5,721,485	36%
Georgia	1,849,656	22%	1,014,262	12%	2,863,918	33%
Hawaii	102,739	9%	145,513	13%	248,252	22%
Idaho	257,948	19%	233,806	17%	491,754	36%
Illinois	1,772,366	16%	1,315,672	12%	3,088,038	28%
Indiana	801,579	15%	709,556	13%	1,511,135	28%
Iowa	301,444	12%	293,442	11%	594,886	23%
Kansas	368,441	15%	286,847	12%	655,288	27%
Kentucky	647,130	17%	459,237	12%	1,106,367	29%
Louisiana	866,303	22%	452,581	12%	1,318,884	34%
Maine	129,293	12%	139,451	12%	268,744	24%
Maryland	755,915	15%	452,051	9%	1,207,966	24%
Massachusetts	242,879	4%	531,029	10%	773,908	14%
Michigan	1,110,519	13%	921,020	11%	2,031,539	25%
Minnesota	462,517	10%	399,529	9%	862,046	19%
Mississippi	453,574	18%	408,632	16%	862,206	34%
Missouri	834,076	16%	580,551	11%	1,414,627	28%
Montana	178,919	22%	102,306	13%	281,225	34%
Nebraska	233,282	15%	190,606	12%	423,888	27%
Nevada	620,817	26%	257,626	11%	878,443	37%
New Hampshire	158,520	14%	93,608	8%	252,128	22%
New Jersey	1,250,736	17%	749,402	10%	2,000,138	27%
New Mexico	421,705	24%	234,019	13%	655,724	38%
New York	2,220,839	13%	1,806,989	11%	4,027,828	24%
North Carolina	1,593,276	20%	1,117,065	14%	2,710,341	33%
North Dakota	70,031	12%	62,392	10%	132,423	22%
Ohio	1,460,837	15%	1,250,465	13%	2,711,302	28%
Oklahoma	633,071	20%	381,381	12%	1,014,452	32%
Oregon	559,347	17%	480,649	15%	1,039,996	31%
Pennsylvania	1,426,872	13%	1,114,294	10%	2,541,166	24%
Rhode Island	125,046	14%	87,170	10%	212,216	24%
South Carolina	765,291	19%	468,964	12%	1,234,255	31%
South Dakota	111,335	16%	79,858	11%	191,193	27%
Tennessee	849,557	16%	872,052	16%	1,721,609	32%
Texas	6,166,602	27%	2,618,242	11%	8,784,844	38%
Utah	406,843	16%	435,507	17%	842,350	33%
Vermont	47,759	9%	56,663	11%	104,422	20%
Virginia	1,020,551	15%	686,787	10%	1,707,338	25%
Washington	947,718	16%	677,634	11%	1,625,352	27%
West Virginia	266,650	17%	198,372	13%	465,022	30%
Wisconsin	566,533	12%	584,069	12%	1,150,602	24%
Wyoming	93,789	19%	74,473	15%	168,262	34%
Min		4%		8%		14%
Max		27%		17%		38%

[a] Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Note: Percentages of "uninsured" and "underinsured" may not sum to total because of rounding.
Data source: March 2012–13 Current Population Survey (CPS).

Table 4. Underinsured Under Age 65, Total and by Federal Poverty Level, by State, 2011–2012

UNDERINSURED[a] UNDER AGE 65										
	TOTAL, 2011–2012		LESS THAN 100% POVERTY		100%–199% POVERTY		200%–399% POVERTY		400% POVERTY OR MORE	
State	Number of underinsured	Percent of population	Number of underinsured	Percent of population	Number of underinsured	Percent of population	Number of underinsured	Percent of population	Number of underinsured	Percent of population
United States (2012)	31,653,855	12%	15,959,850	30%	9,745,342	20%	4,247,733	6%	1,700,930	2%
United States (2011–2012)	31,112,183	12%	15,879,464	30%	9,274,283	19%	4,384,403	6%	1,574,033	2%
Alabama	582,071	14%	292,887	34%	230,720	29%	53,258	4%	5,206	0%
Alaska	73,672	11%	31,843	33%	19,195	18%	15,073	8%	7,561	3%
Arizona	657,244	12%	364,750	27%	160,625	14%	101,649	6%	30,220	2%
Arkansas	357,034	15%	186,285	32%	102,599	19%	46,808	6%	21,342	4%
California	3,507,450	11%	1,980,504	26%	921,257	14%	415,002	5%	190,687	2%
Colorado	616,371	14%	254,776	35%	178,326	27%	113,419	9%	69,850	4%
Connecticut	313,463	10%	175,661	41%	91,276	22%	34,221	5%	12,305	1%
Delaware	79,411	10%	40,789	28%	23,048	17%	11,393	5%	4,181	2%
District of Columbia	46,898	9%	32,532	24%	7,888	11%	3,489	4%	2,989	1%
Florida	1,854,797	12%	990,043	30%	491,315	16%	265,017	6%	108,422	2%
Georgia	1,014,262	12%	579,540	29%	277,444	18%	113,414	4%	43,864	2%
Hawaii	145,513	13%	90,354	37%	43,785	19%	8,312	3%	3,062	1%
Idaho	233,806	17%	85,360	34%	88,257	27%	46,656	11%	13,533	4%
Illinois	1,315,672	12%	589,774	29%	482,166	23%	186,539	6%	57,193	1%
Indiana	709,556	13%	373,260	34%	202,759	19%	101,435	6%	32,102	2%
Iowa	293,442	11%	118,536	34%	109,214	23%	56,743	6%	8,949	1%
Kansas	286,847	12%	133,027	30%	93,619	21%	49,841	7%	10,360	1%
Kentucky	459,237	12%	213,340	27%	159,977	21%	70,482	6%	15,438	1%
Louisiana	452,581	12%	252,117	25%	131,117	18%	44,712	4%	24,635	2%
Maine	139,451	12%	63,245	37%	43,709	22%	24,961	7%	7,536	2%
Maryland	452,051	9%	238,408	33%	105,485	14%	70,831	5%	37,327	2%
Massachusetts	531,029	10%	290,415	34%	169,272	23%	54,998	4%	16,344	1%
Michigan	921,020	11%	471,835	30%	285,685	20%	137,626	6%	25,874	1%
Minnesota	399,529	9%	154,992	27%	138,861	22%	79,528	6%	26,148	1%
Mississippi	408,632	16%	220,366	34%	115,955	21%	54,026	7%	18,285	3%
Missouri	580,551	11%	292,717	29%	172,317	20%	95,098	6%	20,419	1%
Montana	102,306	13%	50,454	32%	33,168	20%	16,225	6%	2,459	1%
Nebraska	190,606	12%	72,066	33%	59,457	22%	45,831	9%	13,252	2%
Nevada	257,626	11%	134,399	27%	75,318	15%	32,094	4%	15,815	3%
New Hampshire	93,608	8%	39,010	34%	30,329	22%	14,017	4%	10,252	2%
New Jersey	749,402	10%	405,093	36%	210,377	18%	82,058	4%	51,874	2%
New Mexico	234,019	13%	127,717	27%	68,234	20%	23,277	5%	14,791	3%
New York	1,806,989	11%	1,132,976	31%	392,553	14%	182,527	4%	98,933	2%
North Carolina	1,117,065	14%	521,994	32%	371,415	22%	171,512	7%	52,144	2%
North Dakota	62,392	10%	24,403	34%	21,249	26%	14,693	7%	2,047	1%
Ohio	1,250,465	13%	581,115	30%	392,229	22%	218,940	7%	58,181	2%
Oklahoma	381,381	12%	196,027	30%	117,895	19%	54,788	6%	12,671	1%
Oregon	480,649	15%	215,748	35%	166,556	25%	76,239	8%	22,106	2%
Pennsylvania	1,114,294	10%	640,618	34%	333,848	19%	110,151	3%	29,677	1%
Rhode Island	87,170	10%	45,933	27%	30,928	22%	8,677	4%	1,632	0%
South Carolina	468,964	12%	273,015	32%	98,636	12%	78,693	6%	18,620	2%
South Dakota	79,858	11%	27,825	25%	28,352	22%	17,789	7%	5,892	3%
Tennessee	872,052	16%	430,069	36%	272,693	25%	129,432	8%	39,858	3%
Texas	2,618,242	11%	1,275,740	25%	826,537	17%	382,066	6%	133,899	2%
Utah	435,507	17%	163,070	43%	196,322	34%	62,787	7%	13,328	2%
Vermont	56,663	11%	25,803	37%	16,643	19%	10,152	6%	4,065	2%
Virginia	686,787	10%	354,101	35%	192,379	18%	94,350	5%	45,957	2%
Washington	677,634	11%	280,232	29%	237,361	21%	102,663	6%	57,378	3%
West Virginia	198,372	13%	92,694	29%	65,813	22%	30,079	6%	9,786	2%
Wisconsin	584,069	12%	230,779	31%	162,647	23%	152,277	9%	38,366	2%
Wyoming	74,473	15%	21,227	31%	27,473	28%	18,555	12%	7,218	4%
Min		8%		24%		11%		3%		0%
Max		17%		43%		34%		12%		4%

[a] Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data source: March 2012–13 Current Population Survey (CPS).

Table 5. Uninsured Under Age 65, Total and by Federal Poverty Level, by State, 2011–2012

UNINSURED UNDER AGE 65										
	TOTAL, 2011–2012		LESS THAN 100% POVERTY		100%–199% POVERTY		200%–399% POVERTY		400% POVERTY OR MORE	
State	People	Percent	People	Percent	People	Percent	People	Percent	People	Percent
United States (2012)	47,296,988	18%	17,383,796	33%	13,501,469	27%	11,335,826	15%	5,075,897	6%
United States (2011–2012)	47,617,535	18%	17,720,248	33%	13,614,695	28%	11,215,821	15%	5,066,771	6%
Alabama	660,730	16%	294,272	34%	170,281	21%	151,854	12%	44,323	4%
Alaska	129,873	20%	33,870	35%	28,868	27%	42,882	23%	24,253	10%
Arizona	1,140,186	20%	425,653	32%	364,154	33%	244,817	15%	105,562	6%
Arkansas	510,383	21%	209,969	36%	151,972	29%	106,921	14%	41,521	7%
California	6,992,371	21%	2,766,547	36%	1,992,080	30%	1,572,094	18%	661,650	6%
Colorado	736,879	16%	255,119	35%	187,301	28%	192,995	15%	101,464	6%
Connecticut	285,748	9%	92,320	22%	67,440	16%	76,756	10%	49,232	3%
Delaware	92,570	12%	30,330	20%	29,460	22%	20,856	10%	11,924	5%
District of Columbia	49,802	9%	18,405	14%	11,233	16%	10,779	11%	9,385	4%
Florida	3,866,688	25%	1,416,672	43%	1,083,019	35%	917,227	20%	449,770	10%
Georgia	1,849,656	22%	792,355	40%	459,228	29%	405,796	16%	192,277	8%
Hawaii	102,739	9%	46,323	19%	26,094	11%	21,073	6%	9,249	3%
Idaho	257,948	19%	91,238	37%	91,985	28%	58,213	14%	16,512	5%
Illinois	1,772,366	16%	668,542	33%	494,737	24%	428,994	14%	180,093	5%
Indiana	801,579	15%	291,705	27%	250,850	24%	173,253	11%	85,771	5%
Iowa	301,444	12%	92,958	27%	83,807	18%	90,502	10%	34,177	4%
Kansas	368,441	15%	141,285	32%	98,102	22%	90,938	12%	38,116	5%
Kentucky	647,130	17%	282,728	36%	201,431	26%	115,389	10%	47,582	5%
Louisiana	866,303	22%	393,220	39%	221,474	30%	181,163	17%	70,446	7%
Maine	129,293	12%	32,761	19%	38,148	19%	42,938	12%	15,446	4%
Maryland	755,915	15%	248,343	34%	208,643	28%	209,207	16%	89,722	4%
Massachusetts	242,879	4%	66,462	8%	57,086	8%	67,346	5%	51,985	2%
Michigan	1,110,519	13%	396,077	26%	311,636	22%	247,770	11%	155,036	5%
Minnesota	462,517	10%	151,920	27%	116,106	18%	124,744	9%	69,747	3%
Mississippi	453,574	18%	189,123	29%	138,977	26%	88,009	12%	37,465	7%
Missouri	834,076	16%	353,336	35%	208,462	24%	198,650	13%	73,628	4%
Montana	178,919	22%	58,874	38%	52,604	31%	47,458	17%	19,983	9%
Nebraska	233,282	15%	61,555	28%	73,397	27%	67,965	13%	30,365	5%
Nevada	620,817	26%	240,693	48%	185,493	37%	148,719	20%	45,912	7%
New Hampshire	158,520	14%	40,748	36%	40,570	30%	48,884	15%	28,318	5%
New Jersey	1,250,736	17%	411,045	36%	384,962	33%	300,336	16%	154,393	5%
New Mexico	421,705	24%	178,039	37%	113,491	34%	90,245	21%	39,930	8%
New York	2,220,839	13%	795,554	21%	577,298	20%	553,842	12%	294,145	5%
North Carolina	1,593,276	20%	573,311	35%	469,017	27%	382,691	16%	168,257	7%
North Dakota	70,031	12%	23,481	33%	16,585	20%	21,356	11%	8,609	4%
Ohio	1,460,837	15%	575,183	30%	412,896	24%	336,841	11%	135,917	5%
Oklahoma	633,071	20%	199,261	30%	184,567	30%	158,294	16%	90,949	9%
Oregon	559,347	17%	194,843	32%	160,539	24%	140,178	14%	63,787	6%
Pennsylvania	1,426,872	13%	461,502	24%	431,329	25%	351,121	11%	182,920	5%
Rhode Island	125,046	14%	48,022	28%	33,409	24%	30,069	13%	13,546	4%
South Carolina	765,291	19%	301,508	35%	203,594	25%	188,196	15%	71,993	7%
South Dakota	111,335	16%	39,547	35%	29,013	22%	31,237	12%	11,538	6%
Tennessee	849,557	16%	323,619	27%	285,277	26%	172,107	10%	68,554	5%
Texas	6,166,602	27%	2,295,143	44%	1,893,761	39%	1,410,012	22%	567,686	9%
Utah	406,843	16%	131,185	35%	114,178	20%	107,176	12%	54,304	8%
Vermont	47,759	9%	12,859	19%	12,394	14%	16,192	9%	6,314	3%
Virginia	1,020,551	15%	340,389	33%	289,533	27%	252,245	13%	138,384	5%
Washington	947,718	16%	327,215	34%	319,382	28%	217,453	13%	83,668	4%
West Virginia	266,650	17%	90,000	28%	68,336	23%	75,401	15%	32,913	8%
Wisconsin	566,533	12%	188,328	25%	147,307	20%	158,167	10%	72,731	4%
Wyoming	93,789	19%	26,811	39%	23,189	24%	28,470	19%	15,319	9%
Min		4%		8%		8%		5%		2%
Max		27%		48%		39%		23%		10%

Data source: March 2012–13 Current Population Survey (CPS).

Table 6. Uninsured or Underinsured Under Age 65, Total and by Federal Poverty Level, by State, 2011–2012

	UNINSURED OR UNDERINSURED[a] UNDER AGE 65									
	TOTAL, 2011–2012		LESS THAN 100% POVERTY		100%–199% POVERTY		200%–399% POVERTY		400% POVERTY OR MORE	
State	People	Percent	People	Percent	People	Percent	People	Percent	People	Percent
United States (2012)	78,950,843	29%	33,343,646	63%	23,246,811	47%	15,583,559	20%	6,776,827	8%
United States (2011–2012)	78,729,718	29%	33,599,712	63%	22,888,978	46%	15,600,224	20%	6,640,804	8%
Alabama	1,242,801	30%	587,159	68%	401,001	50%	205,112	17%	49,529	4%
Alaska	203,545	32%	65,713	69%	48,063	46%	57,955	30%	31,814	13%
Arizona	1,797,430	32%	790,403	59%	524,779	47%	346,466	22%	135,782	8%
Arkansas	867,417	35%	396,254	67%	254,571	48%	153,729	21%	62,863	11%
California	10,499,821	31%	4,747,051	61%	2,913,337	44%	1,987,096	23%	852,337	8%
Colorado	1,353,250	30%	509,895	70%	365,627	54%	306,414	24%	171,314	9%
Connecticut	599,211	20%	267,981	63%	158,716	38%	110,977	15%	61,537	4%
Delaware	171,981	23%	71,119	48%	52,508	39%	32,249	15%	16,105	6%
District of Columbia	96,700	18%	50,937	38%	19,121	27%	14,268	14%	12,374	5%
Florida	5,721,485	36%	2,406,715	73%	1,574,334	51%	1,182,244	26%	558,192	12%
Georgia	2,863,918	33%	1,371,895	69%	736,672	47%	519,210	20%	236,141	9%
Hawaii	248,252	22%	136,677	55%	69,879	30%	29,385	9%	12,311	4%
Idaho	491,754	36%	176,598	71%	180,242	55%	104,869	25%	30,045	9%
Illinois	3,088,038	28%	1,258,316	62%	976,903	47%	615,533	20%	237,286	6%
Indiana	1,511,135	28%	664,965	61%	453,609	44%	274,688	17%	117,873	7%
Iowa	594,886	23%	211,494	61%	193,021	41%	147,245	16%	43,126	5%
Kansas	655,288	27%	274,312	63%	191,721	43%	140,779	19%	48,476	6%
Kentucky	1,106,367	29%	496,068	63%	361,408	47%	185,871	16%	63,020	6%
Louisiana	1,318,884	34%	645,337	64%	352,591	47%	225,875	21%	95,081	9%
Maine	268,744	24%	96,006	56%	81,857	42%	67,899	19%	22,982	6%
Maryland	1,207,966	24%	486,751	67%	314,128	43%	280,038	21%	127,049	6%
Massachusetts	773,908	14%	356,877	42%	226,358	30%	122,344	9%	68,329	3%
Michigan	2,031,539	25%	867,912	56%	597,321	42%	385,396	17%	180,910	6%
Minnesota	862,046	19%	306,912	54%	254,967	39%	204,272	15%	95,895	5%
Mississippi	862,206	34%	409,489	63%	254,932	47%	142,035	19%	55,750	10%
Missouri	1,414,627	28%	646,053	63%	380,779	44%	293,748	20%	94,047	6%
Montana	281,225	34%	109,328	70%	85,772	51%	63,683	23%	22,442	10%
Nebraska	423,888	27%	133,621	62%	132,854	49%	113,796	22%	43,617	7%
Nevada	878,443	37%	375,092	75%	260,811	52%	180,813	25%	61,727	10%
New Hampshire	252,128	22%	79,758	70%	70,899	52%	62,901	19%	38,570	7%
New Jersey	2,000,138	27%	816,138	72%	595,339	51%	382,394	20%	206,267	6%
New Mexico	655,724	38%	305,756	64%	181,725	54%	113,522	26%	54,721	11%
New York	4,027,828	24%	1,928,530	52%	969,851	33%	736,369	16%	393,078	7%
North Carolina	2,710,341	33%	1,095,305	66%	840,432	49%	554,203	23%	220,401	9%
North Dakota	132,423	22%	47,884	66%	37,834	47%	36,049	18%	10,656	4%
Ohio	2,711,302	28%	1,156,298	60%	805,125	46%	555,781	18%	194,098	7%
Oklahoma	1,014,452	32%	395,288	60%	302,462	50%	213,082	22%	103,620	11%
Oregon	1,039,996	31%	410,591	67%	327,095	48%	216,417	22%	85,893	8%
Pennsylvania	2,541,166	24%	1,102,120	58%	765,177	44%	461,272	14%	212,597	5%
Rhode Island	212,216	24%	93,955	56%	64,337	46%	38,746	17%	15,178	4%
South Carolina	1,234,255	31%	574,523	67%	302,230	37%	266,889	21%	90,613	9%
South Dakota	191,193	27%	67,372	60%	57,365	44%	49,026	19%	17,430	8%
Tennessee	1,721,609	32%	753,688	64%	557,970	51%	301,539	18%	108,412	7%
Texas	8,784,844	38%	3,570,883	69%	2,720,298	56%	1,792,078	28%	701,585	11%
Utah	842,350	33%	294,255	78%	310,500	53%	169,963	19%	67,632	10%
Vermont	104,422	20%	38,662	56%	29,037	34%	26,344	15%	10,379	5%
Virginia	1,707,338	25%	694,490	68%	481,912	46%	346,595	18%	184,341	6%
Washington	1,625,352	27%	607,447	63%	556,743	49%	320,116	19%	141,046	7%
West Virginia	465,022	30%	182,694	57%	134,149	45%	105,480	21%	42,699	10%
Wisconsin	1,150,602	24%	419,107	56%	309,954	43%	310,444	19%	111,097	6%
Wyoming	168,262	34%	48,038	69%	50,662	52%	47,025	31%	22,537	13%
Min		14%		38%		27%		9%		3%
Max		38%		78%		56%		31%		13%

[a] Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
Data Source: March 2012–13 Current Population Survey (CPS).

Table 7. Average Health Insurance Premiums as Percent of Median Household Income, by State, 2003 and 2012

	MEDIAN INCOME				PREMIUMS AS A PERCENT OF MEDIAN INCOME					
State	Median income for single-person household (under age 65)		Median income for family household (all under age 65)		Single premiums as percent of median income for single-person household (under age 65)		Family premiums as percent of median income for family household (all under age 65)		Average premiums as percent of median household income for under-65 population*	
	2002–03	2011–12	2002–03	2011–12	2003	2012	2003	2012	2003	2012
United States	$24,400	$26,700	$61,000	$70,000	14.3%	20.2%	15.2%	22.1%	14.9%	21.6%
Alabama	20,952	22,799	58,000	62,458	15.1%	21.8%	13.9%	20.4%	14.2%	20.8%
Alaska	25,082	31,174	66,634	80,000	16.0%	23.8%	15.9%	22.4%	15.9%	22.8%
Arizona	20,800	25,003	55,536	60,800	15.4%	20.8%	16.2%	25.1%	16.0%	23.9%
Arkansas	19,788	22,000	45,000	53,030	15.8%	20.3%	17.7%	25.1%	17.3%	23.8%
California	25,400	26,049	58,548	65,004	13.0%	20.8%	15.5%	24.5%	14.9%	23.4%
Colorado	27,540	30,000	65,797	85,739	13.2%	17.6%	14.5%	18.7%	14.1%	18.4%
Connecticut	26,520	32,399	80,450	99,000	13.9%	18.3%	12.6%	17.1%	12.9%	17.4%
Delaware	26,520	29,000	68,340	71,000	14.5%	19.3%	15.4%	22.0%	15.1%	21.2%
District of Columbia	32,464	42,000	50,811	86,870	11.5%	13.3%	21.2%	19.8%	16.5%	16.6%
Florida	23,529	25,000	56,770	62,150	15.3%	20.7%	16.4%	24.9%	16.1%	23.6%
Georgia	24,024	26,000	58,707	63,000	15.1%	19.8%	14.7%	23.2%	14.8%	22.3%
Hawaii	25,000	29,000	63,638	63,038	12.1%	17.5%	12.4%	23.4%	12.3%	21.2%
Idaho	21,442	24,176	52,577	62,934	15.5%	18.4%	16.3%	22.3%	16.1%	21.5%
Illinois	24,960	28,800	64,276	70,000	14.8%	18.8%	15.1%	22.5%	15.0%	21.5%
Indiana	24,000	25,938	65,001	65,788	14.6%	21.2%	14.3%	23.5%	14.4%	23.0%
Iowa	24,480	27,601	64,480	74,999	13.4%	18.6%	13.1%	19.1%	13.1%	19.0%
Kansas	23,912	28,000	63,775	68,100	14.2%	17.7%	14.0%	20.2%	14.0%	19.6%
Kentucky	21,425	22,000	54,078	62,325	16.0%	24.5%	16.9%	25.2%	16.7%	25.1%
Louisiana	23,500	24,000	46,257	58,050	14.1%	22.4%	18.9%	26.0%	17.7%	25.0%
Maine	23,000	25,000	56,886	72,930	16.7%	22.8%	18.1%	22.2%	17.8%	22.4%
Maryland	28,560	32,001	78,044	92,400	12.0%	16.6%	11.8%	16.5%	11.9%	16.5%
Massachusetts	28,000	33,000	77,750	97,263	12.5%	18.5%	12.7%	17.6%	12.6%	17.9%
Michigan	24,391	24,159	65,514	76,621	15.1%	22.2%	14.4%	18.8%	14.6%	19.7%
Minnesota	27,040	31,000	79,272	95,463	13.6%	17.2%	12.7%	16.1%	12.9%	16.4%
Mississippi	20,000	21,221	45,103	55,000	16.5%	22.2%	17.9%	25.8%	17.6%	24.9%
Missouri	24,480	25,200	64,273	68,000	13.5%	20.4%	14.0%	22.0%	13.9%	21.6%
Montana	20,000	25,000	49,552	60,200	17.5%	22.3%	17.2%	24.4%	17.3%	23.9%
Nebraska	23,582	28,000	65,607	80,923	14.9%	18.2%	13.9%	17.9%	14.1%	18.0%
Nevada	25,000	27,501	55,029	60,000	14.3%	18.0%	16.0%	21.5%	15.6%	20.5%
New Hampshire	26,849	31,200	80,910	95,504	13.3%	18.2%	12.1%	17.1%	12.4%	17.4%
New Jersey	29,355	30,000	85,000	90,034	13.0%	19.5%	12.0%	18.8%	12.2%	19.0%
New Mexico	18,972	23,000	45,000	51,811	17.7%	21.9%	20.7%	30.6%	19.9%	28.4%
New York	25,013	30,000	61,380	68,000	14.4%	20.1%	15.4%	24.9%	15.1%	23.4%
North Carolina	20,565	24,000	53,043	64,481	16.6%	23.5%	16.0%	24.2%	16.1%	24.0%
North Dakota	22,524	29,459	57,144	85,050	13.3%	18.3%	13.8%	16.9%	13.7%	17.2%
Ohio	23,970	25,000	63,397	68,842	14.3%	20.3%	14.4%	22.4%	14.4%	21.9%
Oklahoma	20,420	25,000	50,150	62,064	16.1%	19.4%	17.4%	21.8%	17.1%	21.3%
Oregon	21,846	25,002	57,477	65,070	15.4%	21.8%	15.4%	23.8%	15.4%	23.2%
Pennsylvania	24,000	26,499	66,111	79,344	14.4%	20.3%	13.8%	19.4%	14.0%	19.6%
Rhode Island	26,000	28,000	65,280	82,153	14.3%	21.0%	14.5%	19.3%	14.4%	19.8%
South Carolina	21,000	23,957	55,200	60,000	16.1%	21.3%	16.2%	23.8%	16.1%	23.1%
South Dakota	20,617	26,000	58,855	71,169	16.3%	20.8%	14.4%	21.1%	14.9%	21.0%
Tennessee	21,624	24,000	52,000	62,000	16.6%	21.1%	17.8%	24.0%	17.5%	23.2%
Texas	22,112	26,020	48,000	60,000	15.4%	19.7%	19.9%	24.4%	18.9%	23.2%
Utah	22,710	27,000	61,200	74,357	14.8%	19.1%	13.6%	19.6%	13.9%	19.5%
Vermont	24,480	30,000	65,740	75,405	14.7%	18.6%	14.4%	20.0%	14.5%	19.6%
Virginia	25,149	30,000	75,000	86,029	13.2%	17.7%	12.2%	17.9%	12.5%	17.8%
Washington	25,000	30,000	66,788	75,050	14.1%	17.9%	13.8%	21.7%	13.9%	20.6%
West Virginia	19,992	23,000	43,860	60,240	19.1%	25.6%	20.9%	26.0%	20.5%	25.9%
Wisconsin	25,500	28,000	64,016	78,738	14.7%	20.5%	14.9%	20.6%	14.9%	20.6%
Wyoming	23,002	25,000	57,002	77,533	16.1%	23.4%	16.9%	20.1%	16.7%	21.0%

* Weighted by single and family household distribution in state.
Data source: Median household incomes—2003, 2004, 2012, and 2013 Current Population Surveys (CPS); Total average premiums for employer-based single and family health insurance plans—2003 and 2012 Medical Expenditure Panel Survey—Insurance Component.

Table 8. Insured Individuals Under Age 65 with Premiums That Exceed the Affordable Care Act Threshold, Total and by Federal Poverty Level, by State, 2011–2012

INSURED INDIVIDUALS UNDER AGE 65 WITH PREMIUMS THAT EXCEED THE AFFORDABLE CARE ACT THRESHOLD OR MEDICAID[a]									
	TOTAL, 2011–2012			BELOW 100% POVERTY		100%–199% POVERTY		200%–399% POVERTY	
State	People	Percent of insured	Percent of population	People	Percent of population	People	Percent of population	People	Percent of population
United States (2012)	29,241,328	13%	11%	8,109,966	15%	12,124,544	24%	9,006,818	12%
United States (2011–2012)	28,671,344	13%	11%	8,011,646	15%	11,886,679	24%	8,773,019	11%
Alabama	541,581	16%	13%	148,132	17%	256,306	32%	137,143	11%
Alaska	44,375	9%	7%	10,268	11%	23,528	22%	10,579	6%
Arizona	637,938	14%	11%	155,576	12%	260,922	23%	221,440	14%
Arkansas	263,170	14%	11%	77,490	13%	109,886	21%	75,794	10%
California	3,101,895	12%	9%	949,477	12%	1,312,738	20%	839,680	10%
Colorado	415,046	11%	9%	94,904	13%	157,358	23%	162,784	13%
Connecticut	299,193	11%	10%	72,896	17%	119,760	29%	106,537	14%
Delaware	80,211	12%	11%	23,884	16%	32,701	24%	23,626	11%
District of Columbia	37,721	8%	7%	18,508	14%	13,637	19%	5,576	6%
Florida	1,863,735	16%	12%	512,044	16%	719,212	23%	632,479	14%
Georgia	912,873	14%	11%	311,996	16%	369,522	23%	231,355	9%
Hawaii	141,374	14%	12%	56,521	23%	55,807	24%	29,046	9%
Idaho	174,912	16%	13%	30,533	12%	89,889	27%	54,490	13%
Illinois	1,192,392	13%	11%	284,092	14%	572,828	27%	335,472	11%
Indiana	619,136	13%	11%	185,281	17%	252,360	24%	181,495	12%
Iowa	324,510	14%	12%	57,869	17%	156,713	34%	109,928	12%
Kansas	300,254	15%	12%	78,393	18%	121,439	27%	100,422	13%
Kentucky	487,602	16%	13%	105,896	13%	221,883	29%	159,823	14%
Louisiana	416,901	14%	11%	144,044	14%	150,357	20%	122,500	11%
Maine	119,664	12%	11%	20,450	12%	46,294	23%	52,920	14%
Maryland	418,841	10%	8%	123,495	17%	153,023	21%	142,323	11%
Massachusetts	617,587	12%	11%	170,288	20%	217,961	29%	229,338	17%
Michigan	815,945	11%	10%	261,177	17%	328,406	23%	226,362	10%
Minnesota	509,954	12%	11%	101,747	18%	229,687	36%	178,520	13%
Mississippi	346,831	17%	14%	140,990	22%	136,182	25%	69,659	9%
Missouri	639,600	15%	13%	182,075	18%	252,590	29%	204,935	14%
Montana	86,507	14%	11%	25,299	16%	30,354	18%	30,854	11%
Nebraska	199,470	15%	13%	51,361	24%	86,547	32%	61,562	12%
Nevada	255,514	15%	11%	80,459	16%	103,588	21%	71,467	10%
New Hampshire	114,553	12%	10%	22,631	20%	38,053	28%	53,869	16%
New Jersey	530,268	9%	7%	148,329	13%	227,181	19%	154,758	8%
New Mexico	227,013	17%	13%	67,578	14%	86,683	26%	72,752	17%
New York	1,579,069	11%	10%	545,168	15%	574,081	20%	459,820	10%
North Carolina	985,457	15%	12%	236,451	14%	437,122	25%	311,884	13%
North Dakota	64,847	12%	11%	11,252	16%	27,096	33%	26,499	13%
Ohio	1,121,196	14%	12%	303,019	16%	494,242	28%	323,935	11%
Oklahoma	326,930	13%	10%	123,473	19%	126,667	21%	76,790	8%
Oregon	432,213	16%	13%	99,201	16%	210,641	31%	122,371	12%
Pennsylvania	1,158,531	12%	11%	349,669	19%	452,716	26%	356,146	11%
Rhode Island	90,933	12%	10%	23,496	14%	42,826	31%	24,611	11%
South Carolina	557,412	17%	14%	189,977	22%	241,624	30%	125,811	10%
South Dakota	85,440	14%	12%	15,357	14%	37,036	28%	33,047	13%
Tennessee	783,506	17%	14%	197,551	17%	332,476	30%	253,479	15%
Texas	2,257,083	13%	10%	625,379	12%	931,148	19%	700,556	11%
Utah	352,791	16%	14%	83,147	22%	176,223	30%	93,421	11%
Vermont	67,036	14%	13%	19,728	29%	29,773	35%	17,535	10%
Virginia	706,953	12%	10%	146,489	14%	256,138	24%	304,326	15%
Washington	552,268	11%	9%	142,259	15%	236,991	21%	173,018	10%
West Virginia	167,329	13%	11%	42,809	13%	82,191	27%	42,329	8%
Wisconsin	593,949	14%	12%	134,946	18%	237,408	33%	221,595	13%
Wyoming	51,835	13%	10%	8,592	12%	26,885	27%	16,358	11%
Min		8%	7%		11%		18%		6%
Max		17%	14%		29%		36%		17%

[a] Affordable Care Act thresholds refers to the maximum premium contribution as a share of income in marketplaces or Medicaid if eligible to participate.
Data source: March 2012–13 Current Population Survey (CPS).

Table 9. Distribution of Insured Population Under Age 65 with High Out-of-Pocket Medical Costs or High Premiums, by Federal Poverty Level, 2012

	UNDER-65 POPULATION						
		POVERTY GROUP (PERCENT OF FEDERAL POVERTY LEVEL)					
	TOTAL	<100%	100%–137%	138%–199%	200%–249%	250%–399%	400% OR MORE
Total insured population	220.5	35.5	14.2	22.0	17.4	47.4	84.1
Employer-sponsored insurance	153.2	8.8	5.7	12.5	12.3	39.0	75.3
Medicare	8.7	3.1	1.4	1.4	0.7	1.1	0.9
Medicaid	37.0	19.3	5.2	5.3	2.4	3.1	1.6
Military	4.4	0.7	0.3	0.5	0.4	1.0	1.4
Individual	17.3	3.7	1.4	2.2	1.6	3.6	4.8
Total insured population who are underinsured[a]	31.7	16.0	4.1	5.7	1.4	2.8	1.7
Employer-sponsored insurance	16.0	5.5	2.1	3.7	1.0	2.3	1.4
Medicare	2.4	1.2	0.5	0.4	0.09	0.1	0.05
Medicaid	8.6	6.5	1.0	0.9	0.1	0.09	0.02
Military	0.6	0.4	0.04	0.09	0.01	0.02	0.02
Individual	4.0	2.3	0.4	0.6	0.2	0.3	0.2
Total insured population with premiums that exceed Affordable Care Act threshold or Medicaid[b]	29.2	8.1	5.6	6.5	3.7	5.3	0
Employer-sponsored insurance	18.4	3.4	3.3	4.6	2.9	4.2	0
Medicare	1.6	0.6	0.4	0.3	0.1	0.1	0
Medicaid	4.6	2.5	1.1	0.7	0.2	0.1	0
Military	0.4	0.2	0.09	0.05	0.03	0.04	0
Individual	4.3	1.5	0.6	0.8	0.5	0.8	0

Note: Columns may not sum to total because of rounding.

a Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.

b Affordable Care Act thresholds refers to the maximum premium contribution as a share of income in marketplaces or Medicaid if eligible to participate.

Data source: Analysis of March 2013 Current Population Survey (CPS).

Table 10. Poor Under Age 65 Who Are Uninsured, Underinsured, or Paying High Premiums in States Not Yet Expanding Medicaid, 2011-2012

UNDER AGE 65				
BELOW 100% POVERTY, COUNT OF PEOPLE				
State not currently expanding Medicaid	Uninsured	Underinsured[a]	Total uninsured or underinsured[a]	Premiums that exceed ACA threshold or Medicaid[b]
24 states not expanding	**8,610,116**	**6,969,782**	**15,579,898**	**3,624,859**
Alabama	294,272	292,887	587,159	148,132
Alaska	33,870	31,843	65,713	10,268
Florida	1,416,672	990,043	2,406,715	512,044
Georgia	792,355	579,540	1,371,895	311,996
Idaho	91,238	85,360	176,598	30,533
Indiana	291,705	373,260	664,965	185,281
Kansas	141,285	133,027	274,312	78,393
Louisiana	393,220	252,117	645,337	144,044
Maine	32,761	63,245	96,006	20,450
Mississippi	189,123	220,366	409,489	140,990
Missouri	353,336	292,717	646,053	182,075
Montana	58,874	50,454	109,328	25,299
Nebraska	61,555	72,066	133,621	51,361
New Hampshire	40,748	39,010	79,758	22,631
North Carolina	573,311	521,994	1,095,305	236,451
Oklahoma	199,261	196,027	395,288	123,473
South Carolina	301,508	273,015	574,523	189,977
South Dakota	39,547	27,825	67,372	15,357
Tennessee	323,619	430,069	753,688	197,551
Texas	2,295,143	1,275,740	3,570,883	625,379
Utah	131,185	163,070	294,255	83,147
Virginia	340,389	354,101	694,490	146,489
Wisconsin[c]	188,328	230,779	419,107	134,946
Wyoming	26,811	21,227	48,038	8,592

[a] Underinsured defined as insured in household that spent 10% or more of income on medical care (excluding premiums) or 5% or more if income under 200% poverty.
[b] Affordable Care Act (ACA) thresholds refers to the maximum premium contribution as a share of income in marketplaces or Medicaid if eligible to participate.
[c] Wisconsin will provide Medicaid to parents and childless adults with incomes up to 100 percent of poverty as of April 2014.
Data source: March 2012–13 Current Population Survey (CPS).

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State-Level Field Network Study of the Implementation of the Affordable Care Act

March 2014

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CALIFORNIA: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

In September 2010, six months after the passage of the Affordable Care Act, California became the first state in the nation to create its own insurance exchange, eventually named Covered California. In April 2011, the Board of Covered California held its first meeting. Although its fifth and final member had yet to be appointed, the Board hired an interim director and outlined an ambitious process to develop a comprehensive business plan and budget.[1]

This accelerated timeline was consistent with California's desire to be, in the words of the state's Health and Human Services Secretary and Exchange Board Chair Diana Dooley, the "lead car" in implementation of federal health care reform.[2] Because of the speed with which it approached this task, as well as the sheer size of its coverage expansion, the decisions California has made have been influential both regionally and nationally. What has transpired in the state has had implications for other states as they addressed difficult issues, including minimizing adverse selection, promoting cost-conscious consumer choice, and seamlessly coordinating with public programs.[3,4]

Navigating California's Policy Process

Soon after the passage of federal reform, the legislative leadership in California introduced its own bills and moved quickly to pass them. The legislation signed into law in California in September 2010 consisted of two bills. A state Senate bill established the basic governance and structure of the exchange, and a state Assembly bill outlined its activities and put in place insurance market regulations, some of which apply even to carriers that do not participate in the exchange.[5]

During the process of passing enabling legislation, leaders in Governor Arnold Schwarzenegger's administration and in the state legislature played important roles. The day-to-day activities, including drafting the Assembly and Senate bills and engaging with stakeholders, though, were led by an experienced team of legislative and administration staff, working closely with outside consultants with expertise in designing and running exchanges.[6] This work received support from philanthropic foundations and involved the participation of a broad range of stakeholders, many of whom had been involved in insurance market reform for many years.

On one of the central issues for the exchange — whether it would serve as an active purchaser that negotiates on behalf of its enrollees — there was agreement among the political principals in the legislature and the administration. In initial conversations, Schwarzenegger made it clear that he wanted the exchange to negotiate. The political principals in the administration and legislature also agreed that they wanted to allow the Board as much flexibility as possible.

There was a great deal of accord among the principals and staff of the Democratic-controlled legislature and the Republican Schwarzenegger administration, and the legislative process moved very quickly. Nevertheless, a substantial amount of organized opposition was brought to bear at key points. The opposition to making the exchange an active purchaser was led, in particular, by Anthem Blue Cross and the California State Chamber of Commerce.

Implementation in the Political and Fiscal Context of the Recession

It was uncertain whether Schwarzenegger would sign the bill, despite the intense involvement of his team in drafting it. This was partly because the California Chamber of Commerce called the bill a "job-killer" and the governor had historically vetoed most measures so termed. There were also strong concerns expressed by members of the governor's inner circle about the impact of the program on state resources. While the federal government was paying for the development and planning of the exchange and the lion's share of the costs associated with the Medicaid expansion until 2019, the state's ongoing fiscal stress remained relevant. In early 2011, newly elected Governor Jerry

Brown proposed, and the Democratic-controlled state legislature passed, $1.6 billion in cuts to the state Medicaid program based on the assumption that these cuts will be paired with tax increases that were by no means certain.[7] Some observers found it difficult to square the state cutting back on its current set of commitments and activities to lower-income Californians while simultaneously planning to increase others.

With severe constraints on state resources, it was vital to develop exchange designs that offered the best chance for success. California's experience with a failed small-business purchasing pool demonstrated that there is no guarantee these entities will be successful. It is very important, in particular, to structure the markets inside and outside of the exchange to avoid adverse selection. It was also important to partner across parties and stakeholder groups, as it was in no one's interest to create a program that failed to fulfill its public purpose while simultaneously disrupting the private insurance market. Conversely, a well-designed and administered exchange had the potential to improve the entire insurance market and drive change in the medical delivery system.

Key Decisions

Establishing the Number of Insurance Markets and Exchanges

One of the first decisions states had to make is whether to have an individual insurance market outside the exchange. States that want to ensure the exchange is not affected by adverse selection can substantially reduce this concern by removing the outside market, but this decision may be politically infeasible.[8,9] Even in California, where there was and is wide support for federal reform and a broad cross-section of stakeholders issued a report calling for a sole-source exchange, this option was not seriously considered.[10] However, whether or not states eliminate the outside market, the exchange may over time swallow much of the individual market since the exchange is the only place consumers will receive subsidies.

States also had to consider the option of combining the individual and small-group exchanges. There are technical challenges to doing so, since many states have different regulations, products, and carriers for these markets. However, there are also strong policy reasons to combine the exchanges, particularly in states where exchanges will not develop a large enough risk pool. This was not a big issue in California because of the size of the state. California decided to leave its exchanges as separate pools, in part because of the distinct nature of these two markets. The California legislation specified, however, that a report be delivered to the legislature in 2018 making a recommendation about whether these markets should be merged.

Setting a Vision as an "Agent of Change"

The political principals and staff who designed the California exchange explicitly intended the Board to have significant leeway in setting and achieving goals. Jon Kingsdale, the former executive director of the Commonwealth Connector, the Massachusetts state exchange, laid out the parameters in broader terms: "The authorizing legislation embodies a vision of California's exchange as an agent of change in the marketplace. The governance model suggests this vision, as do the provisions that empower the exchange to selectively contract with health plans and to specify benefits and cost-sharing for all qualified health plans. They suggest an active hand in shaping the market with certain policy goals in mind. The goals are not prescribed in legislation, but, instead, the board is encouraged to consider and act on such goals, rather than play a passive role."

California made many of its major decisions prior to both the Supreme Court ruling and presidential election. However, its process signaled to other states that, even when there is broad agreement among political leadership about federal reform, it is still very difficult to pass the enabling legislation. The process of setting up an exchange is even more complex and challenging. In spite of the subsidies and provisions on elements like risk selection, exchanges are not guaranteed to succeed. Other purchasing pools in the past have failed. Federal health care reform, however, incorporates some lessons from experiences with exchanges and allows states broad leeway to develop exchanges that work for their own marketplaces.

1.2. Goal Alignment

It is very clear that California has taken an *affirming response* to the goals of federal reform in its implementation of Covered California as well as all of its other activities related to putting this sweeping legislation in place. Federal reform aims primarily to expand health care coverage to more Americans through subsidies to purchase insurance as well as an expansion of the Medicaid program for low-income people (called "Medi-Cal" in California). While the Affordable Care Act was being passed, California was already negotiating a waiver to expand its Medicaid population before 2014. The "Low Income Health Programs" provided Medicaid coverage to an additional 500,000 Californians who then joined the conventional program when the official expansion begun on January 1, 2014.

California also quickly affirmed federal reform by creating its own state exchange, which exceeded significantly the threshold requirements for a state-based exchange. California chose to make this exchange an "active purchaser" and took significant steps (documented below) to create a "no wrong door" system for accessing insurance coverage. The Exchange Board also standardized the insurance products offered through this marketplace, which is permitted but not required by reform. The goal, aligned

with the high-level goals of reformers, was to create a simpler shopping experience for customers in order to unleash the power of informed choice and to give them greater clarity regarding the coverage offered by each insurance product.

Covered California has also sought to affirm and expand the commitment within federal health care reform to use purchasing power to improve the system of delivering health care, as well as to expand the number of people with coverage. Covered California has joined the Pacific Business Group on Health (PBGH) as an affiliate member. In addition to being a senior official at the Center for Medicare & Medicaid Innovation, Covered California Executive Director Peter Lee was the former executive director of PBGH. This coalition of large purchasers is committed to delivery system reform and, in particular, to increasing price transparency within the health care system. It has not always been possible for Covered California to implement transparency reforms as quickly as some of the members of the executive leadership and the Board have stated that they would prefer. Due to concerns about the differences in the networks of doctors and hospitals offered on Covered California, quality transparency information will not be immediately available to consumers. The exchange has a "Plan Management and Delivery System Reform" advisory group and is expected to take significant steps in coming years to attempt to use its purchasing power to drive down costs and improve quality.

Part 2 – Implementation Tasks

2.1. Exchange Priorities

California's legislation established an exchange structure consistent with recommendations of Washington and Lee University law professor and leading health policy expert Timothy Jost that the entity "should be placed within an independent agency, which should be explicitly exempted, as necessary, from specific state administrative law or government operations requirements."[11] Critically, the enabling legislation grants the exchange some exemptions to state personnel and contracting procedures and gives its Board the power to promulgate regulations on an emergency basis for two years. There was very little disagreement on this point among the main political actors in the state. They agreed a nonprofit structure would be unlikely to provide adequate transparency and accountability to the public. This, in turn, could undermine the exchange's legitimacy.

There are important trade offs involved in this choice, however. The state's government-run, small-business purchasing pool, the Health Plan of California, was transitioned after several years to the nonprofit Pacific Business Group on Health. Although this venture was ultimately unsuccessful, it was viewed as better run and more tightly managed when it was operated by a nonprofit. The decision-making process became shorter and faster, leading

to a substantial increase in responsiveness to market changes. Some stakeholders pointed out that one of the main reasons this purchasing pool had to be shut down was that its transition out of state control disconnected it from the policy process. This prevented state policymakers from having adequate notice to make legislative or regulatory changes that could have kept the pool viable, including, for example, the price parity requirements ultimately included in federal reform.

The experience with California's public programs, as well as within the Massachusetts and Utah exchanges, suggests that there will be instances in which the state will look to partner with other entities. One influential deciding factor was the tight timeline necessary to get up and running. Many of the California Health and Human Services Agency staff wore "2014 Is Tomorrow" buttons. Creating an exchange was a massive undertaking, even for a state like California that had a significant jump on the process.

2.2. Leadership – Who Governs?

The California Health Benefit Exchange Board

The California Health Benefit Exchange five-member Board of Directors is made up of appointees of the governor and the state legislature who serve four-year terms. Two Board members are appointed by the governor, one is appointed by the Senate Rules Committee, and one is appointed by the speaker of the Assembly. The secretary of the Health and Human Services Agency, or the secretary's designee, serves as an ex-officio voting member of the Board. The Board first met in April 2011 and has held more than thirty-eight meetings since then.[12]

The need for nimble participation in the market was also one of the main reasons for having a five-member Board — a much smaller Board than the marketplaces in Massachusetts, Oregon, and Washington.[13] The California statute also has very strong conflict-of-interest provisions for the Board and does not allow anyone who currently draws money from an entity that could receive funding from the exchange (e.g., a provider or carrier) to serve as a member. However, the staff who designed this provision subsequently commented that they regretted making the conflict-of-interest provisions so stringent.

An analysis performed for the California Chamber of Commerce strongly critiqued the leeway given to the California Health Benefit Exchange Board. Specifically, it raised the concern that the Board's activities could create significant general fund liability for the state by increasing the scope of essential benefits and by unilaterally enrolling people in the state's Medicaid programs.[14] Independent groups, including the nonpartisan Legislative Analyst's Office, pointed out that this conclusion appeared to be in direct contradiction to the plain language of the statute, which was written to protect the general fund; left authority to determine mandated benefits with the legislature; and required the exchange to

coordinate with existing public programs on issues of eligibility and enrollment.[15,16]

Diana S. Dooley, Chair

The current chair of the board, Diana Dooley, was appointed as the Health and Human Services secretary by Brown in 2010. Dooley began her career as an analyst with the State Personnel Board and has worked as legislative director and special assistant to Brown. She has been an owner of public relations and advertising agency, a private practice lawyer, and general counsel and vice president at the Children's Hospital Center. She has also served on the Board of Directors for the UC Merced Foundation, Blood Source of Northern California, and the Maddy Institute at California State University, Fresno and as past president of Planned Parenthood, the Visalia Chamber of Commerce, and the Central California Futures Institute. Dooley is a native of Hanford, California, and holds a bachelor's degree in social science from California State University, Fresno, and a law degree from San Joaquin College of Law.[17]

Kimberly Belshé

Kim Belshé is executive director of First Five LA, an organization that has invested more than $1 billion from tobacco tax revenues in the last twelve years to increase the number of Los Angeles County children ages 0 to 5 who are physically and emotionally healthy, ready to learn, and safe from harm. Previously, she was senior policy advisor with the Public Policy Institute of California and has held leadership positions in state government, where she has led efforts to improve the health and well-being of Californians in underserved communities. She served as the secretary of the Health and Human Services Agency under Schwarzenegger, as director of the Department of Health Services, and as deputy secretary of the Health and Welfare Agency under Governor Pete Wilson. She also serves on the Kaiser Commission on Medicaid and the Uninsured and has previously served on the Board of the Great Valley Center. Belshé was appointed to the Board by Schwarzenegger and will serve her term until January 2015. Belshé is a native of San Francisco, California, and holds a bachelor's degree in government from Harvard College and a master's degree in public policy from Princeton University.[18]

Paul E. Fearer

Paul Fearer was appointed to the board in March 2011 by Speaker of the Assembly John A. Perez and was reappointed to serve until January 2017. Fearer has worked as senior executive vice president and director of human resources of the UnionBanCal Corporation and its primary subsidiary, Union Bank N.A., since 1996. He has also served on the bank's executive management committee, as the deputy director of human resources services with Stanford University, as chair of the board of

directors of the Pacific Business Group on Health, as chair of the executive committee of the Financial Services Group, on committees of the board of the Robert Rauschenberg Foundation in New York City, and as chair and a member of the PacAdvantage small business health benefit exchange. Fearer received a bachelor's degree from the Massachusetts Institute of Technology and did graduate studies at Stanford University.[19]

Susan Kennedy

Susan Kennedy was appointed to the Board by Schwarzenegger after working as his chief of staff and will serve her term until January 2015. Kennedy has also served as deputy chief of staff and a cabinet secretary for Governor Gray Davis, as communications director for Senator Dianne Feinstein, as executive director of the California Democratic Party, and as a commissioner on the California Public Utilities Commission. Kennedy was a leader in Schwarzenegger's health reform initiatives, which passed the state Assembly in 2007, but failed to pass in the state Senate. Schwarzenegger's plan was similar to the Affordable Care Act with the requirement for individuals to purchase health insurance coverage, a ban on denying coverage for pre-existing conditions, and the expansion of tax credits and programs for low-income families. Kennedy owns her own consulting firm in San Francisco and is currently a special advisor with the Berkeley Research Group, a senior policy advisor with the law firm of Alston & Bird, and an external advisor to McKinsey & Company. Kennedy graduated from Saint Mary's College with a degree in management.[20]

Robert Ross, M.D.

Dr. Robert Ross was appointed to the Board by the Senate Rules Committee in June 2011 and will serve through January 2016. Dr. Ross also serves as president and chief executive officer of the California Endowment, a foundation established in 1996 to address Californians' health needs. Before working with the California Endowment, Dr. Ross was director of the Health and Human Services Agency for the County of San Diego and commissioner of public health for the City of Philadelphia. He has also served with the Rockefeller Philanthropy Advisors and as cochair of the Diversity in Philanthropy Coalition. Dr. Ross has been a Board member of the USC Center on Philanthropy and Public Policy, Grantmakers in Health, the National Vaccine Advisory Committee, the National Marrow Donor Program, the San Diego United Way, and the Jackie Robinson YMCA. He is a diplomat of the American Academy of Pediatrics, served on the President's Summit for America's Future, and was a chairman of the national Boost for Kids Initiative. Dr. Ross received his bachelor's and master's degrees in public administration and his medical degrees from the University of Pennsylvania in Philadelphia.[21]

The Executive Director

The Board hired its first executive director, Peter Lee, in August 2011. The executive director reports directly to the Board and is responsible for providing leadership and direction, formulating the exchange's strategic objectives, and maintaining effective relationships and communication with key stakeholders, and the executive and legislative branches of the federal and state government. In particular the executive director:

- Manages the planning, development, implementation, and ongoing administration and evaluation of exchange programs.
- Provides the overall direction and supervision to the executive staff of the exchange in carrying out program goals and objectives.
- Manages the entire staff of the exchange, including eligibility and enrollment staff, purchasing and negotiation staff, and administration and operations staff.
- Advises the Exchange Board on key policy and operational issues.
- Ensures the smooth operation of programs and operations under the Board's jurisdiction.
- Establishes liaison and ongoing communication with stakeholders and the executive and legislative branches of state government with responsibilities related to the duties of the Board and other health coverage issues.
- Advances the mission of the exchange through legislation, program administration, research, and other means, as appropriate.
- Maintains strong liaison and good communication with the executive and legislative branches of state government involved in health coverage issues.
- Assures compliance with applicable state and federal legal and regulatory requirements, including public meeting laws, federal expenditure requirements, and state personnel policies.
- Represents the exchange and its mission and programs at national, state, and local meetings and forums; in the media; and at legislative hearings.[22]

Peter V. Lee

Lee was confirmed by a unanimous vote of the Board to his position as executive director on August 23, 2011. Prior to his appointment, Lee was the deputy director for Medicare & Medicaid Innovation at the Centers for Medicare & Medicaid Services in Washington, D.C., the director of delivery system reform for the Office of Health Reform in the U.S. Department of Health and Human Services, CEO and executive director of the Center for Health

Care Rights, and director of programs for the National AIDS Network. Before working in the public sector, he was an attorney in Los Angeles. Lee holds a bachelor's degree from the University of California, Berkeley, and a law degree from the University of Southern California.[23]

2.3. Staffing

California's current law prohibits the use of the general fund to establish or operate the exchange. As a result, the Board has pursued federal grants as a primary funding source for its programs through 2014 and has received more than $910 million for research, planning, information technology development, and implementation of the exchange. Since the exchange must be self-sustaining from charges assessed on qualified health plans and other supplemental products by 2015, the Board has budgeted for the first years of operation based primarily off these grants.

The exchange also currently utilizes accounting and administrative services from the California Department of Social Services to assist in meeting its federal financial reporting requirements. The exchange expects to create internal policies and procedures and to transition these functions as additional staff positions are available.[24]

Overall, the exchange expects to directly employ nearly 1,000 staff, although hiring efforts throughout 2013 were relatively slow. Plans for three service centers located in Contra Costa, Fresno, and Sacramento counties were expected to require almost 800 staff — 350 of which should have been hired by May 2013. However, by June 2013, the exchange had made only forty-four hiring offers for these service center positions and was awaiting authorization from the legislature to perform background checks on subsequent hiring offers. When Senate Bill 509 became effective in June 2013, allowing the exchange to require fingerprinting and background checks as a condition of employment for both contracted and state employees, hiring efforts resumed at an increased rate.[25]

Employees of the exchange are state employees subject to civil service requirements and are hired under job classifications specified by California law. In its federal grant requests, the exchange has requested funding for positions in a range of classifications, including accountants; program, budget, legal, and information systems analysts; systems software, research program, and personnel specialists; staff services and data processing managers; and a variety of career executive assignment positions for executive level division managers.

Organizational Structure and Staff Breakdown

The Health Benefit Exchange has seven main divisions: operations, finance, product development and sales, legal, program policy, communications and public relations, and government

relations. The operations division is the largest with more than 800 employees. This division includes the chief deputy executive director, with an expected staff of fifty-two; a deputy director of eligibility and enrollment, with thirty-four staff; a chief technology officer, with fifty-five staff; and the deputy director of the service centers, with an expected staff of 660.

The finance division, currently supported through borrowed staff from the California Department of Social Services, is expected to have at least fifty-five employees under a chief financial officer. The product development and sales division contains two branches, a director of the small business health options program with seven staff, and a director of health plan management, with twenty staff. The legal division is managed by the chief counsel and has twelve staff, while the program policy division has nine staff and is managed by a director of program policy. The communication and public relations division is overseen by a director of communications and public relations with a staff of forty-seven. The government relations division has only four staff under a director of government relations.[26]

The service center branches in Contra Costa and Sacramento counties began operating in September 2013 and the third branch in Fresno became operational in November 2013. The exchange manages and operates the service centers in Fresno and Sacramento counties and partners with Contra Costa County's Department of Social Services to manage the Contra Costa service center. Although Contra Costa is responsible for hiring its own staff, the exchange will train their staff and provide oversight, policy, and procedures.

The Fresno and Rancho Cordova (Sacramento County) service centers will each employ 500 staff members, who are primarily state employees, while the Contra Costa service center will have about 200 county staff. Staff members will provide information, answer questions, or refer clients to outside resources either by phone or through online real-time "chat" systems. Due to the diverse population in California, the exchange has hired staff members who speak English, Spanish, Mandarin, Vietnamese, and a variety of other languages, and has devices for the deaf and hearing impaired, to support clients who have questions about coverage options or need help with enrollment.[27]

In its July 2013 report to the legislature, the California State Auditor initially expressed doubt that the Health Benefit Exchange would meet its hiring goals due to delays in the process; however, the service centers began handling statewide calls on November 18th with a relatively modest complement of 407 staff. However, the exchange has conducted several waves of hiring in order to meet its staffing goals and, as of the end of November 2013, 611 staff had been hired out of the total target of 810.[28]

At its peak on the first day of operation, October 1, 2013, the service centers took 23,270 calls, although average daily workloads during October were between 7,000 and 8,000 calls.

Of the more than 200,000 calls received in October, 89 percent were English callers, 8 percent were Spanish clients, 2 percent were Asian language clients, and 1 percent spoke other languages. About half of the non-English speaking clients are handled by exchange staff and the remaining half are served by contracted language representatives. Although the service center maintains goals of 80 percent of calls answered within thirty seconds, 3 percent or less of calls abandoned, and 0 percent of calls receiving busy signals, the data from October demonstrated that staff were only able to answer between 21 and 58 percent of calls within thirty seconds and between 42 and 10 percent of all calls were abandoned.[29] The service centers are rapidly improving their capacity on a week-by-week basis and can be expected to meet their performance goals once the agency is fully staffed in 2014.

Information Technology Contracts

The exchange also relies on the implementation of a large information technology project, the California Health Eligibility and Enrollment and Retention System (CalHEERS), which is a shared system between the exchange, the Department of Health Care Services, the Managed Risk Medical Insurance Board, and other stakeholders. The system streamlines how individuals and businesses obtain health coverage by providing eligibility and enrollment services online and through the call center platform. The exchange obtained project management services from the California Health and Human Services Agency's Office of Systems Integration along with an independent consultant to review the work of its systems developer. The exchange's contract for development of the CalHEERS system was competitively bid throughout 2012, until the contract was awarded to Accenture in November 2012. This contract included the design, development, implementation, and support of the software and equipment necessary to operate the three service centers, including functions required for a call center platform, and a planned roll out using two releases at a cost of about $183 million for initial development and $176 for maintenance and support over the following three and a half years.

In July 2013, an initial release allowed clients to access a Web portal that provided a method to shop for and compare health plans. In October 2013, a second release allowed individuals to check eligibility for Medi-Cal, Healthy Families, or subsidized coverage on the exchange.[30] As a key interface with both internal systems and the public, the second release Web portal experienced more than one million unique visits in its first week of operation and a total of 2.2 million visits through October 2013.[31]

2.4. Outreach and Consumer Education

The exchange has conducted extensive marketing and outreach programs to reach targeted populations, meet federal and state requirements, and increase enrollment in the exchange. In connection with the California Department of Health Care Services, the exchange planned its marketing and outreach campaign around the following goals:

- Provide a one-stop marketplace for information and enroll uninsured Californians in affordable, high-quality plans.
- Provide Californians with educational materials to help them understand the benefits of health insurance coverage.
- Encourage currently insured Californians to continue their health insurance coverage.
- Ensure that affordable health care coverage is available for all Californians.[32]

To support these goals, the exchange identified the core audience of approximately 5.3 million uninsured Californians, 2.6 million of which may qualify for federal subsidies, where the marketing and outreach campaigns could be focused for the greatest effect. Using available demographic information, the agency further refined its outreach strategies based around the idea that different groups will have different needs and motivations. This led the agency to take multiple approaches to market the exchange to groups based around age, gender, income level, and race or ethnicity. The agency worked to provide both statewide and targeted local outreach and marketing through partnerships with community?based organizations and paid media campaigns.[33]

The outreach campaign was split into seven phases beginning in September 2012 through December 2015. Phase I, which involved research, media planning, creative development, partnerships, and social media, provided the build-up to Phase II and was completed by January 2013. Phase II, which encompassed the first phase of consumer outreach and education, ran until July 2013. It primarily involved the development of a comprehensive media plan and the establishment of connections with community-based organizations to educate consumers about the available health insurance options. As part of this second phase, the exchange's paid media campaign was launched in June 2013, with a wide variety of print, radio, social media, and television advertisements designed to educate consumers and small businesses about the exchange, the availability of federal subsidies, and the types of health plans on the marketplace. The exchange assessed the effectiveness of this first marketing blitz and planned for adjustments to its future marketing efforts, according to the available information.[34]

Outreach and Education Grant Program

The outreach and education grant program, part of the Phase III marketing campaign beginning in July 2013, was the primary method to promote public awareness among consumers and small businesses. Out of about 200 applicants, the exchange awarded more than $36.3 million in grants to forty-eight groups that included community-based organizations, health clinics, and government entities. The agency expects that between July 2013 and December 2014, the grantees will reach about nine million consumers and more than 200,000 small businesses to help address the barriers that prevent consumers and small businesses from purchasing health insurance coverage. Grantees are required to comply with the exchange's evaluation and monitoring plan, which includes completion of reports, monthly site visits, and thorough records of expenditures and activities. This plan also includes a mechanism to correct deficiencies when grantees fail to meet pre-existing targets and can result in the termination of the grant, if identified deficiencies are not corrected within a thirty day evaluation period.

In addition, four grantees — the California Academy of Family Physicians, the California Medical Association Foundation, the California Society of Health System Pharmacists, and the National Council of Asian Pacific Islander Physicians — were awarded grants to provide outreach and education to health care professional organizations and associations.[35]

Future Marketing and Outreach Efforts

In order to continue its marketing efforts for Phase III and beyond, the Health Benefit Exchange contracted with Weber Shandwick, a global public relations firm, in May 2013 to provide a creative marketing and paid media campaign through April 2015. Beginning in September 2013, the firm was tasked with overseeing the use of $86 million to advertise the exchange's programs with a $12 million contract fee to cover the firm's development costs. The exchange has also retained the Ogilvy Public Relations group to support its media campaigns for Phase III through December 2014.[36]

Overall, the exchange has allocated a large amount of the federal funds towards these marketing and outreach campaigns. In 2013, the marketing budget was about $89 million, or 24 percent of the total budget, and in 2014 the agency expected expenditures to rise to $106 million, or 28 percent of its overall budget. On the whole, the California State Auditor has found that the exchange's outreach plan is both deliberate and thorough and that it appears to meet state and federal standards.[37]

2.5. Navigational Assistance

Sources of Navigational Assistance

In addition to the self-service functions available through online resources and the live chat and phone operators, the exchange also partners with a variety of entities to provide assistance and information on health plans, enrollment, and subsidies. Certified educators, who attended two and a half days of training from the exchange in July and August 2013, are expected to disseminate clear, accurate, and consistent information that will help to remove barriers that might prevent consumers and small businesses from applying for coverage through the exchange.

In addition, certified enrollment counselors were training during October 2013 to provide individual assistance to consumers who are attempting to enroll. California's assister program provides one-on-one, in-person assistance to help consumers learn about their health insurance options and to reduce any potential barriers to access. However, the assistance program also encompasses outreach and education, and there is no firm line demarcating these two program areas. The in-person assisters and navigators fulfill two very similar roles with differences only in the types of funding, compensation, and timelines involved.

In-person assisters began operating prior to the initial enrollment period in October 2013. They are funded through federal grants and receive a flat fee of $58 for each successful application, or $25 for a successful annual renewal. Navigators are paid from the exchange's operating funds, receive ongoing grants, and began operating only after the initial enrollment period started in October 2013.

Entities that are eligible to receive compensation as part of the navigational assistance program include American Indian tribes, attorneys, chambers of commerce, city governments, industry organizations, community clinics, community colleges, and universities. In addition, consumer assistance is also expected to be provided by outside public and private entities such as insurance agents, hospitals, commercial clinics, or county health departments that do not receive compensation from the exchange.[38]

Individuals are able to apply for the federal subsidy in person or by contacting local agencies by phone and they may also obtain paper copies of the application to complete and submit at their convenience. The exchange has also worked with the California Department of Health Care Services to ensure that local county health agencies play a large part in enrolling eligible individuals. As a part of this effort, county workers were also trained to use the exchange Web site to determine eligibility for Medi-Cal benefits.[39]

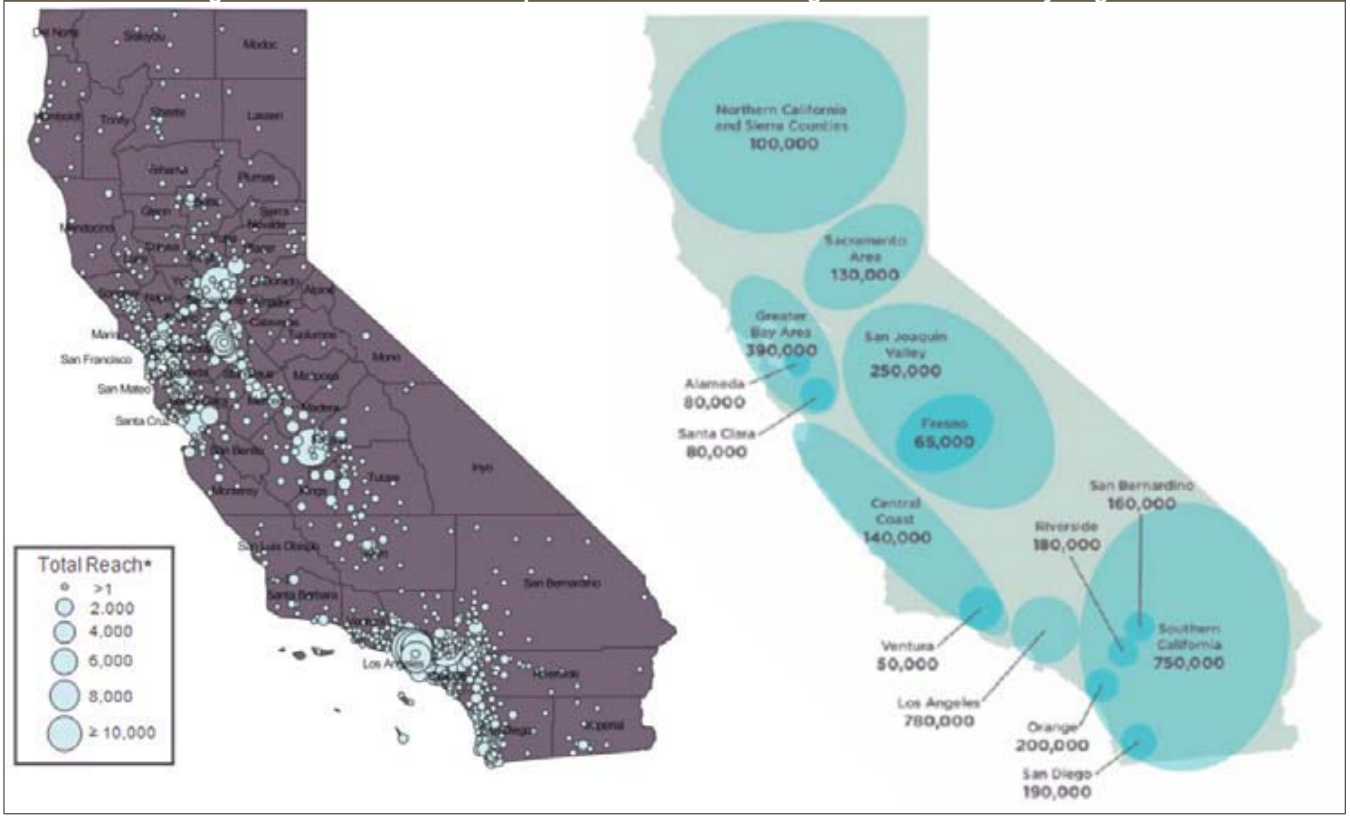
Certified licensed agents who represent the exchange were also trained to sell health insurance plans in both the individual and small-business markets. The certified insurance agents may enroll individuals through the exchange and receive market-rate commissions for such enrollments.[40]

Capability of Assistance to Meet Anticipated Needs

The Health Benefit Exchange currently has more than 600 staff members in its service centers who are available by phone or through live online chats. In addition, more than 2,500 certified educators and more than 5,000 certified enrollment counselors were trained across the state to provide education and enrollment information to consumers. More than 19,000 certified licensed agents also registered with the exchange to help enroll Californians during the 2013 open enrollment period. Through a partnership with the California Department of Health Care Services, the exchange has also trained more than 10,000 county eligibility workers to assist consumers in enrolling for health insurance through the exchange marketplace. The exchange Web site also contains many self-service tools designed to allow individuals to choose an appropriate health plan, as well as a section with online community events where Californians can talk to certified educators about the benefits of the exchange's products.[41] As Figure 1 displays, grantees are expected to reach approximately nine million Californians and more than 200,000 small business owners throughout California. [42]

After the first grant process is completed, the exchange plans to conduct an analysis of the grantee results to identify gaps in outreach or education in specific geographical areas or target populations and use this information to administer a second set of grants in 2014. Based on its research, the exchange expects that 50 percent

Figure 1. Grantee Reach Comparison to Individuals Eligible for Subsidies by Region[41]



of consumers will need assistance from its network of more than 21,000 individual assisters from more than 3,600 entities.[43]

Types of Organizations

As mentioned above, the exchange has awarded forty-eight grants to promote outreach and assistance. Table 1 provides a

Table 1. Outreach and Education Grantees[43]

2-1-1 San Diego	Community Health Councils
Access California Services	Council of Community Clinics
AHMC Health Foundation	East Bay Agency for Children
Asian Americans Advancing Justice - Los Angeles	Fresno Healthy Communities Access Partners
Bienestar Human Services, Inc.	John Wesley Community Health (JWCH) Institute, Inc.
Cal State LA University Auxiliary Services, Inc.	Loma Linda University Medical Center
California Black Health Network	Los Angeles County Federation of Labor, AFL-CIO
California Council of Churches	Los Angeles Unified School District (LAUSD)
California Family Resource Association(CFRA)	NAACP (California National Association for the Advancement of Colored People)
California Health Collaborative	Planned Parenthood Mar Monte, Inc
California Rural Indian Health Board, Inc.	Redwood Community Health Coalition
California School Health Centers Association	Sacramento Covered
Catholic Charities of California, Inc.	Sacramento Employment and Training Agency (SETA)
Central Valley Health Network	San Bernardino Employment and Training Agency (SBETA)
Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA)	Santa Cruz County Human Services Department
SEIU Local 521	The Regents of the University of California
SEIU United Long Term Care Workers	UC Davis, Center for Reducing Health Disparities
Social Advocates for Youth (SAY), San Diego, Inc.	United Ways of California
Solano Coalition for Better Health	University of Southern California
St. Francis Medical Center of Lynwood Foundation	Valley Community Clinic
The Actors Fund	Ventura County Public Health
The East Los Angeles Community Union	Vision y Compromiso
The Los Angeles Gay and Lesbian Community Services Center	Women's Health Specialists

complete listing of all forty-eight groups that were awarded grants as of August 2013.

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations

Exchanges are designed to facilitate access to private insurance and public programs. The Affordable Care Act directs exchanges to determine eligibility for public programs for people who interact with them. The state of California expanded on these responsibilities. Specifically, the Board is required to "coordinate … eligibility, enrollment, and disenrollment … with state and local government entities administering other health care coverage programs … and California counties, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage."[45]

This topic has inspired a great deal of conversation in California. It was identified by the California Department of Health and Human Services as one of the key opportunities in federal reform. According to a state planning document, "important policy and information technology systems issues will need to be carefully considered, including how the exchange's eligibility and enrollment functions will interact with Medi-Cal (i.e., California's Medicaid program), Healthy Families, and other public programs."[46]

Coordination among public programs was a complex issue in California even before the advent of the exchange. California is one of eight states with a stand-alone children's health insurance program and, like many other states, it has a host of additional programs to assist specific populations such as women and infants, and children in need of specialty care. Because of the complexity of the market and the number of varying interests involved, California did not submit an application for a federal "Early Innovator" grant. These grants are for states that plan to use their exchanges to engage in technologically innovative methods to coordinate between public programs and private insurance coverage.

Almost every task that is expected of the exchange, including consumer protection, risk management, and coordination with public programs, will require the development of new health information technology solutions and careful work to guarantee that these technologies interface seamlessly with legacy systems. Fortunately, a great deal of work has already been done. In California, this includes work on the Health-E-App and One-E-App systems. To as great an extent as possible, given the tightly compressed timeline of implementation, states and the federal government should build on existing efforts.[47]

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs)

Participation and Competitiveness

Thirty-two health insurance companies expressed interest in offering individual plans on California's Health Benefit Exchange in late 2012. Thirteen were tentatively approved to offer coverage in the first open enrollment beginning on October 1, 2013. Of the thirteen, four — Anthem Blue Cross, Kaiser Permanente, Blue Shield of California, and Health Net — covered more than 80 percent of individuals insured in California's individual market in 2013.[48] However, a number of small, regionally based insurers also chose to participate and were approved to offer coverage, including: Chinese Community Health Plan, L.A. Care Health Plan, and Valley Health Plan.

In the months leading up to open enrollment, one of the original thirteen plans approved to offer coverage through the exchange would not sign a final contract, and another would be dropped for regulatory reasons. Ventura County Health Care Plan (VCHCP) announced in August of 2013 that it would not be offered on the exchange for 2014, citing an "ongoing analysis of enrollment projections, start-up costs and certain factors whose outcome and impact are difficult to predict." The plan has indicated it hopes to offer plans in 2015. However, its departure highlights the difficulties and relative high cost smaller plans face.

In November 2013, it was announced a second of the original thirteen approved plans would not be sold on the state's exchange. Alameda Alliance for Health, a public nonprofit county health plan, was removed from the list of approved plans for failing to meet financial solvency requirements set by the Department of Managed Health Care. Alameda Alliance plans had been on the exchange site since open enrollment began October 1, so prospective enrollees had to be informed they would need to choose another plan. Like VCHCP's departure, the removal of Alameda Alliance four weeks after the start of open enrollment is indicative of the pace of reform implementation.

Notably absent from the list of companies expressing interest in offering plans on the exchange were prominent health insurers UnitedHealth, Aetna, and Cigna. With UnitedHealth — the nation's largest insurer — and other big names choosing to remain out of the state's exchange, stakeholders and the media questioned competitiveness in the marketplace. However, while UnitedHealth, Aetna, and Cigna are large national insurers, together they represented only 7 percent of California's individual market prereform.[49] Participation by both the "big four" in California, as well as a surprising number of midsize and small insurers, guaranteed that the exchange would have adequate competition.

Plan Types and Network Availability

Eleven insurers were offering plans on California's exchange as the deadline to obtain coverage by January 1 approached. Consumers in all of California's urban areas have a range of options for plan type, including HMOs, PPOs, and EPOs. A large number of California's rural counties also have robust choice, with only a select few lacking one of the three plan types available to urban consumers.

However, the nature of federal reform — including the elimination of medical underwriting — as well as California's decision to be an active purchaser in order to hold down premiums meant insurers were likely to significantly narrow networks for 2014. Prior to, and even during, the early months of open enrollment it was unclear to stakeholders and consumers how narrow the networks would be.

Covered California issued a press release in December 2013 saying more than 80 percent of the state's physicians were included within plans sold on the exchange, as well as more than 360 hospitals.[50] However the networks of individual plans are much smaller. Blue Shield of California, covering around 20 percent of California's individual market, said 2014 plans would include only 50 percent of the physicians it included in 2013. Consumer reactions are likely to play a large role in the development of plan networks in future years.

2.7(b) Clearinghouse or Active Purchaser Exchange

Because California has a tradition of active purchasing through its children's health insurance program, small-business purchasing pool, and state-employee purchasing pool, policymakers were building on an established history. The lesson for other states, however, is not necessarily that they should all make their exchanges active purchasers. Rather, they should let the decision in this critical area be driven — as California's was — by the experiences of their state, as well as by the nature and structure of their private insurance markets.

For an exchange to be successful it must have broad public support and be able to attract an adequate number of covered lives. California is distinct in important ways from other states both politically and demographically. In other states, an exchange may have to work hard to attract 100,000 people to the pool. This size is critical if the entities want to avoid getting "upside-down" on risk and to keep the administrative load per enrollee to a minimum. This is less of a problem in California where it is likely that the exchange will have at least one million to two million lives in private insurance coverage served by five or six major insurers, regardless of the choices it makes.

There are some cautionary lessons from California's experience in selective contracting. Chiefly, it is not primarily the size of a group that determines rates. Cost and utilization of health care services among enrollees is a major driver of rates. For example,

the state public employee retirement system, CalPERS, is one of the largest health care purchasers in the country, but the high prevalence of chronic disease among state workers, and their higher relative age, drives rates up for this group.

Having many different carriers participating in a marketplace increases competition. But having a smaller number of carriers presents the potential for partnerships through the development of strong relationships over time. In California, state employees in the Sacramento region have access to a virtually integrated delivery system, a partnership between Blue Shield of California, Catholic HealthCare West, and Hill Physicians group. This alliance has kept premiums stable for the employees who choose it and has been working to integrate the different systems and improve quality of care.[51] According to the terms of the arrangement, the insurer, hospital system, and physicians' association were given autonomy to redesign their care delivery systems to promote better coordination and improve efficiency. For example, they worked to eliminate redundancies, such as having the same patient participate in multiple chronic disease management programs. At the end of the pilot period, CalPERS estimated it saved $15.5 million through this "active purchasing" partnership and said it plans to expand the program.[52]

2.7(c) Program Articulation

From the earliest phases of design, California pursued a "no wrong door" approach to exchange articulation with existing and future programs. One of eleven states working in cooperation with the federal government on Enroll UX 2014 — a set of design prototypes aimed at adopting best practices into the user experience — California ensures consumers are directed to any program for which they may be eligible.[53] Covered California's online portal allows consumers to directly enroll in individual and family coverage, Medi-Cal, and SHOP plans. The Web site can also direct individuals to California's online voter registration site. Consumers are not able to enroll in Medicare through the portal.

2.7(e) Government and Markets

In every state, exchange boards will have to be very active in mitigating adverse selection among plans in the exchange, between the exchange and the outside market, and across market segments (e.g., individual, small-group, self-insured). Adverse selection occurs when actions by insurers or enrollees deliberately or inadvertently lead to an insurance risk pool of people who are substantially less healthy and more costly to insure. Once a poor risk profile has been developed for a particular product, it is difficult for the risk-bearing entity to remain financially viable. A review of the state's experience with its small-business exchange emphasizes the importance of avoiding adverse selection and warns that "very strong measures are needed to prevent exchanges from falling into a death spiral."[54]

The Affordable Care Act has several provisions that differentiate its exchanges from voluntary purchasing pools such as PacAdvantage. First, an exchange is the only place in which individuals and businesses can receive subsidies and tax credits, which will create a "captive audience." This makes it less likely that the exchange will be selected against by the outside market because — particularly in states like California — the group is likely to be large enough to have an acceptable risk profile. Second, carriers within an exchange are required to offer products only at specified actuarial values (i.e., catastrophic, bronze, silver, gold, and platinum). This will help consumers make meaningful comparisons among products and may somewhat reduce the likelihood that plans will be adversely selected against within the exchange. Further, insurers are required to offer the same products at the same price both within and outside of the exchange. This also helps reduce selection against the exchange. The carriers who participated in PacAdvantage were unwilling to offer the same price for the same product. This requirement has the important implication, though, that there can be no price advantage because of negotiating clout or administrative efficiencies for participating in the exchange.

Some carriers expressed concern that the structure created by these regulations will mean that price negotiated by an exchange will effectively set prices for the rest of the products within and outside this market. They believe that because the rating factors allowed are very specific, any price change in a market segment for any product may require price changes for all the other products in the portfolio. The rating factors that are allowed are now limited to a very small set, including age and tobacco use.

The full impact on market dynamics and prices is yet to be determined. It is clear, though, that elements of the reform law — in particular those related to exchanges — will have unforeseen implications for the private insurance market. There may also be significant consequences for providers who depend on payments from private insurers that participate in the exchange. In the individual market, where an exchange will have a long-term captive audience because of the subsidies, these new purchasing pools may indeed set prices for the market. The exchange cannot negotiate a better price exclusively for its enrollees, but its activities may bring down the price for all participants in the individual market. In the small-group market, on the other hand, the exchange may not have as great an effect on the prices in the market since the tax credits are of limited duration and there is no requirement for employers with fewer than fifty employees to offer coverage. Overall, the requirement that prices be equal inside and outside the exchanges means the California exchanges are less likely to be subject to adverse selection, but it also takes away an important putative advantage — lower prices.

California built upon federal legislation to reduce the likelihood of adverse selection within and against the exchange. First,

while the federal legislation requires plans to offer only the silver and gold levels of coverage within the exchange, California requires plans to offer all levels of coverage. Critically, this requirement relates to plans whether or not they participate in the exchange. Therefore, there will be a direct comparison across all carriers in the market at these actuarial values. The exception to this is related to the second important regulation that California put in place: the restriction that plans can only offer the catastrophic coverage product — and access the relatively young and healthy enrollees to whom this product will appeal — if they participate in the exchange.

The federal law also includes a provision on statewide risk adjustment that applies to plans both in and outside an exchange. In theory, this should eliminate most concerns about adverse selection because plans that have unhealthier pools will receive money from those with healthier ones. However, there are important caveats because risk adjustment, even under ideal circumstances, is imprecise. There is some disagreement as to whether it was done effectively in the past, for example, within California's small-business purchasing pool.[55] But even assuming risk adjustment is done perfectly, it is designed to smooth differences within relatively narrow bands. If carriers' payments to each other become very large proportions of total revenues, this may undermine the entire model. The subsidies paired with risk adjustment, therefore, will not guarantee success for an exchange either in terms of fulfilling its public purposes or succeeding as an entity operating within the private market. Therefore, states should give serious consideration to adopting the further steps that California took to reduce adverse selection.

2.8. Data Systems and Reporting

Data systems and reporting are still in development.

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

The Small Business Health Options Program (SHOP)

There is enthusiasm among small business owners in California about the promise of the small-group exchange in spite of the state's uneven experience with purchasing pools. According to John Arensmeyer, CEO of Small Business Majority, "When we tell small business owners about the exchange provisions in the Affordable Care Act, there is tremendous interest, and one-third say that an exchange will make it more likely that they will offer coverage." On the other hand, there is no penalty in the law for groups with fewer than fifty employees that do not provide insurance. Some have discussed the possibility of ceasing to offer insurance in favor of increasing employees' salaries, many of whom

would qualify for subsidies to purchase insurance on the individual exchange.

The primary value proposition of small group exchanges has been a broader range of choice for employees than is traditionally offered within the outside market where insurers place strict participation requirements on small groups. In California and other states, the trade off for this choice is that the plans offered through small group exchanges have generally been more expensive than comparable plans in the outside market. These exchanges, therefore, have tended to cater to a niche clientele. Some businesses are willing to pay the relatively higher premiums to get this set of choices for their employees. One of the most popular products in PacAdvantage, California's defunct small group purchasing pool, was PairedChoice. This option allowed employers to combine a Kaiser HMO plan, generally offered to their employees, with a PPO plan, generally taken up by the owners and their relatives.

The small group exchange will need to develop a value proposition that appeals to small businesses and insurers alike. Small group exchanges have historically struggled to attract and retain insurers. Indeed, Anthem Blue Cross, the insurer with the largest share of the state's small group business, chose to drop out of the SHOP exchange and continue to participate in a private exchange, CalChoice, which competes with the SHOP. Some observers expressed concern that the main value proposition of the Affordable Care Act's small group exchange for insurance carriers — access to groups that utilize a modest tax credit that expires after two years — may not be adequate to attract their business. Insurers generally prefer not to split the business of a small group with another carrier. With California choosing to offer "employee choice," business that many insurers would prefer to have combined may be sliced. Therefore, they may continue to prefer selling policies in the market outside the exchange.

Another critical issue is the relationship among the exchanges and the health insurance agents who serve this market. The small-group exchange is more likely to be successful if it enrolls a great number of people, and brokers have the broadest and most well-established set of relationships with the small group market. California chose to allow only certified insurance agents to sell SHOP products. Certified enrollment counselors will serve solely the individual market.

Size of the Small Group Market

An option available to states from 2014 to 2016 is to temporarily limit the size of employers who can participate in the small group exchange to those with fifty or fewer employees. In 2016, it will expand to up to 100 employees in all states. California has chosen to limit enrollment to smaller groups until 2016.

In California, as in many other states, this presents challenges for implementation. In California, the small-group market (i.e., two to fifty individuals) is age-rated, whereas the midsize market

(i.e., fifty-one to 100 individuals) is community-rated. The practical implication is that premiums for individuals, and hence for the group, can be different across these market segments. The technical requirements for producing the premiums for these two markets are distinct and combining them without standardizing the underlying law would be very challenging, if not prohibitively complicated.

The natural default for many states has been to restrict the size of the market for the first two years as these technical issues are worked out. However, an exchange set up to cater to the traditional small group market exclusively, even for a limited time, may make different decisions than an exchange planning to serve groups of up to 100 individuals. These markets often have different structures, are served by distinct delivery channels, have varying compensation schedules for agents, and carry different customer service expectations. Further, for states that are smaller than California, limiting the size of groups that can participate raises concerns about the total size of the market.

Part 4 – Summary Analysis

4.1 Policy Implications

What groups and institutions appear to be winning or are likely to win (i.e., gain benefits, resources, and influence) as health reform is implemented? What groups and institutions are losing or are likely to lose? How has the implementation of health reform affected the power and alignment of groups, interests, and institutions in health policymaking?

In many ways, the implementation of health care reform has not — or at least not yet — dramatically changed the status quo in California in terms of health care coverage. One somewhat surprising trend is that more than 96 percent of enrollees in the state exchange in the first two months enrolled in one of the four plans that had the largest share of the market for individual insurance before reform — Anthem Blue Cross, Kaiser Permanente, Blue Shield of California, and HealthNet. Some analysts had predicted that new entrants to the marketplace for commercial insurance, such as traditional Medicaid Managed Care plans, LA Care, and Molina, would do extremely well given their familiarity with marketing to subsidized populations. This dynamic may change, however, after California implements legislation passed in 2013 (SB X 1-2, Hernandez), that will give consumers the ability to remain with their Medicaid Managed Care plans as their income increases. Traditional safety net health care providers also expected to be well positioned to expand under reform, but are beginning to feel as if the provisions designed to assist them, such as the requirement that plans include "Essential Community Providers" in their networks, will have no substantial influence on the status quo.

The enrollment infrastructure has been changed somewhat through the creation of certified enrollment counselors, a new

class of people able to assist consumers in selecting a coverage option. Covered California has also created large call centers with staffs that are empowered to enroll people in private or public coverage. However, for the time being, the incumbent enrollment infrastructure has been largely kept in place. There have been many concerns expressed by insurance agents about difficulties becoming certified insurance agents able to place business within the exchange, but these difficulties have also extended to certified enrollment counselors. There have also been few major changes or immediate-term threats to the roles of the substantial county-based enrollment infrastructure of public employees. In fact, one of the three call centers created by Covered California is administered by Contra Costa County.

The biggest changes in terms of long-term implications for health care markets, as well as policy, has little to do with the choices that California has made and more to do with the financial implications of reform. In the past, the individual market in the state was dominated — with the substantial and significant exception of Kaiser Permanente — by broad network PPOs. Insurers kept premiums down for consumers primarily through risk selection, as well as through often nontransparent changes to consumer cost-sharing.

However, in a policy framework in which consumer cost-sharing is standardized and risk selection is not possible, the only effective, immediate-term way to generate a lower price point is to purchase health insurance from lower-cost providers. Hence the networks that were put together by insurers for Covered California, as well as those for networks across the nation, whether or not the exchanges chose to be selective purchasers, are quite narrow. There are many hospitals, including prominent facilities such as Cedars-Sinai Medical Center in Los Angeles, that are in very few or no exchange networks. It is an open question as to what extent this dynamic will accelerate or moderate in the future as plans — and through them providers — compete for the business of newly subsidized customers. However, there has already been something of a backlash within the state — in particular directed at "Exclusive Provider Networks" (EPOs) that provide no access to out-of-region providers. It is possible that there will be legislative move to address these issues.

Also, in California, as elsewhere, the broader changes in health reform have led to hundreds of thousands of consumers who were currently purchasing health coverage in the individual market having to pay more for similar or less comprehensive coverage since they are no longer benefitting from risk selection. Conversely, of course, there are millions of consumers who are now eligible for generous subsidies. These subsidies, however, end at 400 percent of poverty, causing dramatic effective marginal tax consequences for crossing this income threshold for consumers in areas with higher health care costs.

Another interesting question, as yet unresolved, is the extent to which the changes in federal reform will catalyze the balance of power among the different agencies of state government. Since the passage of reform, the Department of Managed Health Care was reorganized to report directly to the secretary of Health and Human Services. There is some question as to whether it is appropriate for the regulator of health insurance to report to the same person who is the chair of the Board of Covered California, a participant in the health insurance marketplace. And the role of the Department of Managed Health Care is growing. Over the past ten years, as there has been an increasing imperative for insurance companies to reach a lower premium through increased consumer cost-sharing, many carriers have developed products that were subject to the lower regulatory threshold of the Department of Insurance.

This department is run by the insurance commissioner, currently Dave Jones, a Democrat, who is an elected constitutional officer in the state. In the past, the majority of the individual market fell under the Department of Insurance, but under the exchange only some of the products offered by one carrier, HealthNet, are regulated by the Department of Insurance. The rest are regulated by the Department of Managed Health Care. However, a ballot initiative that voters will consider in 2014 would give the insurance commissioner the authority to reject rate increases proposed by any insurer participating in the individual or small group marketplace, effectively leading to multiple layers of regulation and complicating the picture in terms of the balance of power going forward in the state.

The balance of power between Covered California itself and the rest of the state infrastructure remains something of an open question. To date, the exchange has coordinated very closely with the Department of Health Care Services, which administers the state Medicaid program, and has generally deferred to the Department on issues related to Medicaid. However, in a structure in which certified insurance agents and certified enrollment counselors, both managed by the exchange, are able to enroll people in Medicaid, this may have a significant impact on the balance of power within the state. Finally, the state legislature has given Covered California a substantial amount of leeway in its first three years of operations. However, it may take a more active oversight role and issue legislation directly affecting Covered California, in particular once the initial phase of setting up this marketplace is perceived to have been successfully accomplished.

4.2. Possible Management Changes and Their Policy Consequences

Although we have seen many states with significant management changes, including the resignation of many executive directors, California's leadership has been consistent at the senior level. There is not expected to be any short-term changes in the

composition of the five-member Board, and Peter Lee, the executive director, has enjoyed the consistent support of the Board. Since the secretary of Health and Human Services is automatically a member of the Board, it is possible this position will change if Dooley retires or if Brown does not win re-election as governor. However, Brown does not currently have any significant opposition within his own party or from the California Republican Party. There have been some changes at the management level, including the retirement of David Maxwell-Jolly, who had served in several positions, including as the first chief operating officer of the exchange. In spite of some turnover, the policy orientation and direction of the exchange has not changed to any great degree since the passage of the enabling legislation. Since California has led the nation — both to the extent that its IT systems have worked relatively well and the fact that it was relatively successful in enrolling people in coverage — there is not likely to be much demand for changes in exchange leadership in the immediate term unless there are massive problems in converting plan selections into enrollments and, ultimately, health care access. California has had significant challenges, and its first year enrollment will fall at the very low end of initial projections, but within the broader context of the implementation of federal health care reform, it has been seen as a model of how to set up and run such a marketplace.

Endnotes

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State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
March 2014

Consumer Assistance Resource Guide: American Indians and Alaska Natives

Prepared by the ***Center for Health Care Strategies***

Early evidence from across the nation suggests that consumer assisters are playing a vital role in helping people enroll in the new coverage options made possible by the Affordable Care Act (ACA). The State Health Reform Assistance Network has engaged with a number of states to develop easy to understand materials to educate consumer assisters about various issues that may confuse consumers and the assisters trying to help them during the eligibility determination and enrollment process. The following resource guide, developed by the Center for Health Care Strategies, was created to help consumer assisters answer some of the most common eligibility and enrollment questions related to coverage for American Indians and Alaska Natives (AI/AN).

American Indians and Alaska Natives

Through the Affordable Care Act and the reauthorization of the Indian Health Care Improvement Act, American Indians and Alaska Natives are entitled to a number of health coverage options, including the ability to access coverage through the marketplaces, public programs, and Indian Health Services. Additionally, AI/ANs are entitled to a number of protections under the ACA such as the cost-sharing obligation and individual mandate exemptions. This guide describes the applicability of ACA provisions to AI/ANs, the various protections available to AI/ANs, and the eligibility/verification criteria for AI/ANs.

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

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES
The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, please visit: *www.CHCS.org*.

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For more information, please contact Christian Heiss at CHeiss@chcs.org or 609-528-8400.

Robert Wood Johnson Foundation

Consumer Assistance Resource Guide

American Indians and Alaska Natives

March 2014

Support for this resource provided through a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

American Indians and the ACA

American Indians and Alaska Natives (AI/ANs) have greater unmet health needs and greater levels of health disparities than other segments of the U.S. population.

The Affordable Care Act (ACA) endeavors to address these needs by providing AI/ANs with access to federally funded health coverage and services to improve their health status and reduce the prevalence and incidence of preventable illnesses and premature deaths.

Specifically, the ACA allows eligible AI/ANs to: (1) continue to use the Indian Health Service (IHS); (2) purchase insurance through marketplaces; and (3) enroll in public programs including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

In addition to these coverage expansions, the ACA permanently reauthorizes the Indian Health Care Improvement Act (IHCIA), which increases funding and enables the IHS to modernize its delivery system and expand its workforce.

Verifying Tribal Membership for Medicaid and the Marketplace

Why is verification needed?

To obtain cost-sharing and tribal exemptions to the individual mandate offered by the ACA, AI/ANs will need to verify their tribal membership or affiliation. States can work with tribes to identify documents, in addition to those outlined below, that can be used to establish tribal membership.

Tribal Documents Accepted as Proof of Citizenship:

1) Tribal Enrollment Card;

2) Certificate of degree of AI/AN blood;

3) A tribal census document;

4) Documents on tribal letterhead, issued under the signature of the appropriate tribal official indicating an individual's affiliation to the tribe; and/or

5) Other documents proving membership, enrollment, and affiliation as determined in consultation with tribes.

Coverage for Non-Citizen Tribal Members

- **Medicaid**: Individuals who are not citizens but are members of a tribe located in a state with an international border are eligible for Medicaid if they meet all other eligibility criteria without being subject to the five-year waiting period (Personal Responsibility and Work Opportunity Reconciliation Act, section 402).

- **Other State Health Coverage Programs**: Eligibility for these programs should be outlined by the pertinent state agency.

- **Marketplace**: An AI/AN born in Canada or Mexico may be eligible for enrollment in a Qualified Health Plan (QHP) offered through the marketplace and may be eligible for premium tax credits or cost-sharing reductions (CSRs) if he/she is a lawful permanent resident or a non-citizen who is lawfully present for the entire period for which enrollment is sought. AI/ANs born in Canada that have maintained residence in the United States since entry can be considered to be lawfully admitted for permanent residence.

Applying the Income Rules to AI/ANs

What types of income are counted?

All income regularly counted in the Modified Adjusted Gross Income (MAGI)-based methodology applies to AI/AN applicants.

What types of income are non-countable?

1) Distributions from Alaska Native Corporations and Settlement Trusts.

2) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior.

3) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
   a) Rights of ownership or possession in properties held in trust under the supervision of the Secretary of the Interior; or
   b) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.

4) Distributions resulting from real property ownership interests related to natural resources and improvements:
   a) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
   b) Resulting from the exercise of federally protected rights relating to such real property ownership interests.

5) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom.

6) Student financial assistance provided under the Bureau of Indian Affairs education programs.

Citation: 42 CFR 435.603 - Application of Modified Adjusted Gross Income

Exemptions to the ACA Individual Mandate Requirements are Available for AI/ANs

Individuals who are members of a federally recognized tribe or a shareholder in an AN Regional, or Village Corporation may qualify for an exemption from the individual mandate requirement to purchase insurance and will not have to pay a tax penalty (know as an Indian hardship exemption). An IHS beneficiary, or a person eligible to receive IHS services, can also qualify for a hardship exemption.

To qualify, an AI/AN will need to verify his/her membership in a tribe or eligibility for services from the Indian Health Service, a tribal health care provider, or an urban Indian health care provider (I/T/U).

The Centers for Medicare & Medicaid Services (CMS) provides instructions on applying for an exemption based on AI/AN status, available at: http://marketplace.cms.gov/getofficialresources/publications-and-articles/tribal-exemption.pdf

Qualifying for an Exemption Based on Hardship

Hardship exemptions, beyond the Indian hardship exemption, may also be provided to individuals who:

- Were homeless, evicted in the past six months, or faced eviction/foreclosure
- Received a shut-off notice from a utility company
- Experienced domestic violence recently
- Experienced the death of a close family member recently
- Experienced a fire, flood, or other disaster that caused substantial property damage
- Filed bankruptcy in the last six months
- Had a cancellation in their individual insurance plan and believe other marketplace plans are unaffordable
- Had medical expenses they could not pay in the last 24 months
- Were determined ineligible for Medicaid because the state did not expand eligibility
- Experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member

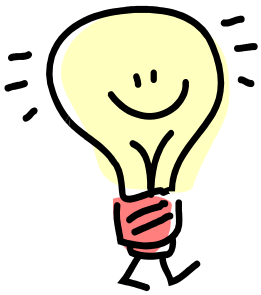
The marketplace will use an application to collect the information necessary to determine eligibility and grant a certificate of exemption for an applicant. Applications can be found at: http://marketplace.cms.gov/getofficialresources/publications-and-articles/affordability-sbm-exemption.pdf (State Based Marketplace) and http://marketplace.cms.gov/getofficialresources/publications-and-articles/affordability-ffm-exemption.pdf (Federally Facilitated Marketplace).

Individual Mandate Exemptions for AI/ANs

The following chart details the path that certain individuals within the AI/AN population must take to be exempt from the individual mandate:

CATEGORY OF AI/AN	TYPE OF EXEMPTION
Enrolled member of a federally recognized tribe or shareholder in an Alaska Native Village or Regional Corporation.	Indian Exemption – Individual applies once for a permanent exemption. Individual must notify the Internal Revenue Service (IRS) when they become ineligible.
AI/AN who may not be (1) enrolled in a tribe or (2) a shareholder in an Alaska Native Claims Settlement Act Corporation, including: • Members of federally recognized tribes; • Urban Indians who are members of state recognized tribes or descendants in first or second degree; and • Those considered by the Department of the Interior to be Indian and those considered by Health and Human Service (HHS) to be Indian for IHS eligibility.	Hardship Exemption – Individual applies once for a permanent exemption. Individual must notify the IRS when they become ineligible.
Household members who are eligible for IHS, including: • Descendants who are under 19 years old; • Adopted children, step children, foster children of an Indian (may never be considered AI/AN); • Children who will never qualify as AI/AN; • Children who are considered incompetent (who may not qualify as AI/AN); • Spouses who are not AI/AN, or not eligible for IHS, if there is a resolution from the tribe covering spouses; and • Non-AI/AN women who are pregnant with an Indian child.	Hardship Exemption – Individual applies once for a permanent exemption. Individual must notify the IRS when they become ineligible.
AI/AN who are not eligible for the Indian exemption or the Indian hardship exemption.	Individual may be eligible for exemptions based on other conditions, including: • Living in a non-Medicaid expansion state and income is below 100 percent FPL; • Eligibility for and access to Minimum Essential Coverage; • Affordability exemption; and • Hardship exemption as determined by acceptable circumstances.

Cost-Sharing Obligation Exemption



Cost-Sharing Protections:

- AI/ANs with incomes below 300 percent FPL are exempt from out-of-pocket costs, e.g., co-insurance, co-pays, and deductibles. They are not required to enroll in a specific metal-level plan on the marketplace in order to qualify for a cost-sharing reduction.
- Those with incomes above 300 percent FPL will have limited cost-sharing obligations outside of IHS, I/T/Us, and contracted health services. However, they are exempt from cost-sharing for services provided by IHS, Indian tribes, tribal organizations, and urban Indian organizations (I/T/Us), or through referral under contract health services.

How will providers know that an AI/AN does not have cost-sharing?

- Applicable cost-sharing amounts will be identified on Medicaid or marketplace health plan cards issued to members.
- Providers will receive notices from state agencies about cost-sharing exemption.
- Providers can confirm exemption by contacting the enrollee's carrier/issuer.

When shopping for a plan, will an AI/AN who is eligible for cost-sharing have to pick a specific cost-sharing plan?

In families where household members qualify for different levels of cost-sharing reductions (e.g., one family member is AI/AN), the least common denominator rule applies. The rule is that the entire household would qualify for the cost-sharing variation available to the member who qualifies for the least generous CSR.

How can navigators assist families with split tribal membership?

- Advise AI/AN on benefits specified by the ACA, such as CSRs, income exclusions, special open enrollment periods, and exemption from minimum health care coverage mandate.
- Assist with obtaining documents required for enrollment, including tribal blood cards, etc., where applicable.
- Provide enrollment assistance to household members who might be eligible for different coverage options and offer information on accessing IHS and I/T/U providers and services.

Tribal Sponsorship of Premiums

Payment by I/T/Us to the Marketplace

The marketplace may allow Indian tribes, tribal organizations, and urban Indian organizations to pay the QHP premiums on behalf of qualified individuals.

The IHCIA allows I/T/Us to purchase health benefits coverage for IHS beneficiaries through a:

- Tribally owned and operated health care plan;
- State or locally authorized or licensed health care plan;
- Health insurance provider or managed care organization;
- Self insured plan; or a
- High-deductible or health savings account plan.

How will tribes make payments to the marketplace?

Marketplaces have three options for the methods of premium payment:

- Take no part in payment of premiums, which means that enrollees must pay premiums directly to a QHP issuer;
- Facilitate the payment of premiums by enrollees by creating an electronic "pass through" of premiums without directly retaining any of the payments; or
- Establish a payment CMS-9989-P 52 option where the marketplace collects premiums from enrollees and pays an aggregated sum to the QHP issuers.

A marketplace may consider setting up an upfront group payment mechanism similar to the mechanism currently used by some tribes to enroll members in the Medicare Prescription Drug Program. Under that program, tribes offer a selection of plans from which their members may choose, thus limiting the members' options.

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Deciphering the Data: Health Insurance Marketplace Enrollment Rates by Type of Exchange

In-Brief

The ACA gave states a number of choices in how to implement the broad coverage changes it required. As such, health reform looks different from state to state, and the impact of the ACA may or may not differ because of these state decisions. This Data Brief examines a number of choices related to the establishment and running of the new health insurance marketplaces, and their potential impact on enrollment rates to date. We use existing data sources as well as a new database, HIX 2.0, which provides a rich array of state-level variables to provide an ongoing picture of ACA implementation. HIX 2.0, developed by researchers at the University of Pennsylvania, documents and codes state-level variation in the political setting, institutional structures, and operational decisions likely to affect outcomes on the marketplaces.

One of the linchpins of the Affordable Care Act (ACA) is the establishment of "Health Insurance Exchanges" [now called "Marketplaces"] where consumers can select health plans they prefer among various combinations of coverage and premiums. As originally intended, these marketplaces would be state-based, with a default federally-facilitated marketplace in states that were unable or unwilling to establish their own. The state could run its marketplace through an existing or new state agency, a quasi-governmental organization, or a non-profit entity.

The law specified five core functions for the exchanges: determining eligibility; enrolling individuals; conducting plan management activities (e.g., certifying that health plans as "qualified" to be sold, rate review, regulating marketing); assisting consumers (e.g., in-person help, "Navigators", websites, and call centers); and providing financial management services (e.g., accounting, auditing, and reporting).

As it turned out, just 16 States (and DC) established their own marketplaces; 27 states chose, or defaulted to, a federally-run marketplace. Because of time constraints, two of the state-based marketplaces (New Mexico and Idaho) are using the federal IT platform while they develop their own. In 2011 regulations, states were offered the option of a federal-state partnership, in which states could retain consumer assistance and plan management functions, and seven states chose that option. In early 2013, states choosing the federally-run marketplace were given the option of taking on only plan management functions, and seven states chose that option.

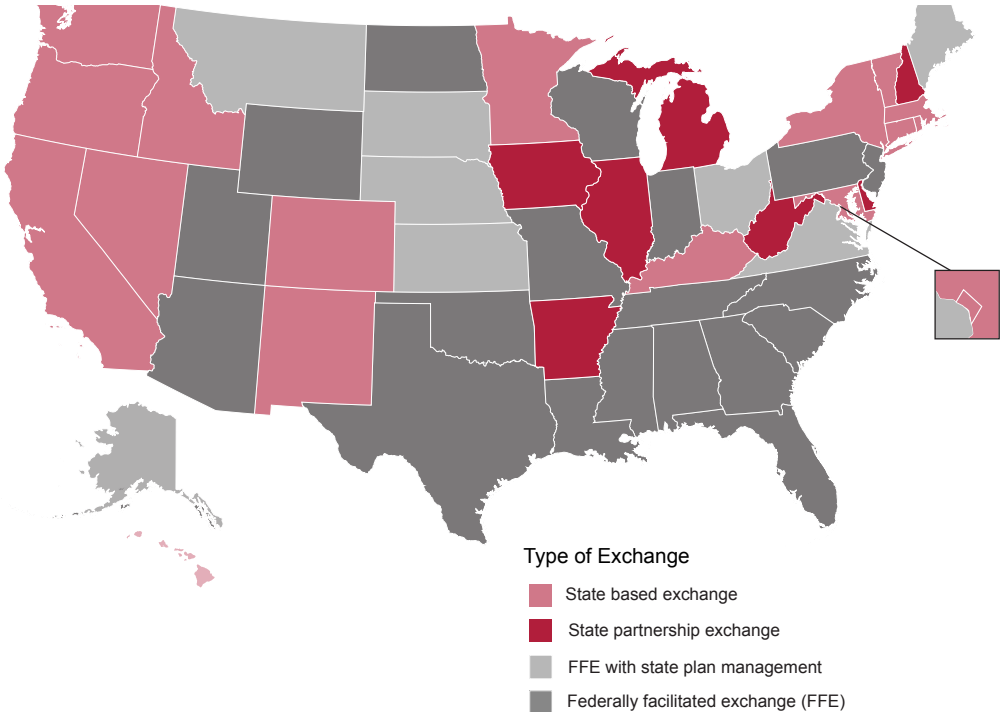
DID MARKETPLACE TYPE CORRELATE WITH ENROLLMENT RATES?

Given the variability in how states have implemented this aspect of the ACA, it is reasonable to ask how these decisions have affected each state's ability to enroll its target population into plans on the marketplace. Have states of one type or another had higher enrollment rates? This Data Brief looks at the enrollment numbers as of the end of February, five months into the open enrollment period on the marketplaces, which ends March 31, 2014. We use cumulative enrollment figures for each state from October 1, 2013 - March 1, 2014, provided by the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS). Enrollment is measured as the number of people selecting a plan, whether or not they have yet paid a premium for it.

Health insurance marketplaces were created by the ACA as a way to make health insurance more affordable and easier to purchase for individuals. (The ACA also created marketplaces for small businesses, which is beyond the scope of this brief.) The purpose was to extend affordable coverage to the uninsured who do not qualify for Medicaid, as well as to make coverage more secure for those who purchase insurance on the individual market. Thus, capturing enrollment success would ideally entail capturing the degree to which the marketplaces are meeting intended enrollment goals.

An overall basic enrollment objective is for the marketplaces to enroll as many of the potentially eligible enrollees as possible. But given the goals of the ACA, covering as many eligible uninsured would be a more specific way to capture marketplace success. However, the enrollment numbers available do not provide sufficient detail to provide a direct link to this measure of success. While no measure is perfect, given the data available at this point, we measure total enrollment as a fraction of the potential population for the marketplace in each state, including the uninsured not eligible for Medicaid and people with plans on the individual market. Here we use the percentage of eligible people as calculated by the Kaiser Family Foundation. They include legal residents who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. The estimate excludes uninsured individuals with incomes below the poverty level who live in states did not elect to expand the Medicaid program. We call this measure the enrollment rate.

Type of Health Insurance Marketplace Exchange



WHAT WE FOUND

Overall, more than 4.2 million people have enrolled and picked a plan through the exchanges, about 14.8% of all potential eligibles. The enrollment rate varies from state to state, with a high of 54% in Vermont to a low of 5% in Massachusetts. We should note that Massachusetts had the lowest rate of uninsurance in the nation since its health reform in 2006; its previous success might mean that the remaining uninsured population could be especially difficult to reach.

We found that, on average, state-based marketplaces have had higher enrollment rates (20.3% of eligibles) than the federally-facilitated ones (12.4%) or the partnership states (13.9%). The states retaining plan management functions within a federally-facilitated marketplace have similar enrollment rates to the other federally-run ones (11.4% vs. 12.6%). All of the federal-facilitated marketplaces were likely affected by the extremely difficult rollout of the HealthCare.gov site when it launched on Oct. 1, 2013, as were the two state-based marketplaces relying on the federal site (New Mexico and Idaho).

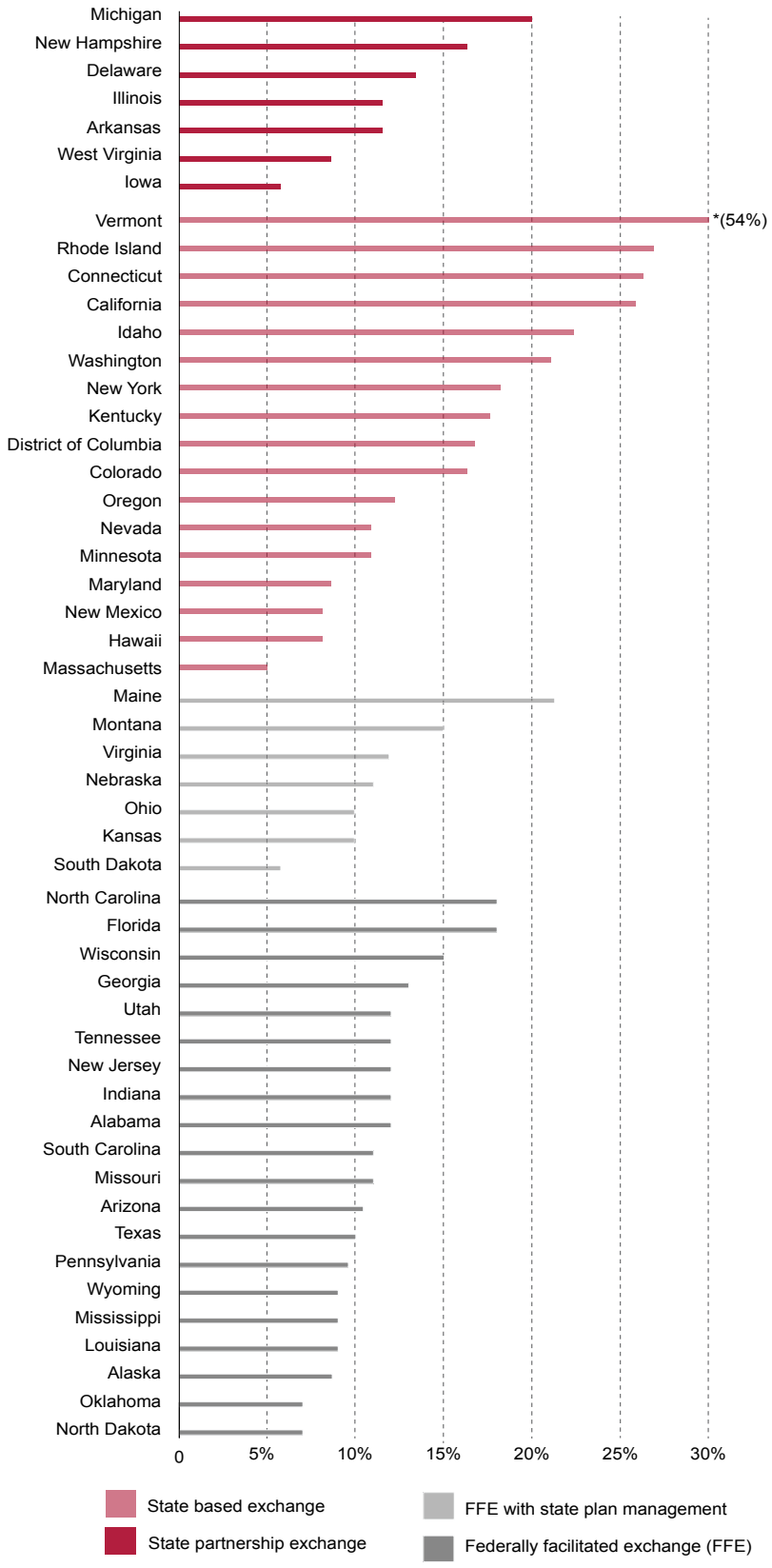
These averages, however, hide significant differences among the types, especially among the state-based marketplaces. Within the federally-run marketplaces, enrollment rates vary from 6% in South Dakota to 21% in Maine.

The "average" state-based marketplace is doing as well in its enrollment as the best federally-run exchange. And a number of those states are doing significantly better. Many of the less-successful state-based marketplaces, particularly Massachusetts, Minnesota, Oregon, Maryland, and Hawaii, had documented problems with the rollout of their sites, which is likely reflected in their enrollment rates.

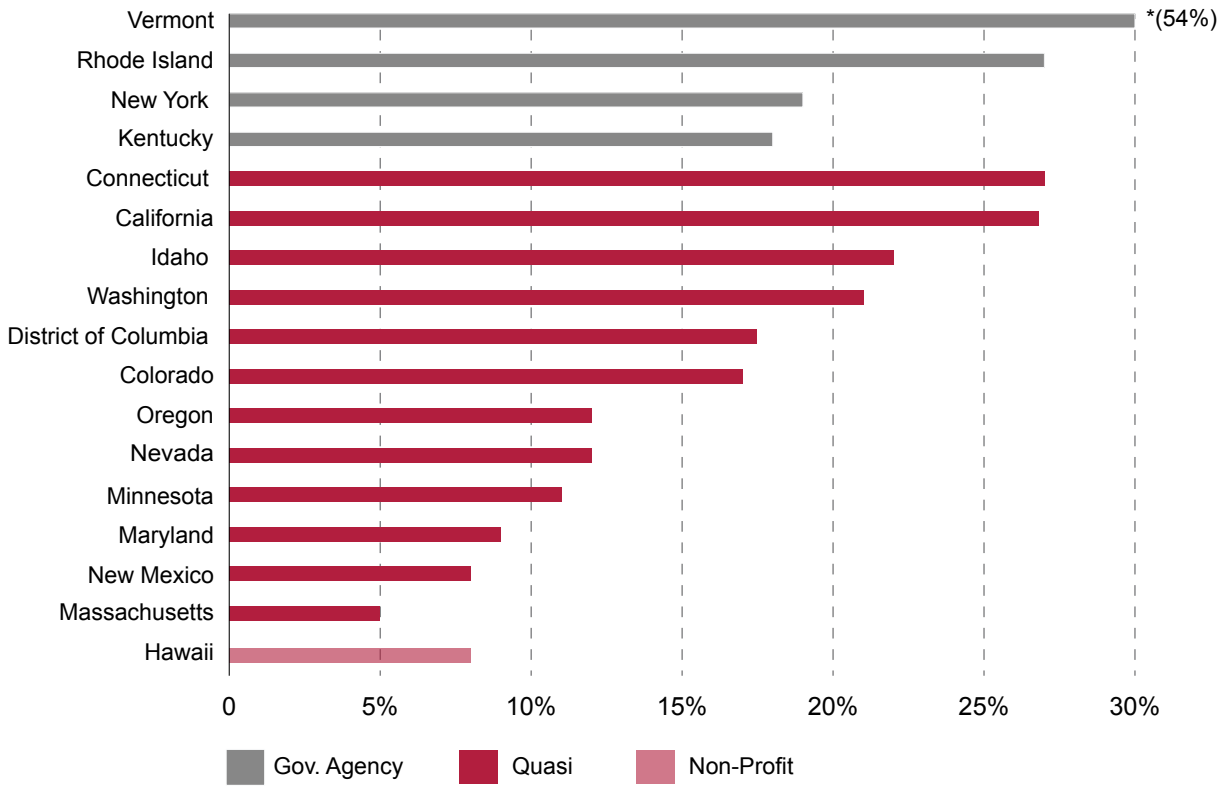
Each state choosing to run its own marketplaces decided on a formal governance structure, and that decision seems to have made a difference in enrollment rates. Each option had its potential advantages and disadvantages. Housing a marketplace in a state agency might allow the state to use its existing infrastructure and resources most efficiently; it might also overwhelm an existing agency and subject the new marketplace to cumbersome state rules and regulations. States choosing to create a quasi-governmental organization, on the other hand, would have government oversight but more flexibility in its processes, such as hiring and procurement. But this option also involves investing in new infrastructure, and managing new relationships with state agencies. Creating a non-profit entity might give a state the most flexibility, and perhaps increase its consumer-friendliness; however, this non-governmental entity might also have the most difficulty interacting with the state's agencies and databases.

Twelve states chose a quasi-governmental organization to govern their exchange; four states chose an existing state agency, and only one, Hawaii, chose to create a non-profit entity (although Arkansas will transition from a partnership to state-based marketplace in July 2015 and has decided on non-profit governance). The four states that chose an existing state agency are having higher enrollment rates, on average, than the others.

Federally-Facilitated, State-Based and Partnership Health Insurance Marketplace Enrollment as a Percent of Potential Enrollees



State-Based Health Insurance Marketplace Enrollment as a Percent of Potential Enrollees by Governance Structure for Exchange



WHAT DOES IT MEAN?

Traditionally, states have regulated their own insurance markets. The ACA introduced what has been called a "hybrid federalism" into the process. In effect, ACA became a case study in the political and organizational factors affecting state-level implementation of a federal mandate. Because of partisan divides, legal delays, and technological glitches, the implementation of the ACA differed from state to state. It is likely that all these factors contributed to the wide variation across states in enrollment success in the first five months of open enrollment. Given their traditional role in regulating insurance, it is not surprising that state-based marketplaces are having the most success, and that state-based marketplaces governed by existing state agencies are doing the best.

There are many aspects of success our measure does not capture. First, as mentioned above, we do not separate enrollees who were uninsured from those who had individual insurance. Second, we do not address the degree to which enrollees have high health care needs, which could affect pricing in future years. Third, our measure does not account for the variation in the number of people still purchasing individual insurance outside the exchanges. It is possible that our measure may artificially understate coverage success in those states with relatively robust individual markets, because potential enrollees may be more likely to continue to purchase individual insurance outside the exchange. Fourth, while the number is likely to be small, some exchange participants were previously insured in the employer-sponsored market and thus not reflected among "potential enrollees". Fifth, many of those enrolled may fail to pay their premiums and therefore quickly lose their enrollment status.

By this measure, even the most successful states (other than Vermont) have enrolled less than half of their eligible populations. When the data are available, it will be important to understand who has enrolled through the exchanges, who has maintained insurance off the exchanges, and who remains uninsured.

We are in the last month of open enrollment for 2014 coverage, and enrollments may surge as the deadline approaches. The next open enrollment period runs from Nov. 15, 2014 to Feb. 15, 2015. Many questions remain about whether these early enrollment patterns will continue. Now that technical problems with healthcare.gov are mostly fixed, will the federally-run marketplaces catch up? Will the states still having technical site problems (such as Massachusetts) solve them and will enrollments in these states jump as a result? Will more states migrate to state-based marketplaces, as the initial opposition (and legal challenges) to the ACA subside?

About the Authors

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About The Leonard Davis Institute of Health Economics

The Leonard Davis Institute of Health Economics (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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Health Policy Resources Center
Research Brief

Health Insurance Marketplaces Offer a Variety of Dental Benefit Options, but Information Availability is an Issue

Authors: Cassandra Yarbrough, M.P.P.; Marko Vujicic, Ph.D.; Kamyar Nasseh, Ph.D.

Key Messages

- *There is considerable variation across states in how dental benefits are offered within the newly established health insurance marketplaces. In some marketplaces, pediatric dental benefits can be purchased only through stand-alone dental plans, while in others all medical plans include embedded pediatric dental benefits.*
- *There is limited information available to consumers on many key attributes of dental plans within the marketplaces, making it challenging to make meaningful comparisons and fully informed decisions.*
- *Stand-alone dental plans and medical plans with embedded dental benefits differ in several ways, including out-of-network coverage, deductible arrangements, and premiums.*
- *Further research is needed to study the implications of alternative marketplace set ups on consumer purchasing decisions and, ultimately, access to dental care.*

Introduction

The Affordable Care Act (ACA) will extend health insurance to millions of Americans. Recognizing the importance of oral health, pediatric dental services are one of the ten essential health benefits that all small group and individual market health plans are required to cover.[1] Early estimates predict that almost 9 million children could gain dental benefits coverage due to the ACA, with 3 million gaining such coverage through health insurance marketplaces (hereinafter referred to as marketplaces).[2] Dental benefits for adults, however, are not an essential health benefit under the ACA. Health plans may still offer adult dental coverage, but they are not required to do so. Therefore, the estimated number of adults potentially gaining private dental benefits through the marketplaces is much smaller.[3]

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Based on the interpretation of the pediatric dental services mandate, health plans sold through the marketplaces are actually not required to include pediatric dental benefits as long as there are stand-alone dental plans (SADPs) available for purchase.[4] Further, all SADPs offered through the marketplaces must include pediatric dental benefits.[5] Thus, the marketplaces can offer pediatric dental benefits in one of three ways: (1) through an SADP, (2) through a dental plan bundled with a medical plan, and (3) through a medical plan that has embedded pediatric dental benefits.[6] As there are no bundled dental plans offered through the marketplaces for 2014,[7] individuals currently have at most two methods of obtaining pediatric dental coverage.[8]

Individuals have until March 31, 2014 to enroll in a health plan to meet the ACA's individual mandate requirement[9] after which they are subject to tax penalties.[10] While pediatric dental benefits are "essential" under the ACA, consumers will not be penalized if they fail to purchase dental benefits for their child.[11] Allowing marketplaces to offer SADPs essentially disconnected pediatric dental benefits from the tax penalty, and consumers are not actually required to purchase them.[12]

Premium subsidies are also complex when it comes to dental benefits. To help offset the cost of purchasing health insurance, the ACA established premium assistance for certain income groups in the form of tax credits for plans purchased through the marketplaces.[13] How premium assistance applies to SADPs, however, is not straightforward. Individuals can technically apply their premium tax credits toward pediatric SADP premiums, but it is unlikely that the tax credit will be large enough to offset any of the cost of the pediatric SADP.[14] Additionally, adult dental coverage purchased through an SADP is not subject to premium assistance because it is not considered essential under the ACA.[15]

As a result of the absence of a true requirement to purchase pediatric dental benefits under the ACA, the structure of a state's marketplace plays a crucial role in the expansion of dental benefits coverage for children. Specifically, the purchase of pediatric dental benefits is only guaranteed if a state either (1) only offers medical plans that embed or bundle pediatric dental benefits, or (2) requires consumers that purchase pediatric medical benefits to also purchase pediatric dental benefits. To date, only Kentucky, Nevada and Washington require consumers to purchase pediatric dental benefits.[16]

With so much variability, a critical overarching policy question is, to what extent will the establishment of health insurance marketplaces increase access to dental care for children in the United States? This ultimately depends on how effective the marketplaces are at expanding dental benefits coverage for children, and how effectively this expansion of coverage increases access to dental care. These issues warrant significant research effort. A first step is simply to understand how pediatric dental benefits are actually being offered within the marketplaces, and this is the focus of our analysis.

In this research brief, we analyze key attributes of all medical plans and SADPs offered through both the federally-facilitated marketplace (FFM) and select state-based marketplaces (SBMs) focusing primarily on pediatric dental benefits. We assess the level of information that is available to consumers when shopping for dental benefits within the marketplaces. We categorize states according to how dental benefits are offered in their marketplace. We compare key attributes of medical plans that have embedded dental benefits to SADPs. We conclude with a discussion of the policy implications of our findings.

Data & Methods

In 2014, 34 states are participating in the FFM, and the remaining 17 states (including the District of Columbia) have established SBMs (see Table 1).[17]

Federally Facilitated Marketplace Analysis

We analyzed medical plan and SADP information for individuals and families from the Centers for Medicare and Medicaid Services' (CMS) website healthcare.gov. We downloaded data for all plans available in the 34 states participating in the FFM, as well as data for plans in 2 states that are temporarily operating through the FFM until their SBMs are ready (see Table 1).[18,19,20,21] The data used in this analysis were downloaded on January 13, 2014.[22,23]

The data available through the FFM list every medical plan and SADP offered by rating area.[24] We used the variable "Plan ID – Standard Component" (Plan ID) as the unique plan identifier and counted each Plan ID as a unique observation. We summarized the number of medical plans and SADPs offered, the number of medical plans with embedded dental benefits, the actuarial value of plans, and the average pediatric premiums for medical plans with and without embedded dental benefits and for SADPs.[25]

State-Based Marketplace Analysis

We visited the 15 SBM websites between December 2, 2013 and January 6, 2014.[26,27,28,29,30,31,32,33,34,35,36,37,38,39,40] Five SBM websites provided robust data on the medical plans and SADPs available for purchase, and these states were included in our analysis (see Table 1).[41,42,43,44,45] The remaining ten SBM websites either provided less robust information, or required individuals to create an account to preview medical plan and SADP information.[46] These states were not included in our analysis (Table 1).

For the five states included in our analysis, we summarize the number of medical plans and SADPs available for purchase, the number of medical plans with embedded dental benefits, the actuarial value of plans, and the average child premiums for SADPs. Where we were not able to collect reliable premium information within a SBM, we omitted that state from the analysis of premiums.

In-Depth Analysis of Pediatric Dental Benefits within a Sample of Plans

We carried out a more detailed analysis on a sample of plans. Using data from the 36 states on the FFM, we randomly selected 50 medical plans with embedded pediatric dental benefits (sample created January 14, 2014) and 50 SADPs (sample created January 23, 2014). We then analyzed each plan's Statement of Benefits and Coverage (SBC). The SBCs were found using the links provided by CMS on the healthcare.gov website. We collected information on key plan attributes including deductibles, services covered, coinsurance levels, and dental provider networks. In general, the SBCs for SADPs provided most of this information. However, information on dental benefits within the SBCs of medical plans that include embedded dental benefits was more limited. In these cases, we conducted additional web-based research to collect missing information (between January 14 and 27, 2014). If information was still not available, we then conducted telephone calls to the individual insurance company offering the plan (between January 16 and 28, 2014).

We analyzed medical plans and SADPs by actuarial value. The actuarial value is the percentage of the total average costs that a plan will pay for the benefits it covers.[47] There are four medical plan actuarial values: platinum, gold, silver and bronze.[48] The percentage of costs that a plan pays ranges from 60% (bronze) to 90% (platinum). Some consumers may also be eligible to purchase a catastrophic plan. Only three primary

care visits are paid for by catastrophic plans; all other services must be paid for by the consumer until the deductible is met.[49] There are two SADP actuarial values. High actuarial value plans pay 85% of average costs, and low actuarial value plans pay 70% of costs.[50]

Results

Figure 1 summarizes the breakdown of how dental benefits are being offered in the marketplaces. Within the 41 states we analyzed, there were a total of 3,180 medical plans and 697 SADPs being offered. The number of medical plans offered by each state ranges from 11 in New Hampshire to 257 in Wisconsin. The number of SADPs offered by each state ranges from two in Vermont to 51 in Michigan.

Looking across all medical plans, 26% have embedded pediatric-only dental benefits. Another 0.7% of medical plans have embedded pediatric and adult (i.e. family) dental benefits. Only 0.4% of medical plans have embedded adult-only dental benefits, and all of these plans are offered in Ohio. Looking across all SADPs, 42% offer pediatric-only dental benefits, and 58% offer family dental benefits. Family SADPs can be purchased for children only, adults only, or a mix of children and adults. In accordance with the ACA, none of the SADPs offer adult-only dental benefits.[51]

Table 2 demonstrates that there is considerable variation across states in how pediatric dental benefits are being offered. In seven states, none of the medical plans offered have an embedded pediatric dental benefit. On the opposite end of the spectrum, there are two states where every medical plan has an embedded pediatric dental benefit. SADPs are offered in every state we analyzed.

While none of the states we reviewed mandate that medical plans have embedded pediatric dental benefits, some states chose to not allow medical plans to include embedded pediatric dental benefits. For example, for 2014, the board governing California's marketplace decided not to allow medical plans to embed pediatric dental benefits.[52] This policy decision has been reversed for 2015.[53]

Figure 2 summarizes the breakdown of medical plans and SADPs by their actuarial value,[54] or the percentage of an enrollee's costs that a plan will typically pay. Silver, with an actuarial value of 70% is the most common type of medical plan being offered across the marketplaces. There is some state-level variation in the breakdown of actuarial value of plans offered, with silver making up only 22.5% of the plans offered in Arkansas, compared to 38.1% of the plans offered in Tennessee. There is no significant difference in the actuarial value breakdown of medical plans with and without embedded dental benefits (results not shown).

Just over half of SADPs are low actuarial value. Similar to medical plans, there is some state-level variation. In Arkansas, for example, 44% of offered SADPs are low actuarial value compared to 100% of the SADPs offered in Washington. The actuarial value breakdown of pediatric-only and family SADPs mirrors the overall breakdown (results not shown).

Table 3 summarizes the dental benefits information available to consumers when they shop the marketplaces for plans. As noted in the methods section, this analysis is at the plan level and is based on a random sample of 50 medical plans with embedded pediatric dental benefits and 50 SADPs with either pediatric-only or family dental benefits. These plans were selected from the FFM and are meant to provide a general picture of the type of information available to consumers. While there could be significant differences within SBMs in terms of information that is available to consumers, the analysis provides several important insights from the consumer perspective.

Overall, much more dental information is available for SADPs compared to medical plans with embedded pediatric dental benefits. This is primarily because the dental benefits information is limited within medical plan SBCs, which are a key resource for consumers as they navigate through the marketplace. In general, the majority of medical plans with embedded pediatric dental benefits do not clearly state whether they cover any services beyond preventive dental care. Information on coinsurance levels and copayment amounts is even more limited.

Additionally, it is often unclear from the consumer perspective how the deductible applies to pediatric dental benefits within medical plans. Only 20% of the medical plans we analyzed clearly stated that there was a separate dental deductible and even then, the amount of that deductible was not always made available. Consumers may assume that the medical deductible is applicable to pediatric dental benefits, but this is one area where transparency is a major issue.

Information on dental provider networks is also more limited within medical plans that offer embedded pediatric dental benefits. We found that all SADPs but only 56% of the medical plans provide a list of in-network dental providers that can be accessed directly through the SBC. In fact, 24% of the medical plans do not provide consumers with any information on in-network dental providers. We did not investigate dental provider network characteristics such as the number, geographic distribution, or quality of providers and this is an important area for future research.

Finally, we summarize information available on out-of-network coverage. Each medical plan and SADP we examined clearly states whether there is an additional cost for out-of-network services, or if out-of-network services are covered at all. We found that 48% of medical plans and 6% of SADPs do not cover dental services provided out-of-network.

Table 4 summarizes the actual plan characteristics for our random sample of plans. As outlined in the methods section, it is important to note that Table 4 is based on a much more thorough investigation of plans. We did supplemental web-based research and, if necessary, called the company offering the plan to collect information not available elsewhere. Even after these intensive data collection measures certain plan attributes remained unclear. Nevertheless, we feel Table 4 is best interpreted as information the consumer cannot necessarily access easily when shopping for plans, but will become aware of once they start using plan benefits.

In terms of which services are covered, all medical plans with embedded pediatric dental benefits and SADPs cover preventive services. SADPs are slightly more likely to cover restorative and orthodontia services. It is interesting to note that even after more extensive investigation, it is still unclear whether minor restorative services, major restorative services, and orthodontia services are covered within some medical plans.

There are important differences across plan types with respect to the dental deductible. When medical plans use a separate dental deductible, the average dental deductible is similar across these medical plans ($34) and the SADPs ($41). However, 34% of medical plans do not use a separate dental deductible. In these cases, the average combined medical plus dental deductible is $2,935.

Among medical plans that do not have a separate dental deductible, it is crucial to understand whether the deductible applies to all dental services or whether some are exempt. A high deductible with a long list of exempt services provides much higher financial protection to consumers than a high deductible with few exempt services. We found that the vast majority of medical plans without a separate dental deductible do not apply the deductible to preventive services. Still,

among the 12% that do there is an obvious concern that basic preventive dental care services are not first-dollar covered. Even among SADPs, 26% of plans apply the deductible to preventive services. While the average deductible amount for SADPs is much lower, this is still an important finding that some SADPs are not providing first-dollar coverage for basic preventive dental care services.

Figure 3 summarizes data on pediatric dental benefit premiums. We wanted to compare the average cost of obtaining pediatric dental benefits through three channels: a medical plan with embedded pediatric dental benefits; a high actuarial value SADP; and a low actuarial value SADP. As medical plans display only one premium, we developed a method to estimate the pediatric dental benefit premium within these plans. We took the difference between the average pediatric premium for silver medical plans that have an embedded pediatric dental benefit and the average for those that do not. This "shadow" premium is not observed anywhere but can be thought of as, on average, the incremental cost of obtaining pediatric dental benefits through a silver medical plan. In our calculation, we only include medical plans and SADPs from the 25 states on the FFM where SADPs and silver medical plans with and without embedded pediatric dental benefits are offered; in other words, the states where the consumer has all four choices available.

The average shadow premium across the 25 states is $5.11. This average represents the incremental cost of acquiring pediatric dental benefits through a silver medical plan. The shadow premium varies significantly across states, ranging from -$34.10 in South Dakota to $33.83 in Alaska. Many states actually have a negative shadow premium, meaning that silver medical plans without embedded pediatric dental benefits are, on average, more expensive than silver medical plans with embedded pediatric dental benefits.

The average high actuarial value SADP pediatric premium is $38.89, ranging from an average of $27.91 in Nebraska to $77.24 in Alaska. The average low actuarial value SADP pediatric premium is $30.98, ranging from an average of $23.32 in Nebraska to $52.93 in Alaska.

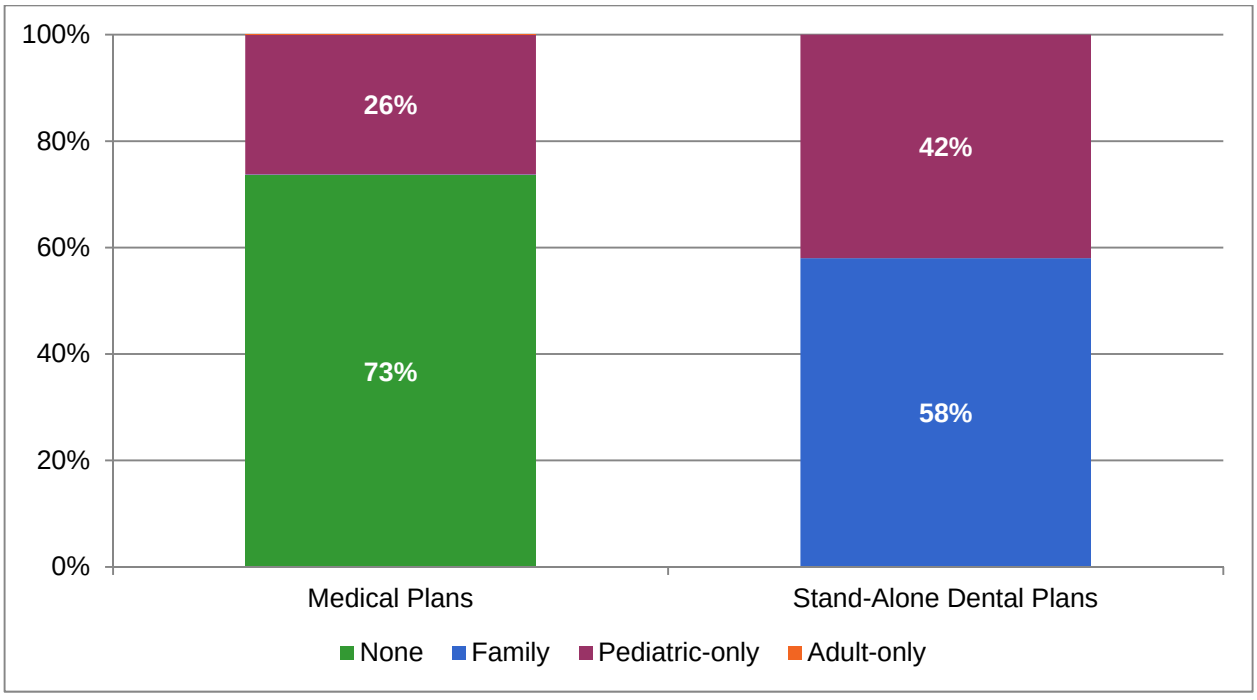
Finally, Figure 4 sheds light on the relationship between the number of plans offered and premiums. It examines whether increased competition among SADPs and increased choice for consumers leads to lower premiums. We found no relationship between the number of SADPs being offered within a state and the average pediatric premium. We also examined whether the presence of medical plans with embedded pediatric dental benefits impacts premium levels for SADPs. We did not find any impact (results not shown). These initial findings suggest that increased competition in terms of the number of plans offered may not lead to lower premiums. However, a more robust analysis is needed to verify this result. Interestingly, Figure 4 also demonstrates that the difference in the average premium for high and low actuarial value dental plans varies across states and is actually negative in one state.

Table 1: States Included in our Analysis

	Federally-Facilitated Marketplace	State-Based Marketplace
Included in our Analysis	AK, AL, AR, AZ, DE, FL, GA, IA, ID, IL, IN, KS, LA, ME, MI, MS, MO, MT, NE, NH, NJ, NM, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV, WY	CA, MN, NV, VT, WA
Not included in our Analysis	-	CO, CT, DC, HI, KY, MD, MA, NY, OR, RI

Source: CMS. **Note:** Idaho and New Mexico are temporarily running through the FFM but plan to establish their own SBM in the near future.

Figure 1: Dental Benefits Available within Medical and Stand-Alone Dental Plans



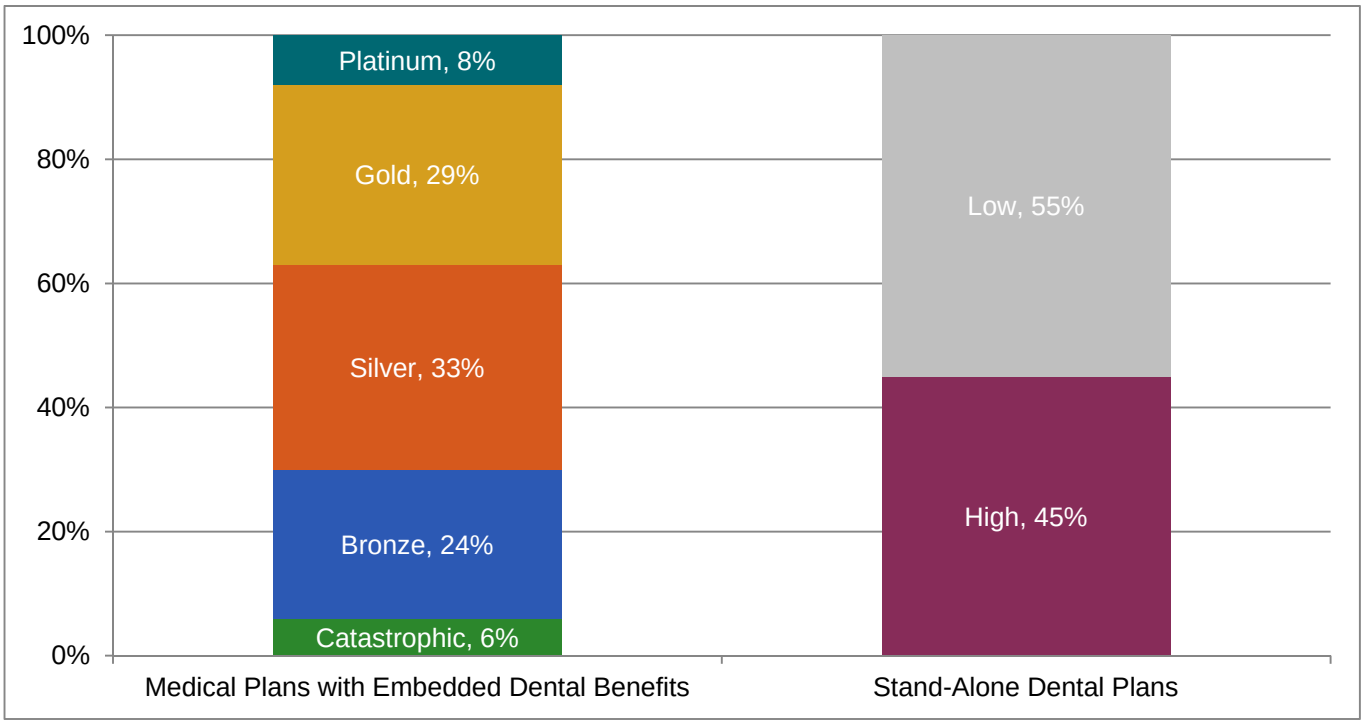
Source: ADA Health Policy Resources Center analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans and SADPs offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by a unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We then analyzed each unique medical plan and SADP for the type of dental benefits offered. Analysis is based on 3,180 medical plans and 697 SADPs.

Table 2: Percentage of Medical Plans with Embedded Pediatric Dental Benefits

	State
0%	AR, CA, MS, MT, NJ, NM, UT
<50%	AL, AZ, FL, GA, IA, ID, IL, IN, KS, ME, MI, MN, MO, NV, NH, OH, OK, SC, SD, TX, VA, WI
50-99%	AK, DE, LA, NC, ND, NE, PA, TN, WA, WY
100%	VT, WV

Source: ADA Health Policy Resources Center analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We then analyzed each unique medical plan for the type of dental benefits offered. Analysis is based on 3,180 medical plans.

Figure 2: Actuarial Value of Medical and Stand-Alone Dental Plans



Source: ADA Health Policy Resources Center analysis of data from the FFM and select SBMs. **Notes**: We analyzed all medical plans offered for 36 states operating through the FFM and 5 states operating SBMs. For FFM states, we analyzed unique plans identified by unique Plan ID. For SBMs, we visited each state's marketplace website and analyzed documents (CA, VT, and WA) or browsed plans (MN and NV). We categorized plans by actuarial values assigned by CMS. Analysis is based on 866 medical plans with embedded adult, family, or pediatric dental benefits and 697 SADPs.

Table 3: Information Available to Consumers on Plan Characteristics

	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Does the dental plan indicate coverage of preventive services?		
Yes	100%	100%
No	0%	0%
Unclear	0%	0%
If yes, consumers can determine:		
Whether the deductible applies	14%	18%
If there is a copay	14%	14%
Coinsurance level	100%	100%
Does the plan indicate coverage of restorative services?		
Yes	8%	98%
No	0%	0%
Unclear	92%	2%
If yes, consumers can determine:		
Whether the deductible applies	100%	71%
If there is a copay	0%	12%
Coinsurance level	100%	100%
Does the plan indicate coverage of orthodontia services?		
Yes	8%	96%
No	0%	2%
Unclear	92%	2%
If yes, consumers can determine:		
Whether the deductible applies	100%	44%
If there is a copay	0%	8%
Coinsurance level	100%	100%
Does the plan indicate that there is a separate dental deductible?		
Yes, and the amount is shown	14%	100%
Yes, but the amount is not shown	6%	0%
No	0%	0%
Unclear	80%	0%
Does the plan provide a list of in-network dental providers?		
Yes, list is accessed from SBC	56%	100%
Yes, but list is not accessed from SBC	20%	0%
No	24%	0%
Does the plan indicate coverage of dental services out-of-network?		
Yes	52%	94%
No	48%	6%
Unclear	0%	0%

Source: ADA Health Policy Resources Center analysis of a random sample of 50 medical plans with embedded pediatric dental benefits and 50 SADPs from the FFM. **Notes:** We randomly selected 50 medical plans with embedded pediatric or family dental benefits and 50 SADPs with either pediatric or family dental benefits. We reviewed the SBC for each plan, considering information made available through the SBC as information available to the consumer. We treated the SBC as information available to the consumer because the hyperlink to the SBC is made available on the FFM; thus it is easily accessible to a consumer shopping the FFM. We did not include SBM plans in our random sample because we could not simulate shopping as a consumer on the SBMs for CA, VT, and WA without creating a user account.

Table 4: Summary of Plan Characteristics

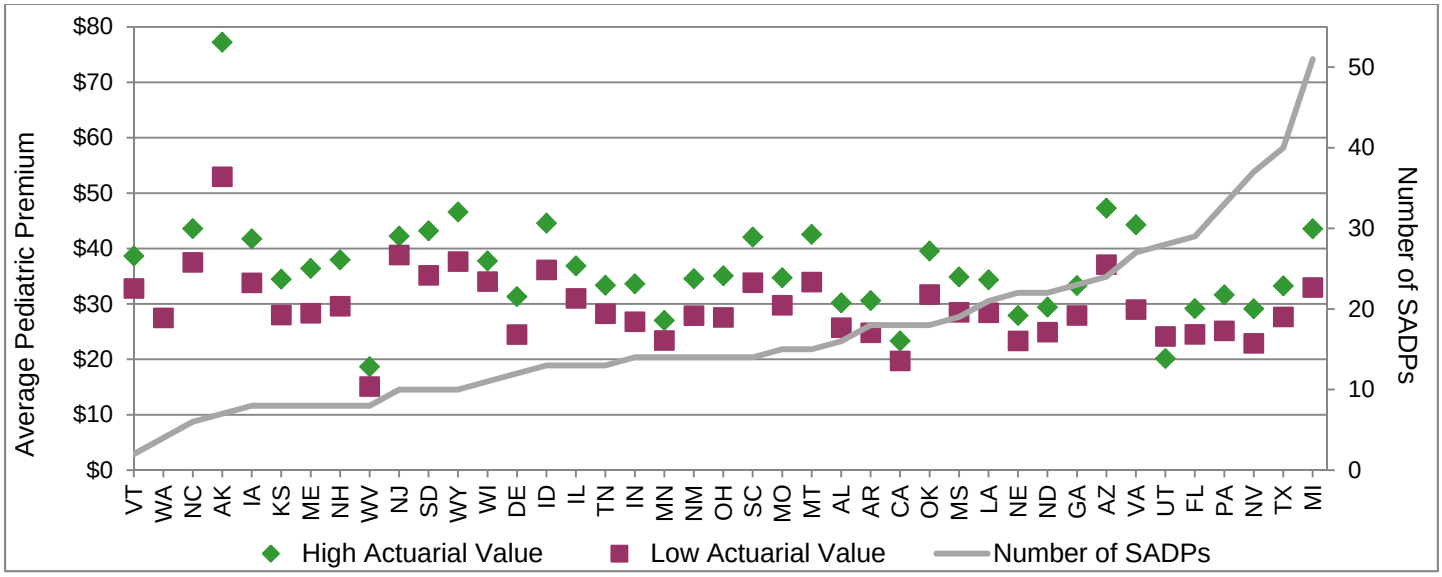
	Medical Plans with Embedded Pediatric Dental Benefits	Stand-Alone Dental Plans
Is there a separate dental deductible?		
Yes	42%	100%
Average amount	$34.21	$41.10
No	34%	0%
Average amount	$2,935.29	N/A
Unclear	24%	0%
Are preventive services covered?		
Yes	100%	100%
No	0%	0%
Unclear	0%	0%
If yes, average that plan pays	98%	97%
If preventive services are covered, does the deductible apply?		
Yes, medical deductible is used	12%	0%
Yes, dental deductible is used	2%	26%
No	86%	74%
Unclear	0%	0%
Are restorative services covered?		
Yes	84%	100%
No	0%	0%
Unclear	16%	0%
If yes, average that plan pays	Minor: 71% Major: 60%	Minor: 65% Major: 49%
If restorative services are covered, does the deductible apply?		
Yes	73%	70%
No	27%	30%
Unclear	0%	0%
Are orthodontia services covered?		
Yes	64%	96%
No	4%	4%
Unclear	32%	0%
If yes, average that plan pays	55%	50%
If orthodontia services are covered, does the deductible apply?		
Yes	78%	44%
No	22%	56%
Unclear	0%	0%
Is there a copayment for any services?		
Yes	16%	16%
No	52%	84%
Unclear	32%	0%

Source: ADA Health Policy Resources Center analysis of a random sample of 50 medical plans with embedded pediatric dental benefits and 50 SADPs from the FFM. Supplemental web searches and phone calls for medical plans. **Notes:** We randomly selected 50 medical plans with embedded pediatric or family dental benefits and 50 SADPs with either pediatric or family dental benefits. We reviewed the SBC for each plan. We did not include SBM plans in our random sample because we could not simulate shopping as a consumer on the SBMs for CA, VT, and WA without creating a user account. We collected information on deductibles, out-of-pocket maximums, dental service coinsurance levels, and dental services covered. If SBCs did not have all of the information, we searched for information through internet searches. If information was still not available, we telephoned the insurance company offering the plan.

Figure 3: Average Monthly Pediatric Premium for Dental Benefits by Plan Type

Source: ADA Health Policy Resources Center analysis of data from the FFM. **Notes**: Each small data point represents the average premium in a state and each large data point represents the average across all states (unweighted). Premiums were analyzed separately for silver medical plans with and without embedded pediatric dental benefits, high actuarial value SADPs, and low actuarial value SADPs. States were included in the analysis only if there were silver medical plans with and without embedded pediatric dental benefits, high actuarial value SADPs, and low actuarial value SADPs available for purchase. This resulted in 25 states being included. States were excluded if all four types of plans were not available for purchase. This resulted in 11 states being excluded. To calculate the premium for pediatric dental benefits when they are embedded within a silver medical plan in a state, we first calculated the average premium for silver medical plans that have embedded pediatric dental benefits in a state. We then subtracted the average premium for silver medical plans that do not have embedded pediatric dental benefits in that state. This is a 'shadow' premium in the sense that it is not observed.

Figure 4: Average Monthly Pediatric Premium for Stand-Alone Dental Plans by State



Source: ADA Health Policy Resources Center analysis of data from FFM and select SBMs. **Notes:** We summarized the average pediatric premium for high actuarial value SADPs and low actuarial value SADPs by state. We first calculated the average pediatric premium for each unique SADP offered in a state. We then average the pediatric premium for all high actuarial value SADPs in a state, and all low actuarial value SADPs in a state. We also calculated the number of unique SADPs offered in each state. The states are ordered from left to right along the x-axis from the state with the fewest number of SADPs offered (VT) to the state with the highest number of SADPs offered (MI). 41 states are included in this analysis.

Discussion

Our analysis has uncovered several important findings related to dental benefit offerings within the health insurance marketplaces. First, there is much more information related to dental benefits available to consumers for SADPs compared to medical plans with embedded dental benefits. Second, after considerable effort to fill many information gaps we found that covered services and coinsurance levels are very similar for both types of plans. Third, deductibles are significantly lower within SADPs, due to the fact that many medical plans with embedded dental benefits use a single deductible for medical and dental services combined. However, it is important to note that most of these medical plans do not apply the deductible to preventive dental services. Fourth, out-of-network coverage is much more limited for medical plans with embedded dental benefits compared to SADPs. This is especially important because information on dental provider networks is more limited within these medical plans. Fifth, the cost of purchasing pediatric dental benefits through medical plans appears to be significantly lower than through SADPs.

Our findings provide early insights into how the establishment of health insurance marketplaces under the ACA could affect dental benefits coverage for children and, ultimately, access to dental care. The fact that there is often limited information available for consumers to make meaningful comparisons across plans has important implications. With less-than-full information it is challenging for consumers to make optimal choices. The dental benefit transparency issues we identified are understandable given the challenges surrounding the launch of the FFM and many state marketplaces. As these marketplaces continue to evolve, however, effort should be given to improving the information base and presenting dental benefit plan comparisons in a user friendly, easy to understand way.

The ACA gives states the authority to customize many key aspects of their health insurance marketplaces, including how pediatric dental benefits are offered,[55] and indeed we found significant variation. In some states, none of the medical plans have an embedded dental benefit. In other states, all of them do. SADPs are offered in all states. It is unclear whether these differences in how dental benefits are offered are a result of policy decisions by health insurance marketplace regulatory agencies or a result of other factors. Either way, understanding the implications of these alternative marketplace arrangements on purchasing decisions and, ultimately, access to dental care is extremely important. For example, if all medical plans were required to have an embedded dental benefit, then expanding coverage becomes very easy. If states require that pediatric dental benefits be purchased this also ensures full coverage. Understanding the implications of the alternative marketplace set ups is especially important given the lack of a true mandate. Early enrollment results from California, where pediatric dental benefits can only be purchased as a SADP, confirm the importance of this issue. Through January 2014, only 27% of children enrolling in medical plans also enrolled in a SADP.[56]

Beyond coverage expansion, if the nature of dental benefits differs by whether or not they are embedded in a medical plan – and we found this to be the case – there are further implications of alternative paths to dental coverage that warrant investigation.

Another potential concern is the fact that both medical plans and SADPs apply deductibles to preventive pediatric dental services in some cases. This practice is permitted, as these services are not guaranteed to be cost free like preventive medical services.[57,58] We feel that this issue needs to be revisited in the next round of health insurance marketplace regulation

changes. Pediatric dental care is an important component of primary care. But the lack of first-dollar coverage for basic preventive dental services for children in some plans could impose financial barriers to care, counteracting the purpose of making pediatric dental benefits an essential health benefit.

Our analysis shows that, on average, the cost of obtaining pediatric dental benefits through medical plans is significantly lower than through SADPs. There are a variety of factors that could explain this including benefit differences, out-of-network coverage limitations, and higher deductibles. We did not analyze differences in the size, location, and quality of dental provider networks and this may also be an important factor. The fact that in many states medical plans that include embedded pediatric dental benefits cost, on average, less than those that do not suggests that attributes we did not capture may indeed be important to consumer choices. While further analysis is needed, we nevertheless feel that our finding related to premiums is extremely important. If consumers shop primarily on price, either because price is the most important attribute or because information on other attributes is less readily available, then one would expect a significant uptake of the embedded option. If, however, lower deductibles and more extensive out-of-network coverage are highly valued by consumers, then SADPs could continue to be the primary path to obtaining pediatric dental benefits. The use of narrow networks and limiting coverage for out-of-network services is an increasingly important cost-containment strategy among insurers.[59] The evidence is mixed regarding how consumers value enhanced provider choice compared to lower costs.[60]

This initial research on dental benefit offerings helps shed light on the evolving dental benefits landscape. It also raises several questions that require further analysis. In our next phase of research, we plan to investigate dental provider networks in greater detail and research how different marketplace set ups actually impact consumer purchase decisions. As the ACA continues to reshape the U.S. health care system, it is important to generate evidence on these and other issues in the dental care sector to help guide policy.

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March 2014 | Issue Brief

How Much Financial Assistance Are People Receiving Under the Affordable Care Act?

Larry Levitt, Gary Claxton, and Anthony Damico

The Affordable Care Act (ACA) provides premium subsidies to low and middle income people who buy insurance on their own through new health insurance marketplaces (also known as exchanges). Subsidies generally are available to people with incomes ranging from one to four times the poverty level ($11,490 to $45,960 for a single person and $23,550 to $94,200 for a family of four). Depending on their income, people are expected to pay 2% to 9.5% of their income towards the premium for the second-lowest-cost silver plan in their area, and the federal government covers the remainder of the cost through a tax credit. People choosing more expensive plans pay the entire additional cost, while those choosing less expensive plans get the savings. Tax credits are provided on an advance basis to people based on estimated annual income and then reconciled after-the-fact based on actual income through their tax returns.

Through the end of February, 4.2 million people had applied for and selected a plan through the marketplaces. As expected, the vast majority of enrollees (83%) have qualified for premium subsidies, since people who are not eligible for premium subsidies can buy comparable coverage with similar consumer protections outside of the marketplaces. We estimate that about 21% of those eligible for premium subsidies have applied for assistance, with significant variation across states.

Using the age and tax credit eligibility of enrollees reported by the federal government, along with the marketplace premiums within each state, we estimate that 3.5 million people have qualified for a total of about $10.0 billion in annual premium subsidies, or an average of about $2,890 per person. Total and average subsidies vary significantly by state depending on the share of eligible people who have signed up, the age distribution of enrollees, and the level of premiums in the state. We also estimate that had all states been able to enroll people at the rate of the five most successful states, an additional 3.1 million people would have qualified for premium subsidies, with an additional $8.6 billion in subsidies being provided.

Premium Subsidies by State

The table below shows estimates for each state of the total number of people who have selected a marketplace plan as of March 1, 2014, the percentage of enrollees who have qualified for assistance, the number of subsidized enrollees, subsidized enrollees as a percentage of those eligible, the average subsidy per enrollee, and total premium subsidies in the state. Estimates are based on enrollment as of March 1, 2014 as reported by the federal government, and do not account for the fact that some people have selected a plan but have not paid the first month's premium.

Nationwide, an estimated 83% of marketplace enrollees qualify for subsidies, ranging from 13% in the District of Columbia and 35% in Hawaii to 92% in Wyoming and 93% in Mississippi. (Members of Congress and some of their staff obtain coverage through the DC exchange and are not eligible for subsidies, which is why the percentage there is so much lower than in the rest of the country.)

The take-up rate of subsidies – that is, the percentage of those eligible who have actually enrolled – is 21% in the U.S. as a whole and ranges from 10% or less in a number of states to 32% or more in Washington, Connecticut, California, Rhode Island, and Vermont. In general, states that are running their own exchanges have higher take-up rates, though some have low take-up due to widely-reported difficulties with their enrollment systems.

Among those qualifying for subsidies, we estimate that the average subsidy is $2,890 per person, ranging from a low of $1,350 in the District of Columbia and $1,780 in Utah to a high of $4,370 in Mississippi and $4,980 in Wyoming. These amounts are highly related to the premium levels in areas within each state. Tax credits are calculated by subtracting the amount each person is expected to pay based on a percentage of their income (which does not vary by state) from the premium for the second-lowest-cost silver plan in their area. Where premiums are low, tax credits will tend to be low as well, though the subsidized individuals themselves will pay the same as people with equivalent income who live in areas with higher premiums. Similarly, average subsidies will tend to be higher in states with older enrollees since they face higher premiums.

Based on enrollment as of March 1, 2014, estimated annual subsidies total $10.0 billion nationwide. Over half of that amount is going to people in five states (California, Florida, North Carolina, Texas, and New York), related both to the size of the states and the take-up rate of subsidized enrollees.

Discussion

A significant amount of financial assistance is already flowing to individuals through the ACA. The amount varies significantly by state based primarily on the total number of people eligible for subsidies, the take-up rate among those eligible, and the premium levels within the state.

Some of the states that are running their own exchanges have had a more successful rollout since open enrollment began in October, and these states also have been able to devote greater resources to outreach and consumer assistance through grants received from the federal government. In the five states with the highest take-up of subsidy eligibles, 39% of those eligible have already enrolled (compared to 21% in the U.S. as a whole). If all states were enrolling people at the rate of the five most successful, an additional 3.1 million people would have qualified, with an additional $8.6 billion in subsidies being provided.

Open enrollment goes until the end of March, and a last-minute surge in signups could boost premium subsidies significantly. The challenge going forward is to identify the strategies and practices used in states with higher enrollment and effectively implement them in states with lower enrollment. Enrolling most of the eligible population will likely involve more and improved methods of outreach and education and take several years to accomplish.

TABLE

State-by-State Data on Enrollment and Subsidies Received						
	Total Number of People Who Have Selected a Marketplace Plan as of March 1, 2014 (Thousands of People)	Percentage of Enrollees Who Have Qualified for Assistance	Number of Subsidized Enrollees (Thousands of People)	Subsidized Enrollees as a Percentage of Subsidy-Eligible Individuals	Average Subsidy per Enrollee	Total Premium Subsidies (Millions of dollars)
Nationwide	**4,242**	**83%**	**3,472**	**21%**	**$2,890**	**$10,019**
Alabama	55	86%	47	18%	$2,880	$136
Alaska	7	87%	6	11%	$4,120	$24
Arizona	58	74%	43	14%	$1,940	$83
Arkansas	27	91%	25	17%	$3,230	$81
California	869	88%	765	40%	$3,060	$2,337
Colorado	83	57%	48	19%	$2,440	$116
Connecticut	57	73%	42	39%	$4,110	$172
Delaware	7	79%	5	18%	$2,940	$15
DC	6	13%	1	9%	$1,350	$1
Florida	442	90%	398	25%	$2,950	$1,173
Georgia	139	85%	118	18%	$2,870	$340
Hawaii	5	35%	2	6%	$1,790	$3
Idaho	44	91%	40	31%	$2,110	$84
Illinois	114	77%	88	17%	$2,240	$196
Indiana	65	88%	57	16%	$3,990	$228
Iowa	15	84%	13	10%	$2,410	$31
Kansas	29	78%	23	14%	$1,970	$45
Kentucky	55	70%	38	20%	$2,620	$101
Louisiana	46	87%	40	12%	$3,610	$143
Maine	25	90%	23	30%	$4,070	$93
Maryland	38	N/A	N/A	N/A	N/A	N/A
Massachusetts	13	N/A	N/A	N/A	N/A	N/A
Michigan	145	87%	126	29%	$2,610	$328
Minnesota	32	N/A	N/A	N/A	N/A	N/A
Mississippi	26	93%	24	12%	$4,370	$104
Missouri	74	85%	63	16%	$2,820	$178
Montana	23	86%	19	20%	$2,850	$55
Nebraska	26	87%	22	18%	$2,540	$56
Nevada	29	79%	23	15%	$2,620	$59
New Hampshire	22	74%	16	20%	$3,180	$51
New Jersey	74	83%	62	15%	$3,470	$214
New Mexico	15	78%	12	10%	$2,500	$29
New York	245	72%	176	23%	$2,650	$466
North Carolina	201	91%	182	27%	$3,320	$606
North Dakota	5	84%	4	10%	$2,730	$12
Ohio	79	85%	67	12%	$2,770	$186
Oklahoma	33	78%	26	10%	$2,230	$57
Oregon	39	79%	31	16%	$2,210	$68
Pennsylvania	160	80%	128	18%	$2,460	$314
Rhode Island	19	88%	17	41%	$3,050	$51
South Carolina	56	86%	48	14%	$3,110	$149
South Dakota	7	89%	6	9%	$3,180	$19
Tennessee	78	79%	62	16%	$2,020	$124
Texas	295	82%	242	12%	$2,440	$591

State-by-State Data on Enrollment and Subsidies Received						
	Total Number of People Who Have Selected a Marketplace Plan as of March 1, 2014 (Thousands of People)	Percentage of Enrollees Who Have Qualified for Assistance	Number of Subsidized Enrollees (Thousands of People)	Subsidized Enrollees as a Percentage of Subsidy-Eligible Individuals	Average Subsidy per Enrollee	Total Premium Subsidies (Millions of dollars)
Nationwide	**4,242**	**83%**	**3,472**	**21%**	**$2,890**	**$10,019**
Utah	40	86%	34	17%	$1,780	$61
Vermont	24	55%	13	50%	$2,930	$39
Virginia	103	80%	82	16%	$2,690	$222
Washington	107	81%	87	32%	$3,280	$285
West Virginia	11	86%	9	13%	$3,170	$29
Wisconsin	71	90%	64	21%	$3,590	$231
Wyoming	7	92%	6	13%	$4,980	$31

Source: Kaiser Family Foundation analysis of March 2012 and 2013 CPS. See Methods for more details.

METHODS

We estimated state-by-state financial assistance by extending prior analysis of those who are uninsured or buy coverage on their own discussed in our state estimates of subsidy-eligibles.

For each state we produced average tax credit amounts per eligible person by age using our analysis of the demographics of health insurance units within the state from the pooled 2012-2013 CPS-ASEC, adjusted by an imputation of whether an employer offer of coverage is available derived from the Survey of Income and Program Participation. Premiums for the second-lowest-cost silver plan are based on our analysis of federal data and compilation of insurer rate filings.

We applied those tax credit amounts to the actual age distribution of those who have selected a plan in each state, available in this addendum provided with the latest Marketplace enrollment statistics from the Department of Health and Human Services (HHS). For each state, we applied the percentage of enrollees receiving financial assistance to the total number of people who have selected a plan. Information is not yet available on how many of those who have selected a plan have paid the first month's premium, which is the final step in enrollment.

We assumed that the age distribution of subsidy-eligible enrollees is the same as that for all individuals who have selected a plan, which is likely the case given that they are 83% of the enrolled population. Since state-by-state statistics on the income distribution of enrollees are not available, we assumed that it mirrors our estimates of those eligible for tax credits in each state. The Washington Health Plan Finder has released detailed statistics on the income distribution of enrollees, and that distribution closely matches our estimates of the eligible population in the state.

The share of Marketplace enrollees determined to receive financial assistance was not included in the HHS report for Maryland, Massachusetts, or Minnesota, so these three states were removed from the entire analysis.

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March 2014 | Issue Brief

Sizing Up Exchange Market Competition

Cynthia Cox, Rosa Ma, Gary Claxton, Larry Levitt

The individual health insurance market historically has been highly concentrated, with only modest competition in most states. At the time the Affordable Care Act (ACA) was signed into law in 2010, a single insurer had at least half of the individual market in 30 states and the District of Columbia. While a dominant insurer may be able to negotiate lower rates from hospitals and physicians, without significant competitors or regulatory oversight, there is no guarantee that those savings would be passed along to consumers.[1]

Health insurance exchanges (also called marketplaces) are intended to promote price competition in the individual and small group insurance markets through greater transparency. Tax credits to reduce the cost of premiums, and in some cases out-of-pocket costs, encourage consumers to enroll through an exchange, which in turn gives insurers an incentive to participate in the new markets. Unlike the pre-ACA market, benefits are generally comprehensive and largely uniform, with cost-sharing presented in standardized tiers. With medical underwriting prohibited, premiums are easy to compare, focusing competition on price. Beyond exchanges, several other aspects of the ACA are intended to mitigate potential adverse effects of uncompetitive markets. For example, the ACA's rate review provision requires scrutiny of large premium increases. The Medical Loss Ratio rule also ensures that plans experiencing a windfall from lower-than-expected health care expenses pass at least some of that back to consumers in the form of rebates.

Preliminary exchange enrollment data released by seven states provides an opportunity to look at how competition may be changing in the individual market. To do this, we compared early enrollment across insurers in these exchanges to market share statistics from each state's 2012 individual market prior to full ACA implementation. While the early exchange enrollment results provide only a partial picture of state markets – they do not include coverage sold outside state exchanges or enrollees covered in grandfathered plans — seeing reduced market concentration within an exchange may well be a signal that the market overall is becoming more competitive, or vice versa. Over time, the availability of premium tax credits, which are only available inside exchanges, should greatly increase the number of individual market participants in state markets. If these new avenues for enrollment are more or less competitive, the overall markets are likely to be as well.

Analysis of the early results suggests a diversity of results across states. On one hand, two large states, California and New York, appear to be noticeably more competitive than their 2012 individual markets as a whole. On the other hand, exchanges in Connecticut (where two major insurers decided not to participate in the exchange) and Washington appear to be less competitive than their individual markets were in 2012. In some cases, market share among insurers has shifted significantly under the ACA, including some notable

examples of new entrants picking up substantial enrollment. Full results for the seven states with available data are detailed below.

Measuring Insurance Market Competition

There are several ways to measure insurance market competition. Most analyses of exchange markets thus far have focused on the number of insurers participating in the marketplaces or whether there are any new entrants to the market. By these measures, exchange markets in most states are comprised of several insurers from which consumers can choose. While not all insurers that previously offered coverage in the individual market are participating in exchanges, new Consumer Operated and Oriented Plans ("CO-OPs") are being offered in 23 states, as well as other insurers that previously offered Medicaid HMOs and are new to the individual market. Half of states have 4 or more insurers participating in their exchanges, and a dozen states have ten or more insurers offering. Some areas of the country, particularly in the rural south, only have a single insurer offering exchange coverage. This is the case in West Virginia, much of Alabama, and some parts of North Carolina, Florida, Mississippi and Arkansas. New Hampshire and parts of Wisconsin also have just one insurer offering exchange coverage.[2] Exchange insurers offer multiple plans at various metal levels, so people living in areas with just one insurer still have some amount of choice in the products they purchase but are not necessarily benefiting from competitive market dynamics.

The number of insurers and new entrants tells us something about consumer choice, but choice does not always equate to competition. For example, a market may have several insurers participating, but if one large insurer controls the vast majority of the market, the market would still generally be considered uncompetitive. With plan-level enrollment numbers coming in from a handful of states, we are now able to see not only how many insurers are offering in these markets, but also how actual market share is distributed.

To look more closely at the concentration of actual enrollment, we examined three additional indicators of market competition:

- The market's Herfindahl–Hirschman Index (HHI)
- The market share of the largest insurer
- The number of insurers with greater than 5% market share

The Herfindahl-Hirschman Index is a measure of how evenly market share is distributed across insurers in the market.[3] HHI values range from 0 to 10,000, with an HHI closer to zero indicating a more competitive market and closer to 10,000 indicating a less competitive market. An HHI index below 1,000 generally indicates a highly competitive market; an HHI between 1,000 and 1,500 indicates an unconcentrated market; a score between 1,500 and 2,500 indicates moderate concentration; and a value above 2,500 indicates a highly concentrated (uncompetitive) market.

Another way to measure market competition is by simply looking at the share of the market held by the largest insurer. An insurer that controls a significant portion of the market may be able to leverage that market share to charge higher premiums (or negotiate lower rates from providers).

Finally, the number of insurers with greater than 5% market share is a measure of the degree of choice consumers have. As opposed to simply looking at the total number of insurers participating in a market, setting a threshold (in this case 5% market share) gives an idea of which insurers have sufficient enrollment to potentially grow in the future. For more discussion on these measures of competition, see our October 2011 brief.

Market Competition in Seven State Exchanges

As of the publication of this brief, seven states (California, Connecticut, Minnesota, Nevada, New York, Rhode Island, and Washington) had released marketplace enrollment numbers by insurer. As noted above, we compared enrollment statistics in each of these seven states to enrollment data in the state's individual market in 2012, which is made publicly available by the Department of Health and Human Services under the Affordable Care Act's Medical Loss Ratio provision.

The exchange markets in these seven states are not necessarily representative of the markets in the remaining 44 states. Each of these seven states is running its own exchange, rather than partnering with the federal government or defaulting to a federally facilitated exchange, and subsequently had significantly more funds available for outreach and marketing. All but Minnesota and Nevada are currently in the top ten states leading the nation in marketplace enrollment as a percent of the number of potential marketplace enrollees.

Additionally, the market indicators we examined reflect competition at the state level, not the local level, where competition among insurers truly takes place. Premiums in most states are also set at the local area (by rating areas, which are typically groups of neighboring counties). With the exception of California, states have not released regional exchange plan enrollment data, making a systematic comparison of premiums and market competition difficult in most states. When possible, though, we note whether an insurer that priced relatively low in the majority of the state was able to pick up market share.

California

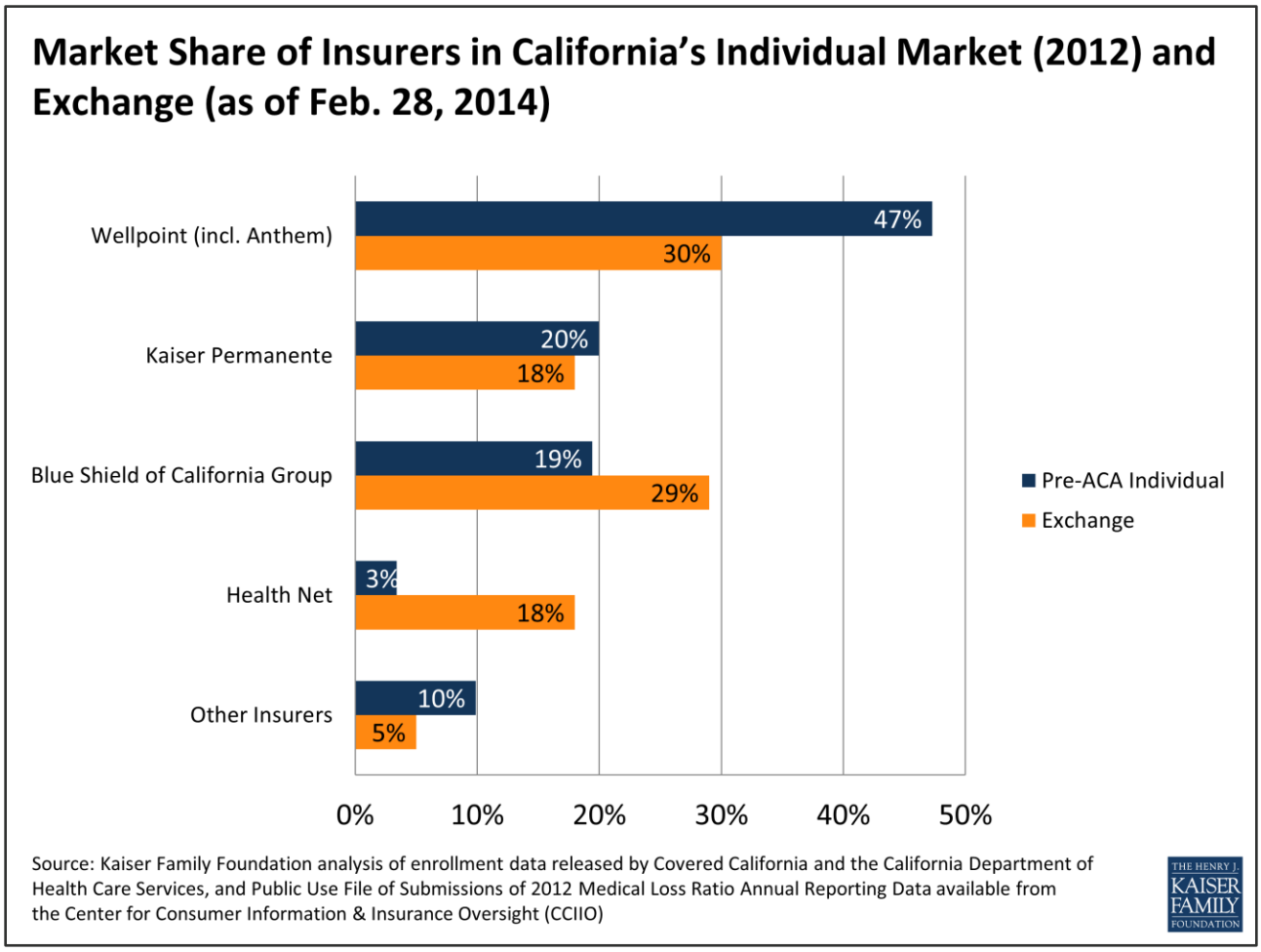
The California exchange market is shaping up to be more competitive than its 2012 individual market. All three indicators (HHI, market share of largest insurer, and number of insurers with greater than 5% market share) point to increased competition. California's individual market was highly concentrated in 2012, but the exchange market has only moderate concentration.

California Insurance Market Competition

Market	Herfindahl-Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	3,052 (Highly Concentrated)	47%	3
2014 Exchange Market (As of February 28, 2014)	2,418 (Moderately Concentrated)	30%	4
How Competitive is Exchange?	More Competitive	More Competitive	More Competitive

Source: Kaiser Family Foundation.

There are eleven insurers participating in California's exchange throughout the state, including eight plans that previously made up 90% of the 2012 individual market. Four new plans (L.A. Care Health Plan, Molina Healthcare, Western Health Advantage, and Valley Health Plan) are also being offered, but together only make up 5% of the exchange's market. Not all plans are available in all areas of the state.



Wellpoint, the parent company of Anthem Blue Cross of California and the state's largest individual market insurer, has significantly less market share in the exchange than it did in the 2012 individual market (30% vs. 47%). Blue Shield of California picked up substantial market share, most likely because it was able to offer the lowest premiums in several parts of the state.

Health Net, previously holding only 3% of the market, now has 18% market share in the exchange. This insurer has the lowest premiums in much of Southern California, where it is also leading enrollment.

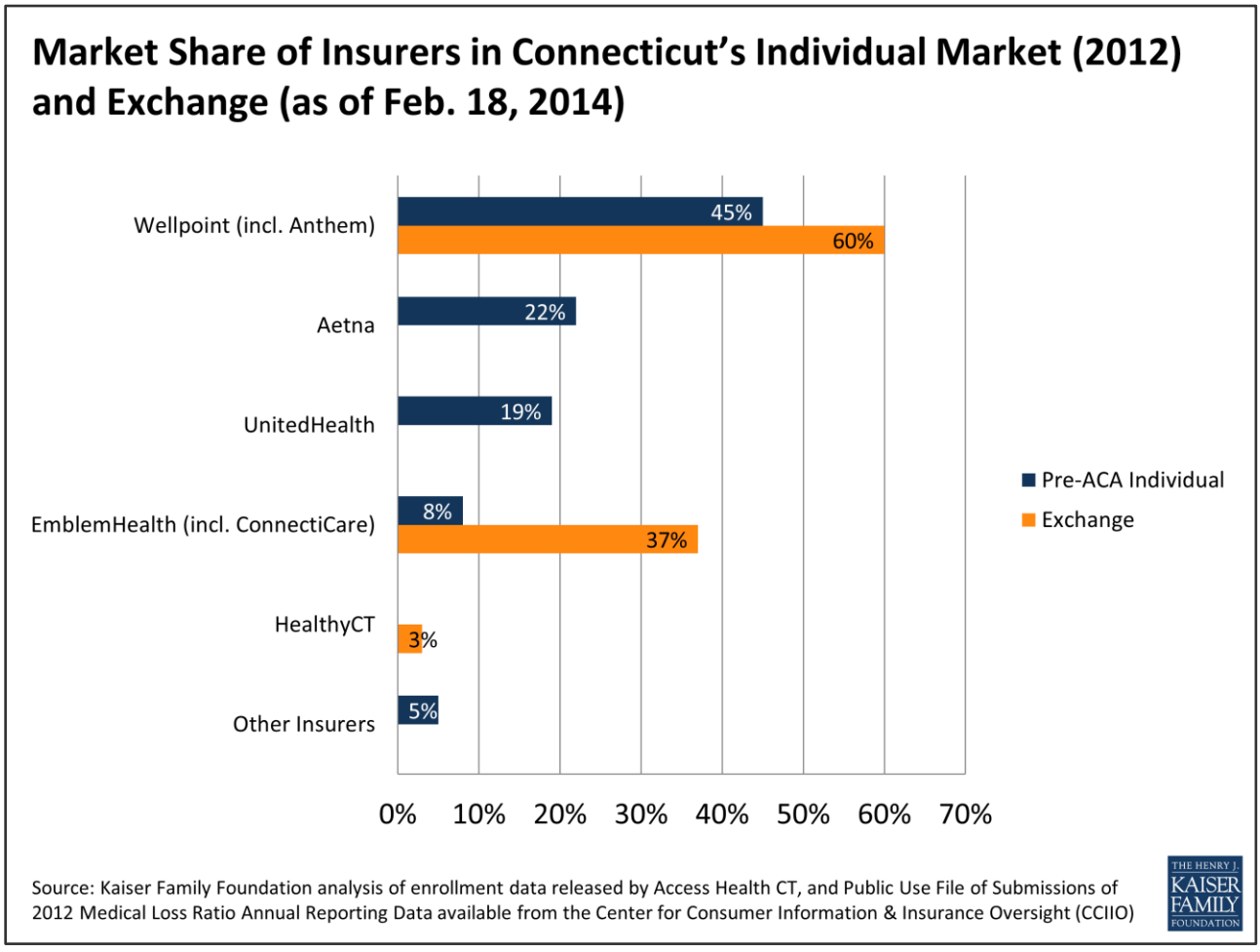
CONNECTICUT

In Connecticut the exchange market looks to be significantly less competitive than its 2012 individual market. All three market indicators (HHI, market share of largest insurer, and number of insurers with greater than 5% market share) point to less competition in the exchange compared to the individual market in 2012.

Connecticut's exchange has just 3 insurers participating. Although five initially indicated they would participate in the state's exchange, Aetna and UnitedHealth subsequently pulled out. Cigna, a sizable insurer in the state's group markets, also decided against participating in the state's exchange.

Connecticut Insurance Market Competition			
Market	Herfindahl–Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	2,962 (Highly Concentrated)	45%	4
2014 Exchange Market (As of February 18, 2014)	4,978 (Highly Concentrated)	60%	2
How Competitive is Exchange?	Less Competitive	Less Competitive	Less Competitive
Source: Kaiser Family Foundation.			

Two of the three exchange insurers, Wellpoint (Anthem) and EmblemHealth (ConnectiCare), together made up just over half (54%) of the individual market in 2012, and now control 97% of the exchange market. The other 2% of the market is HealthyCT, a new entrant. HealthyCT is a CO-OP plan formed in late 2011 that uses a patient-centered medical home model.



Despite a less competitive exchange market and higher than average premiums, Connecticut has been very successful in enrolling consumers. Exceeding the state's own expectations, it is currently ranked second in the nation of states that have enrolled the largest portion of their potential exchange enrollees (Vermont is currently number 1). Connecticut's success could be attributed in part to its usage of Apple-inspired storefronts in enrolling residents through the exchange. Designed to simplify the complexities of health insurance, these retail-like stores are staffed with enrollment counselors and brokers who walk consumers through the enrollment process.

In an effort to encourage more insurers to participate in the first years of the exchange, Connecticut offered a form of market exclusivity to those insurers agreeing to offer coverage in 2014. Insurers that decided not to participate in 2014 are barred from entering for at least 2 more years. While it is not known how heavily this policy factored into insurer's decisions to enter the exchange market in 2014, it is notable that California and New York instituted similar policies and were able to achieve more competitive exchange markets.

MINNESOTA

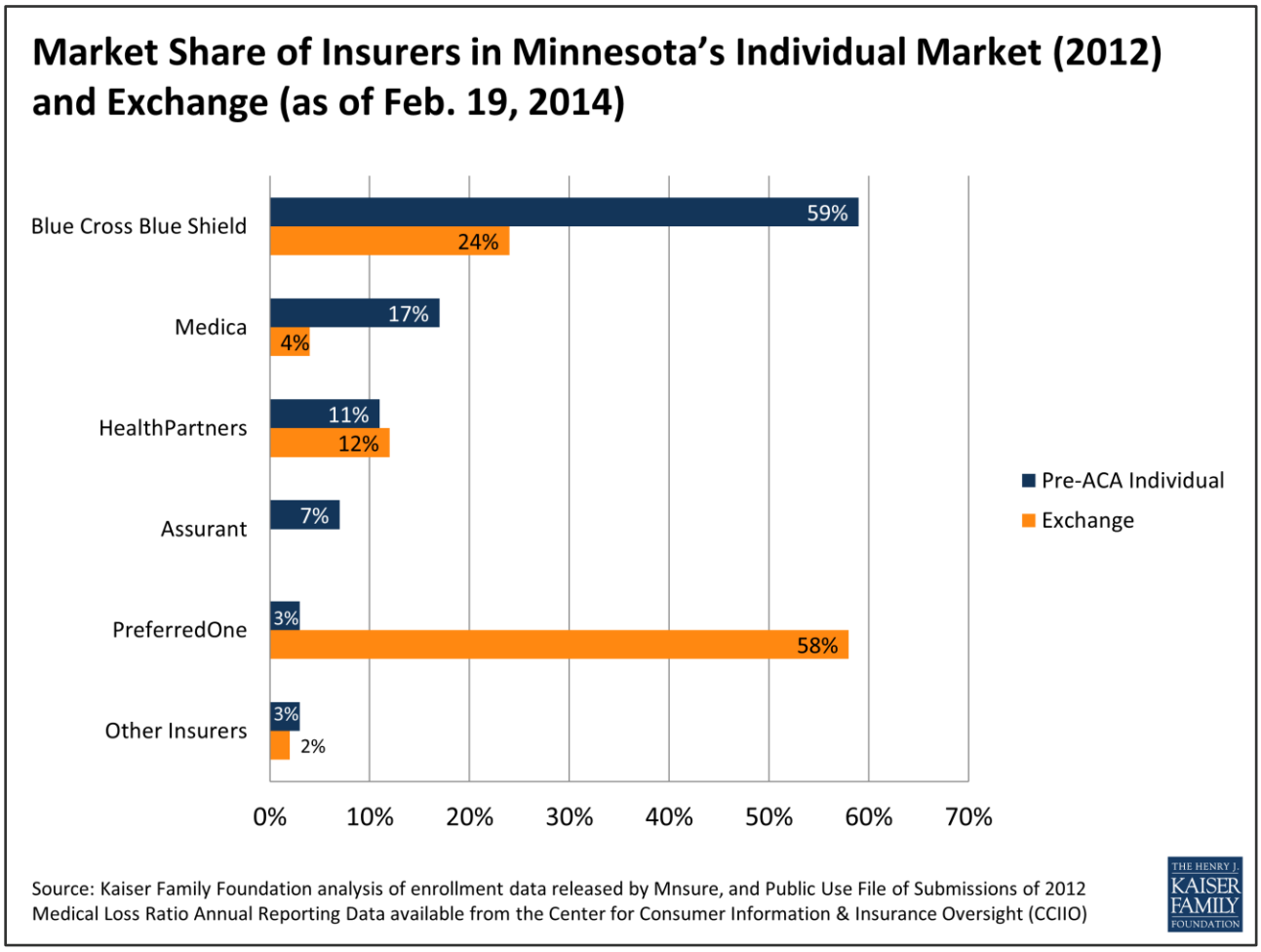
Looking only at the competition indicators, Minnesota's exchange market closely resembles its 2012 individual market. The state's HHI (3,999 vs. 4,104) and the largest insurer's market share (59% vs. 58%) appear to be relatively unchanged from 2012. While the indicators are comparable in the exchange and the 2012 individual market, the insurer leading enrollment in the exchange was actually a very small player in Minnesota's individual market in 2012.

Minnesota Insurance Market Competition

Market	Herfindahl–Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	3,999 (Highly Concentrated)	59%	4
2014 Exchange Market (As of February 19, 2014)	4,104 (Highly Concentrated)	58%	3
How Competitive is Exchange?	Similar	Similar	Less Competitive

Source: Kaiser Family Foundation.

With some of the lowest exchange premiums in the country, PreferredOne was able to seize a significant portion of the exchange market and has clearly had a noticeable effect on the competitive landscape in the state. PreferredOne currently controls more than half (58%) of the exchange market, whereas it held just 3% of the 2012 individual market. In the Minneapolis region, PreferredOne is able to offer the least expensive silver plan in part by offering a narrow network version of its other plans. As part of PreferredOne's "Select" network, these plans only contracts with 17 hospitals in the state, compared to its broader "Choice" network, which contracts with 136 hospitals in the state. The Select network comes with lower monthly premiums: a 40 year-old enrolling in an Accent Select silver plan would pay $154 per month, compared to $172 per month for a broader network Accent Choice silver plan.



PreferredOne has significantly outpaced the previously dominant insurer in the state, Blue Cross Blue Shield. Controlling 59% of the individual market in 2012, Blue Cross Blue Shield (which priced significantly higher than PreferredOne) only has 24% market share in the exchange. Because of these significant market share shifts in the exchange, it's possible that a different picture of the competitiveness of Minnesota's individual market will emerge once information on enrollment outside the exchange becomes available.

Combined, four companies – PreferredOne, Blue Cross Blue Shield, HealthPartners, and Medica – have enrolled 98% of the exchange market. (In 2012, these insurers accounted for 90% of the total market share.) UCare, a nonprofit health plan that previously served Medicare and Medicaid enrollees and is a new entrant in the individual market, comprises 2% market share in the exchange.

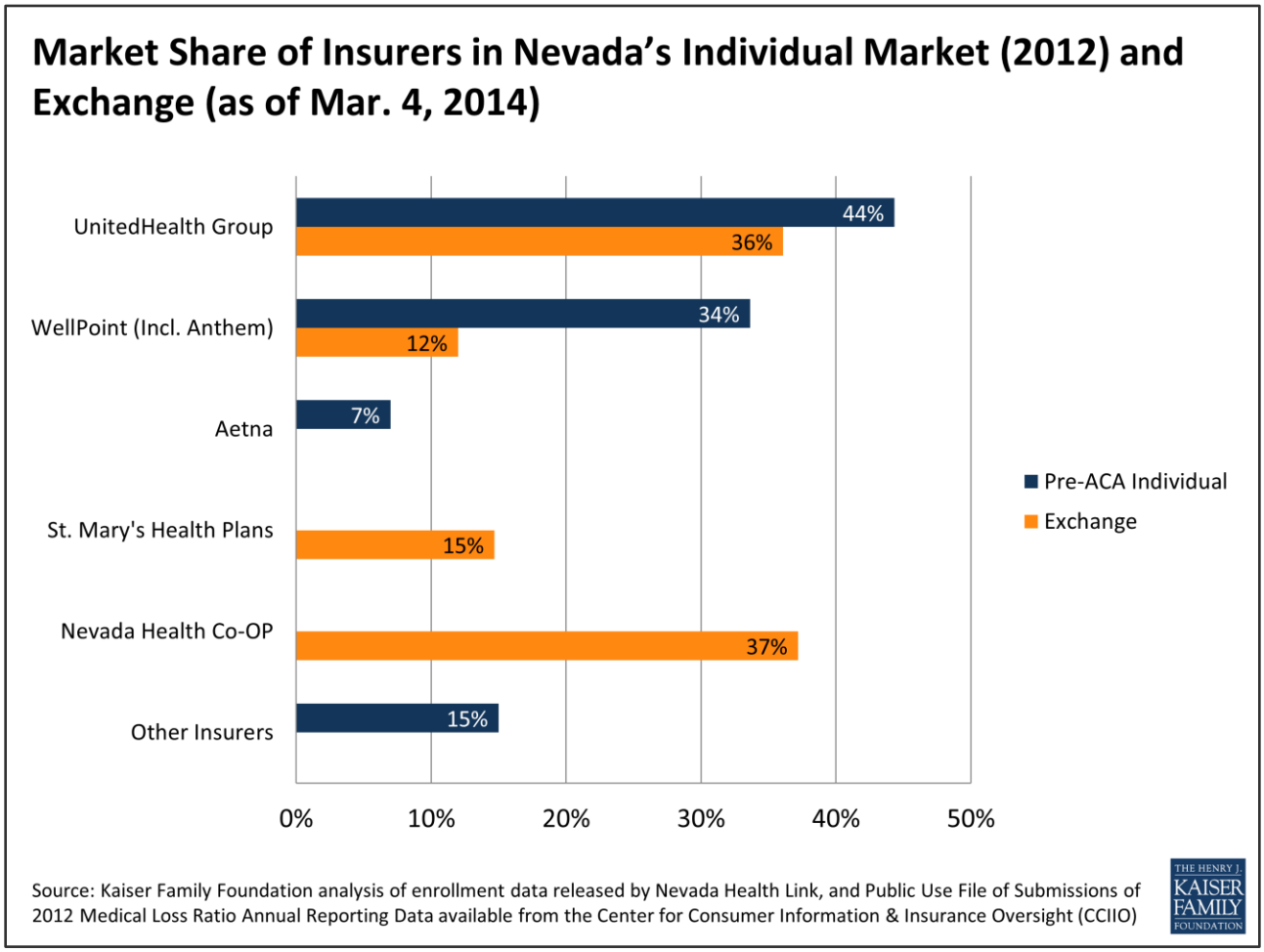
NEVADA

Nevada's exchange is moderately more competitive than the state's pre-ACA individual market was overall. While the exchange HHI score is roughly unchanged, the market share held by the largest insurer decreased somewhat (from 44% to 37%) and the number of insurers with more than 5% market share also increased (from 3 to 4 insurers).

Nevada Insurance Market Competition			
Market	Herfindahl–Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	3,198 (Highly Concentrated)	44%	3
2014 Exchange Market (As of March 4, 2013)	3,049 (Highly Concentrated)	37%	4
How Competitive is Exchange?	Similar	More Competitive	More Competitive
Source: Kaiser Family Foundation.			

In Nevada, two companies (UnitedHealth and Wellpoint) currently make up 48% of exchange market enrollment. These two insurers previously held 78% of the 2012 individual enrollment, but have lost significant market share to a new entrant.

Leading enrollment in the Nevada exchange is a new insurance company called Nevada Health CO-OP. With 37% of the exchange market, Nevada Health is one of the only CO-OP plans to have gained significant enrollment in the seven states with available data. Another prominent new player on the exchange market is St. Mary's Health Plans, which holds 15% of market share. Prior to its participation on the exchange, the health plan only offered coverage in the small group and large group markets.



New York

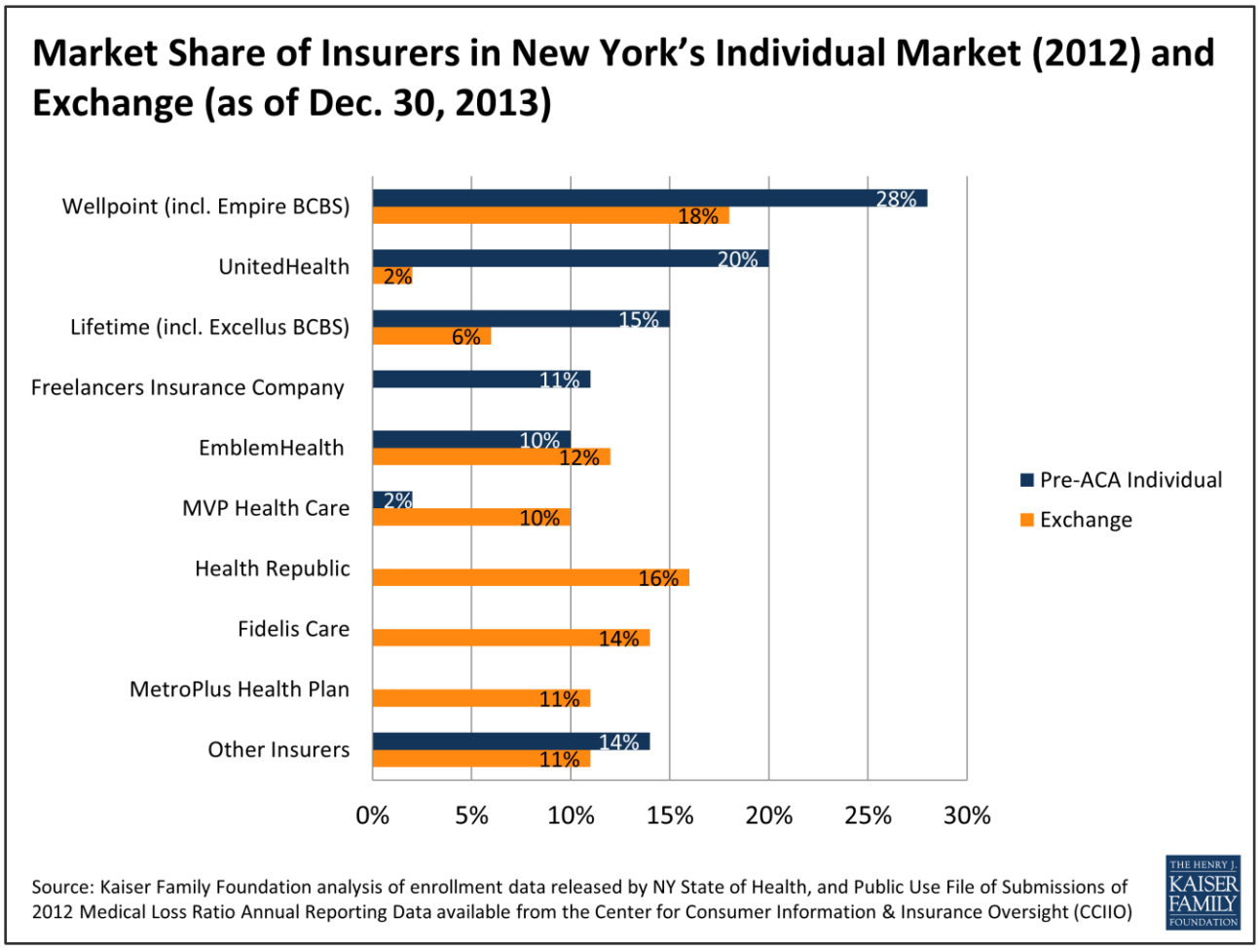
Of the seven states, New York's exchange market is the most competitive and is also more competitive than its pre-ACA individual market as a whole. The state's individual market was moderately concentrated, but its exchange market is now considered unconcentrated (with an HHI of less than 1,500).

New York Insurance Market Competition

Market	Herfindahl-Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	1,641 (Moderately Concentrated)	28%	5
2014 Exchange Market (As of December 30, 2014)	1,197 (Unconcentrated)	18%	7
How Competitive is Exchange?	More Competitive	More Competitive	More Competitive

Source: Kaiser Family Foundation.

New York's exchange acts as an active purchaser, meaning the state selectively contracts with plans, rather than allowing any qualified insurer to participate. Even so, the state has 16 parent companies offering plans in the exchange in various parts of the state, 7 of which hold market shares greater than five percent.



Ten of these companies offered coverage to New Yorkers purchasing their own insurance before the ACA. All together these ten companies enrolled 81% of the individual market in 2012, and now make up just over 54% of exchange enrollment. New York's exchange introduced six new insurers to the individual market that combined hold 45% of the exchange market. The largest new entrant to New York's market is Health Republic, a CO-OP plan that originally received sponsorship from Freelancers Union but is now licensed as an independent company. Other sizable new entrants are Fidelis Care and MetroPlus Health Plan, both of which served Medicaid beneficiaries before the ACA.

While New York's largest individual market insurer, Wellpoint Inc. (which includes Empire Blue Cross Blue Shield), controlled 28% of the 2012 individual market, it now holds only 18% of the exchange market. Several smaller insurers have picked up market share. MVP Health Care, for example, held a mere 2% of the individual market in 2012, but now has about 10% of the exchange market.

UnitedHealth previously held a substantial portion (20%) of the 2012 individual market. Currently the insurer represents only 2% of the exchange market, perhaps because it priced relatively high compared to its competitors.

Rhode Island

All three of the competition indicators suggest that Rhode Island's exchange market is similarly situated to its 2012 individual market. Rhode Island's exchange, like its 2012 individual market, is extremely concentrated, with almost all of the market controlled by a single insurer (Blue Cross & Blue Shield of Rhode Island).

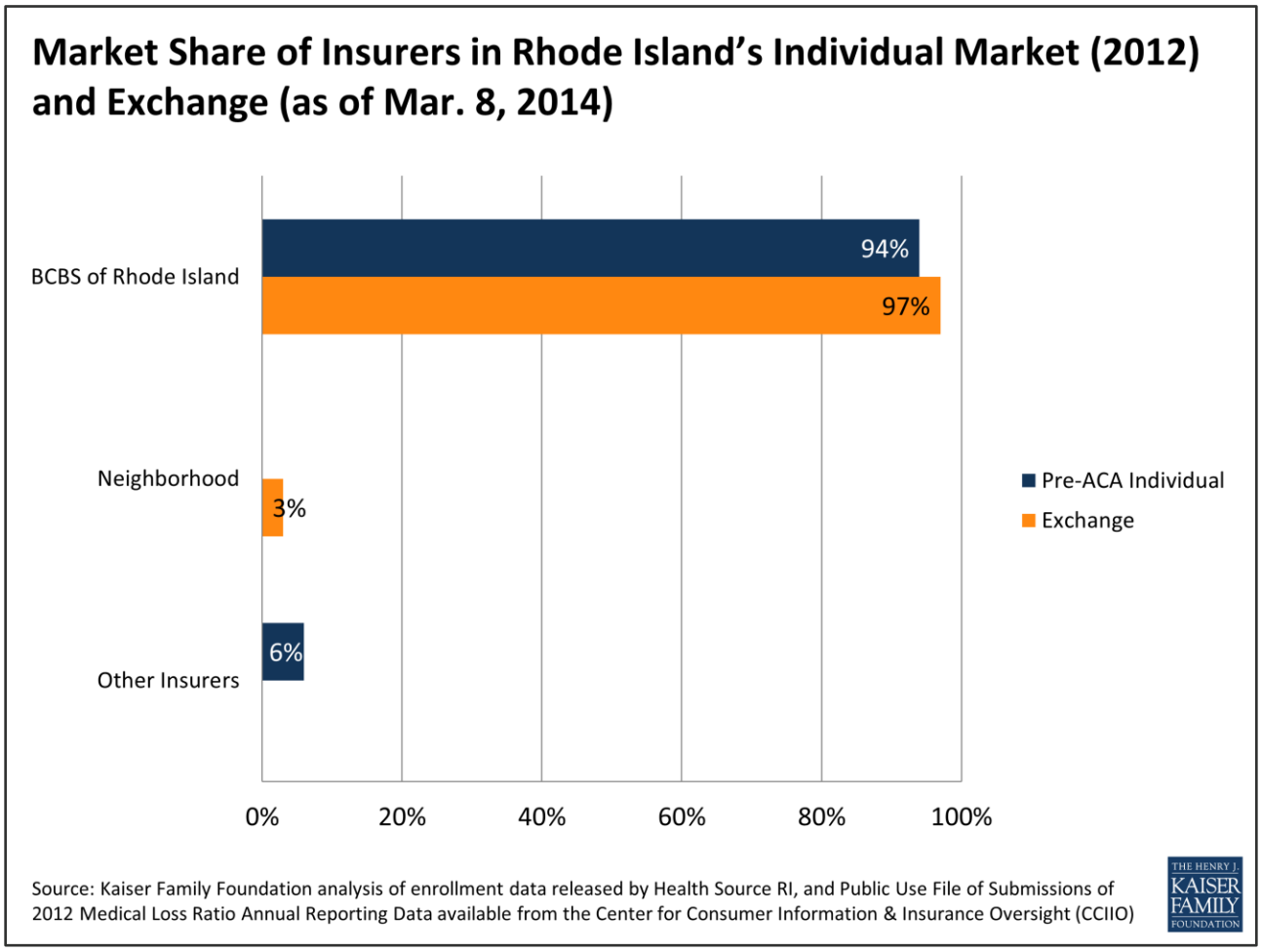
Rhode Island Insurance Market Competition

Market	Herfindahl–Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	8,824 (Highly Concentrated)	94%	1
2014 Exchange Market (As of March 8, 2014)	9,361 (Highly Concentrated)	97%	1
How Competitive is Exchange?	Similar	Similar	Similar

Source: Kaiser Family Foundation.

There are only two insurers competing in Rhode Island's exchange market. Blue Cross Blue Shield of Rhode Island holds 97 % market share. That it controls so much of the exchange is unsurprising as the insurer previously held 94% of the overall individual market before the ACA.

Rhode Island's other plan, Neighborhood Health Plan of Rhode Island (NHPRI), currently holds 3% of the market. Before the ACA, NHPRI served Medicaid enrollees, but entered into the exchange this year. Rhode Island's exchange director has indicated that they are in conversations with other carriers and are hopeful for additional entrants in the coming years.



WASHINGTON

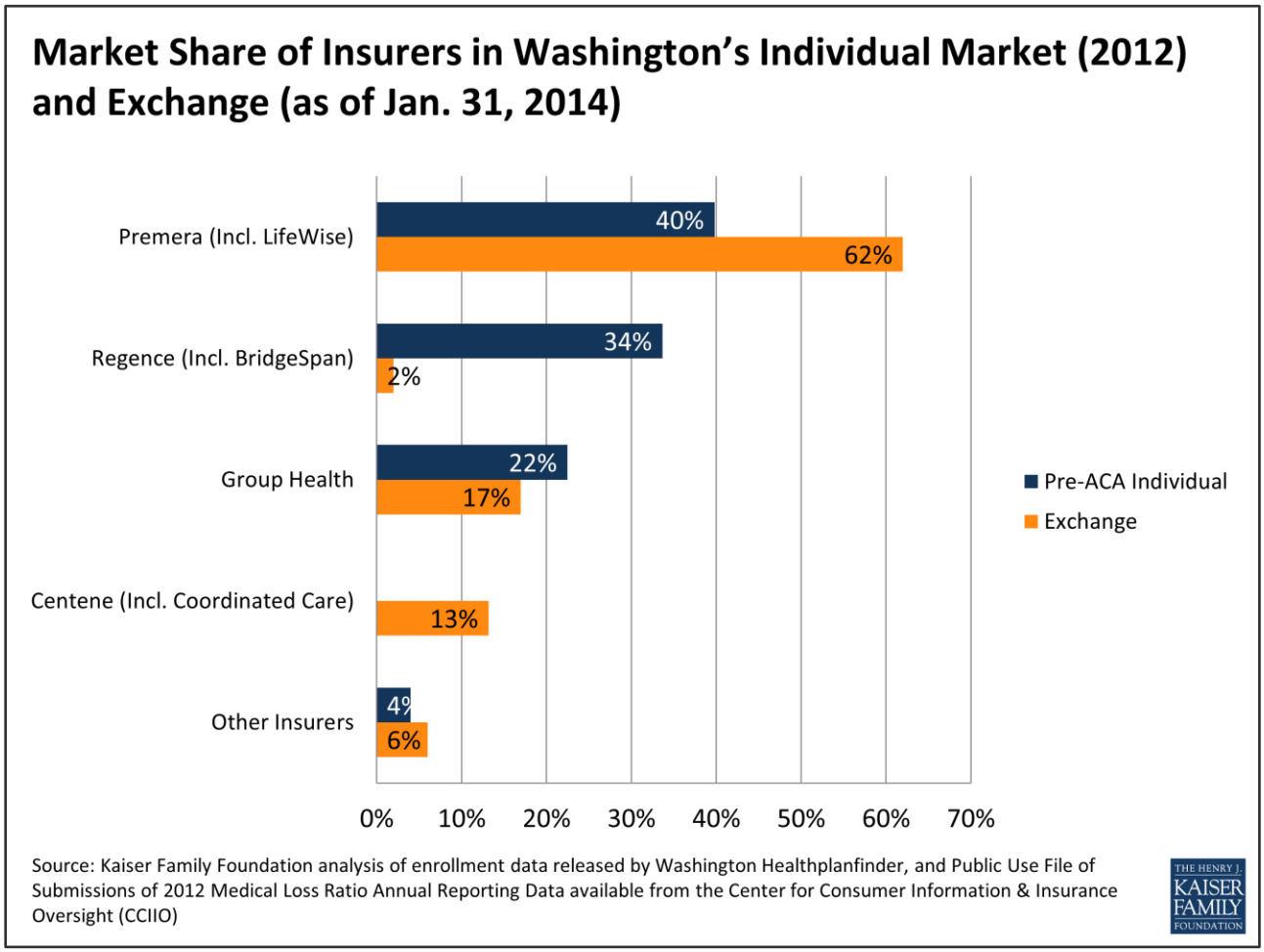
Much like its individual market in 2012, Washington's exchange market is shaping up to be highly concentrated. Washington State initially rejected filings from several insurers wishing to participate in the state's exchange, temporarily leaving the state with just four exchange insurers. Shortly before the exchanges opened, however, the state approved additional insurers, bringing participation to a total of 9 insurers (three of which are owned by the same parent company, Premera).

Washington Insurance Market Competition

Market	Herfindahl-Hirschman Index (HHI)	% Market Share of Largest Company	Number of Companies over 5% Market Share
2012 Individual Market	3,230 (Highly Concentrated)	40%	3
2014 Exchange Market (As of January 31, 2014)	4,309 (Highly Concentrated)	62%	3
How Competitive is Exchange?	Less Competitive	Less Competitive	Similar

Source: Kaiser Family Foundation.

Three parent companies hold about 92% of the exchange market: Premera, Group Health, and Centene. Coordinated Care (a Centene subsidiary) is a new entrant that has picked up substantial market share in the exchange. Centene contracted with the state of Washington in 2012 to serve Medicaid beneficiaries and subsequently entered into the individual exchange market. It now offers the lowest silver premiums in all areas in which it operates.



While Premera's premiums are not the lowest, the insurer did pick up a substantial portion of the market, now controlling nearly two thirds of the exchange market. Premera did offer the second-lowest cost silver plans in much of the state and may have benefited from more name-recognition than Centene.

As in Minnesota, market share in Washington's exchange has shifted significantly as compared to the pre-ACA individual market. Regence, a major player in the individual market previously, has picked up very few exchange enrollees. However, if Regence is still enrolling a significant number of people outside the exchange, the individual market as a whole may end up being more competitive than the exchange-only enrollment information suggests.

Conclusion

The long-term success of the exchanges and other ACA provisions governing market rules will be measured in part by how well they facilitate market competition, providing consumers with a diversity of choices and

hopefully lower prices for insurance than would have otherwise been the case. With the first open enrollment period not yet completed, it is too soon to tell how well the exchanges will work to improve competition in the individual insurance market, which historically has been highly concentrated and dominated by a small number of insurers in most states. Exchange enrollment will certainly change – especially during this last month of open enrollment, but also throughout the year as enrollees gain and lose eligibility – and it will be several years before we can truly evaluate the success of the new markets.

Only scattered information is available so far on enrollment across plans. Seven state-run exchanges have released market share data, but these enrollment numbers do not include individual market enrollment outside of the exchange. Off-exchange individual markets will continue to exist alongside exchanges, so exchange enrollment alone does not tell the whole story of consumer choice and competition.

Nonetheless, early indications suggest that some exchange markets are more competitive than their states' individual markets before the ACA. In particular, the two largest states, California and New York, have significantly more competitive exchange markets compared to their individual markets in 2012. Two states (Connecticut and Washington) that have also been successful at enrolling consumers seem to have less competition than in their 2012 individual markets. Results from the remaining states generally show either similar levels of competition as their pre-ACA markets or mixed signs.

Several insurers with lower-cost silver options have gained significant market share (most enrollees are choosing silver plans). Some exchange insurers may have found a competitive edge in offering narrow network plans that have lower premiums but give enrollees fewer choices of providers. Recent Kaiser polling suggests that consumers who are either uninsured or buying their own insurance prefer a cheaper plan with a narrow network to one that has a higher premium but a broad network. Minnesota's PreferredOne, in particular, appears to have gained significant market share by offering a narrow network plan that comes with the lowest-cost silver premium in the country.

While new entrants to the market have generally not picked up meaningful market share, there are notable exceptions where new plans have altered the competitive landscape significantly, such as in Nevada. And, in Minnesota (where competition appears similar to what it was before) and Washington (where it appears to be somewhat less competitive), exchange enrollment is distributed across plans very differently from how it was before in the individual market. This suggests a more dynamic market than indicated by aggregate statistics alone and points to the potential for greater price competition in the future.

METHODS

Market share was calculated as the percent of a given state's individual or exchange market enrollment that was accounted for by a given insurer (plans that shared a parent company within a given state were collapsed into one insurer). Exchange enrollment numbers reflect nongroup (individual market) purchasers only and do not include SHOP enrollees. The Herfindahl–Hirschman Index (HHI) was calculated by taking the sum of squares of market share by state.

Pre-ACA individual market enrollment data were obtained from Public Use File of Submissions of 2012 Medical Loss Ratio Annual Reporting Data available from the Center for Consumer Information & Insurance Oversight (CCIIO).

The sources for each state's plan level enrollment data are listed below:

- California: Covered California March 13, 2014 Press Release
- Connecticut: Access Health CT February 20, 2014 Board of Directors Meeting
- Minnesota: MNsure February 26, 2014 Board of Directors Meeting
- Nevada: provided by Silver State Health Insurance Exchange
- New York: NY State of Health December 2013 Enrollment Report
- Rhode Island: HealthSource RI March 11, 2014 Press Release
- Washington: Washington Healthplanfinder January 2014 Health Coverage Enrollment Report

ENDNOTES

1 The Medical Loss Ratio provision assures that insurers cannot profit excessively relative to the premiums they charge, but it does not guarantee that insurers will push to get the lowest costs and charge to lowest premiums.

2 Kaiser Family Foundation analysis of insurance company rate filings to state regulators and data released by the U.S. Department of Health & Human Services, available at: http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm.

3 The HHI is generally calculated as the sum of squares of market share of the 50 largest companies. For example, if a state had five insurance carriers, and one carrier has 60% market share while the others each have 10%, the HHI would be 4,000 (because 60^2 + 10^2 + 10^2 + 10^2 + 10^2 = 4,000).

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THE OUT-FRONT WESTERN REGION

An Overview

March 2014

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State-Level Field Network Study of the Implementation of the Affordable Care Act

March 2014

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THE OUT-FRONT WESTERN REGION

An Overview

The U.S. Census Bureau defines four main regions of the country — the West, South, Midwest, and Northeast. This first "Special Analysis Report" focuses on the Western region, which has the largest number of states — six out of thirteen — that are affirmatively implementing the Affordable Care Act. That is, they have state-administered health insurance exchanges and have expanded Medicaid as authorized under the law.

Altogether, there are eleven states in the Western region of the contiguous states, and nine of them are in our sample. A complete list of states of the Western region and those of our sample is contained in Table 1 (see next page).

This report describes the policy setting and goal alignment of all nine Western sample states, with emphasis on five states — California, Oregon, Washington, Colorado, and Nevada — that are clearly out front as ACA-affirming states. New Mexico is also an affirming ACA state, although its exchange will not be state run until 2014. Arizona and Idaho occupy an "In-Between" category; that is, in between affirming and oppositional. Arizona rejected the state-run exchange option but accepted Medicaid expansion. Idaho so far has done the opposite, accepting the state-run exchange option while tabling Medicaid expansion. Utah is the one fully oppositional state in our sample, choosing in 2013 not to run its exchange or expand Medicaid. As shown in Table 1, by one index of "enrollment performance" (the number of individuals who have selected a plan as a percentage of the potential market size during the first month of operation) four of the six fully affirming Western states rank among the top ten states.

Table 1. Western States Goal Alignment with the Affordable Care Act and Initial State Enrollment Performance Rank, as of October 31, 2013

State/General Response	Exchange*	Medicaid Expansion	Early ACA Enrollment Rank**
Affirming			
California	S	Yes	7
Colorado	S	Yes	8
New Mexico	S&F	Yes	40
Nevada	S	Yes	10
Oregon	S	Yes	no data
Washington	S	Yes	5
In-between			
Arizona	F	Yes	28
Idaho	S	No	18
Oppositional			
Utah	F	No	37

* S = state run exchange, F = federally run exchange, S & F = federally supported by the HealthCare.gov Web site in 2013, transitioning to full state support in 2014.

West Region — U. S. Census Bureau:
- *Mountain Division*: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming
- *Pacific Division*: Alaska, California, Hawaii, Oregon, and Washington

This essay and the first set of Western state reports that appear with it largely focus on events and data for the period October 1, 2013, to October 31, 2013, the first month of major coverage expansion and the opening of ACA marketplace exchanges. Our subsequent reports will provide periodic updates and new data for important trends such as enrollment as a percentage of potential market size by state.

** Initial state ACA enrollment rank reflects the number of individuals who enrolled in an ACA exchange plan as a percentage of the potential market size, by state. Market size is taken from estimates made by the Kaiser Family Foundation. State ranks are from one to fifty, with Vermont leading the list. Of the top ten, four are in the West, four in the Northeast, one in the South, and one in the Midwest.
The state rankings are based on the first month enrollment period October 1, 2013, to October 31, 2013. Calculations triangulate data from the following sources: Congressional Budget Office May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage; Kaiser Family Foundation November 2013 Issue Brief, State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act; Department of Health and Human Services Issue Brief, Health Insurance Marketplace: November Enrollment Report.

The field research reports described in this Special Analysis Report contain individual state stories and baseline data covering the first month of exchange operations under the Affordable Care Act. The information can be accessed from the Special Analysis Report or by using the network map available on the project Web site (http://www.rockinst.org/aca/). Initial Round 1 reports for sample states from other regions will be announced and posted along with future Special Analysis Reports. You can receive announcements of both types of reports by emailing info@rockinst.suny.edu.

State Capacity for Affordable Care: Where Did It Come From, Where Is It Going?

What accounts for this apparent fast start of Western states in implementing the ACA? For the three years leading to up to initiation of ACA insurance exchanges and Medicaid expansion, political rhetoric about the perils of Obamacare and the importance of states' rights were at least as pervasive and intense — perhaps more so — in the West as in other regions. Yet once the Supreme Court decision and the presidential election affirmed that the ACA would proceed, implementation of health care reform continued for the most part in this region despite ongoing political resistance. In our future inquiry, we intend to look closely at this dynamic to refine our understanding of the place and power of professionalism in intergovernmental implementation.

In this early period, our Nevada field associate, Leif Wellington Haase, sees a "blend of rhetorical skepticism and operational pragmatism" at work in Nevada's decision to accept a state-run exchange and Medicaid expansion. This duality is apparent in other Western states such as Idaho, New Mexico, and Arizona where Republican governors and legislative leaders have tended to continue proclaiming their personal opposition to Obamacare, while advocating alignment with state-run exchanges, Medicaid expansion, or both.

Clues for understanding the Western response to the ACA can be found in the following capsule descriptions of our sample states. Reading these capsules is only an introduction to the stories of each state. In the month of October 2013, major similarities and differences among the Western states were apparent, as were expected and unexpected outcomes of early implementation efforts described in the full state reports.

Implementation of the Affordable Care Act, Pre-2014

California: Affirming

Field Research Associate Micah Weinberg, Healthy Systems Project, Inc.

In September 2010, six months after passage of the ACA, California became the first state to create its own insurance exchange. Speed has been the hallmark of California's ACA

implementation. Operating under the cover of wide general agreement among the Democratic-controlled legislature and Republican Governor Arnold Schwarzenegger and his staff, and later Democratic Governor Jerry Brown, California moved quickly to take advantage of substantial federal funds associated with ACA.

The state also moved swiftly to develop and control an exchange, following earlier state health policy deliberations. A broad range of stakeholders and interested organizations helped to plan the exchange, which would operate as an active purchaser that would negotiate the best price for enrollees. Despite general agreement among key legislators, staff, and multiple organizations with abundant experience in California health care reform, opposition appeared frequently in hearings and forums associated with enabling legislation for the state exchange. Opponents were particularly vocal about the structure and governance of state exchanges; the number of insurance markets and exchanges; mitigating adverse selection; coordination with state public programs; and other issues.

ACA planners had a full agenda. Among other things, they needed to consider the link between the ACA and existing county-based health programs in directing potential Medicaid expansion recipients to those programs. And they had to ensure the Exchange's eligibility and enrollment functions interacted with Medi-Cal (California's Medicaid program), Healthy Families, and other public programs. During initial implementation, many of the California Health and Human Services Agency staff wore "2014 Is Tomorrow" buttons to convey a sense of urgency. Creating the exchange was a massive undertaking, even for a state like California that had a significant jump on the process. Among other Western states with fast starts, California is truly an early leader.

Colorado: Affirming

Field Research Associates Jeff Bontrager, Kevin Butcher, and Sara Schmitt, Colorado Health Institute

Colorado's decisions to develop its own exchange and expand Medicaid are consistent with the state's long-term approach to health care reform. Prior to the ACA, the state initiated reform efforts, most with bipartisan support and sponsorship, including incremental expansions in Medicaid eligibility and creation of a high-risk pool. In 2008, a bipartisan commission recommended a state-based health insurance exchange, though it didn't gain traction. Following passage of the ACA in 2010, the state passed legislation creating a state exchange. The decision to expand Medicaid in 2013 drew only one Republican vote, but passed due to Democratic majorities in the legislature and a Democratic governor.

Although debate over the ACA and earlier health reform efforts has, at times, been contentious, Colorado has historically

reached general political agreement on issues that benefit Coloradans. Legislators and stakeholders have negotiated over time to develop multiple new approaches to health reform that are generally well aligned with the ACA.

Nevada: Affirming

Field Research Associate, Leif Wellington Haase, New America Foundation

Following passage of the ACA, Nevada became the only state with a Republican governor to set up its own state exchange and to expand the state's Medicaid program.

Governor Brian Sandoval's stance was pivotal. Sandoval chose to implement a law he personally opposed, with the aim of giving Nevada maximum autonomy in setting up and administering the new health insurance marketplace. Sandoval's decision reflected, in large part, the circumstances of a state where the recession hit particularly hard. Nevada has strongly supported an active outreach program, which in part is responsible for the relative strong ACA enrollment rank of tenth highest among all states by October 31, 2013.

New Mexico: Affirming

Field Research Associates R. Burciaga Valdez and Gabriel R. Sanchez, Robert Wood Johnson Foundation Center for Health Policy

Health care reform is not new to New Mexico. Former Governor Bill Richardson attempted to reform the health care system during his second term. In addition, New Mexico established a quasistate agency, the New Mexico Health Insurance Alliance (NMHIA), in 1994 to function as an individual insurance exchange.

In 2012, the state proposed to the Centers for Medicare & Medicaid Services (CMS) that the NMHIA serve as the state's ACA exchange. Legislators and the state attorney general raised concerns about conflicts between the original state-enabling legislation for the insurance alliance and the ACA. This was resolved in 2013 with the development of a new exchange, the New Mexico Health Insurance Exchange (NMHIX), a quasigovernmental nonprofit public corporation.

The NMHIX operates the small business health options component and it relies on the federal platform for the individual market. New Mexico requested and received federal information technology support for individual enrollment in 2013 and plans to transition to full state-run status in 2014.

Governor Susana Martinez broke from Republican governors who oppose the ACA when she announced in early 2013 that New Mexico would expand Medicaid as long as the federal government provided the funding for the initial expansion. "The election is over and the Supreme Court has ruled. My job is not to play party politics, but to implement this law in a way that best serves New Mexico."[1]

Oregon: Affirming

Field Research Associates Billie Sandberg and Jill Rissi, Mark O. Hatfield School of Government, Portland State University

Oregon has taken an affirmative response to the ACA as evidenced by its enthusiastic development and implementation of Cover Oregon in 2011 and its decision to expand Medicaid.

The state has a significant history of health reform deliberations and legislation. Oregon policymakers began discussion and development of a state health insurance exchange in 2004. Legislation forging organizational/structural health reforms followed in 2007 and 2009. Oregon was one of six states to receive a Model Testing award from CMS[2] to support transformation of its health care delivery system through innovation. Development of a state exchange was stymied because of lack of funding until the ACA. There was no question about Oregon's desire to operate its own exchange, although a dispute involving some legislators and health insurance interests over whether it should be an active purchaser resulted in a final decision in favor of a clearinghouse form.

Although Oregon actively supports national health reform and is generously funded by CMS, it has had one of the poorest experiences during the first month of ACA implementation because of Cover Oregon's information technology (IT) failures. Oregon Field Research Associates Billie Sandberg and Jill Rissi conclude that Cover Oregon may have tried to develop an overly complicated, do-it-all system, rather than adopt basic functionality. The IT system was inoperable in October and the state used paper enrollment applications, promising applicants they would be served in time to enroll for 2014.

Washington: Affirming

Field Research Associates Aaron Katz, John Stuart Hall, Patricia Lichiello, Health Policy Center, University of Washington

Washington's response to the ACA was also speedy and fully affirmative. The state legislature, with a Democratic majority in both houses, decided to run an insurance exchange in 2011, ahead of the June 2012 Supreme Court decision on the ACA's constitutionality and well in advance of the 2012 presidential election. Governor Jay Inslee strongly supported the ACA when he was in Congress and throughout his gubernatorial campaign in 2012. In that campaign, Inslee ran against the state attorney general, who joined the lawsuit challenging the ACA over the objections by the previous Democratic governor and the state legislature.

Washington has been at the forefront of efforts to reform the health system, expand coverage — Inslee authorized Medicaid expansion on July 1, 2013 — and alter the fragmented structure of health care delivery, all goals of the ACA. The state's Basic Health Plan (a model for the ACA's Basic Health Option) of subsidized health insurance for uninsured,

low-income residents started in 1988 and reached 130,000 enrollees in the early 2000s. Innovations in Medicaid and in comprehensive health reform were called for in state legislation in the late 1980s and early 1990s. Early discussions of exchange development and Medicaid expansion folded well into ACA incentives. The state was ready to implement both and advance its own progressive health reform agenda once the U.S. Supreme Court upheld the ACA's constitutionality. Importantly, individuals in Washington's health care reform community remain central to ACA development. Relatively successful early implementation of the ACA was due in large part to having highly experienced, long-serving professionals with existing working relationships in key positions.

Arizona: In Between

Field Research Associates John Stuart Hall and Catherine Eden, School of Public Affairs, Arizona State University

In many respects, Arizona mirrors Idaho in its conservative Republican-dominated politics, its "in-between" posture of alignment with ACA goals, and the intensity of political battles over ACA choices.

Arizona has taken both partially affirming and partially oppositional responses to major goals of the ACA. After a substantial planning effort funded by CMS, Arizona declined a state-managed exchange and accepted the federally facilitated exchange option. At the end of October 2013, the state appeared to be consciously avoiding active involvement in the development and trajectory of the federally managed exchange. Still, statewide outreach proceeded enthusiastically, propelled by an Arizona foundation's efforts to promote the ACA and develop a large and committed community-based statewide outreach network representing more than 600 organizations. On Medicaid expansion, the state is aligned with ACA policy. The state's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), is engaged with the Cover Arizona network to promote outreach.

This partial goal alignment appears to be the result of both passionate political beliefs, which guided the decision against a state-run exchange, and a strongly supported policy stance to use federal funds to restore recession-based cuts and expand the state's well-known Medicaid effort. For three years, Governor Jan Brewer was one of the most vocal and vigorous opponents of Obamacare, although she approved substantial state planning, supported by federal grants, for a state-run exchange. Then, after jettisoning the exchange, she led the state to adopt Medicaid expansion. Brewer has had to pay a high political price, nationally and locally, for her ACA efforts, yet has found some support for her "statesmanship" in forging a grand compromise despite vigorous objections by many of her own party to Medicaid expansion.

Idaho: In Between

Field Research Associate David K. Jones, University of Michigan School of Public Health

Within minutes of President Obama's ACA bill-signing ceremony, Idaho was among the original states in the multistate lawsuit against the law. Yet almost simultaneously, the state applied for a $1 million planning grant to begin preparations for an insurance exchange. These actions set the stage for one of the longest and intense state ACA battles in the nation.

Idaho, one of the nation's most Republican states, is the only state led by a GOP governor and legislature to choose to run a state exchange. Governor Butch Otter, who joined other Republican governors and public officials in attempting to have the U.S. Supreme Court invalidate the ACA, is now the target of substantial criticism for leading the adoption of a state-run exchange. He will be opposed in the Republican primary by a state legislator who accuses him of wanting to "prop up Obamacare." Otter responds that he had no choice but to implement the ACA after battling it in court to no avail: "There's such a thing as the rule of law; if I could repeal Obamacare I'd do it."[3]

Legislation to create a state-based exchange was signed into law on March 28, 2013, near the end of one of the most contentious legislative sessions in recent memory.

Given the short amount of time before the beginning of open enrollment on October 1st, the Exchange Board decided to rely on the federal exchange during the first year. Officially, this set-up is designated as a federally supported exchange, as opposed to a state-federal partnership or a federally facilitated exchange (i.e., run by the federal government).

State officials are still deliberating on whether or not to expand Medicaid. The legislature, which is in session for just three months each year, adjourned last year without deciding the issue. Opinion is mixed in 2014, though few Republicans are willing to take another tough Obamacare vote before this year's primary elections.

Utah: Oppositional

Field Research Associate, Sven Wilson

As of October 31, 2013, Utah was the only Western state fully oppositional to ACA. Republican Governor Gary Herbert tried, but failed, to convince the legislature to expand its innovative small business exchange to cover individuals. Nor was he able to convince CMS that the small business exchange met the ACA minimum requirements for a state-run exchange. Also, the state chose not to expand Medicaid. Herbert plans to put Medicaid expansion back on the agenda in 2014, saying that "doing nothing (about Medicaid expansion) is not an option."[4]

Note: Our Utah Report is in progress and is not included in this release.

Recipe for Western State Leadership

A review of these capsule descriptions and our full state reports reveal the following ingredients, in varying amounts, have led to early structural alignment with the ACA in many of the Western states:

- History and prior experience developing a structural base, including public programs for health care reform;
- An early start and full use of time before implementation;
- Different degrees of political disagreement, made less significant by coalescing over pragmatic health reform and fiscal goals;
- High quality professional leadership and independent staff;
- Federal funds to offset fiscal pressure;
- Substantive detailed assessment of exchange options and selection of consultants.

Values Leading to Alignment

Our early leading indicators of goal alignment — adoption of state-run exchanges and state expansion of Medicaid — are important. Beyond that, our research on Western states in the first month of formal implementation reveals that some degree of genuine agreement on ACA and state goals for health reform have been reached among various political, staff, and nongovernmental players.

This may rest, in part, on a Western political culture that stresses independence, innovation, self-reliance, local control, pragmatism, populist views of equity and public involvement, and many tools of progressivism, including instruments of direct democracy and nonpartisan elections. This culture and these forces have played an important role in Western politics and policy for well over a century.[5] Many of these features can be interpreted as supporting Western state actions in connection with the ACA, particularly decisions to run state exchanges. As Nevada Associate Leif Hasse points out, that state's Web site language, public framing, and summary documents all go out of their way to distance Nevada rhetorically from the federal project and to affirm "a system designed by Nevadans for Nevadans."

In Idaho, Governor Bruce Otter expressed similar sentiments: "Our options have come down to this: Do nothing and be at the federal government's mercy in how that exchange is designed and run, or take a seat at the table and play the cards we've been dealt. I cannot willingly surrender a role for Idaho in determining the impact on our own citizens and businesses." And this dynamic is not reserved for Republican oppositionists. Other Western states, including those that have actively

supported federal development of the ACA and President Obama, have been equally zealous in developing their own "home grown" structures for marketplaces and outreach.

While holding these views of state independence and the importance of state control and innovation, each of our out-front Western states must work with the many other governments and private and nonprofit health and medical interests with high stakes in ACA outcomes. The ACA, which easily ranks among the most complex of public policies, is being implemented in an intergovernmental environment that requires significant cooperation and defies dominance by one government or organization. California Associate Micah Weinberg reports on that state's effort to be the "lead car" in implementation of federal health care reform. "Because of the speed with which it approached this task as well as the sheer size of its coverage expansion, the decisions California has made have been influential both regionally and nationally."

Experience and Resources Count

Each of our out-front states has been significantly engaged in health reform efforts in the recent past, some beginning in the early 1980s. In California, Colorado, Oregon, Washington, and New Mexico, decisions to develop state-run exchanges and to expand Medicaid are consistent with each state's long-term approach to health care reform. Even in the in-between state of Arizona, the politically treacherous decision to expand Medicaid can only be understood in the context of past development of that state's well-known experiment in health care cost containment via precapitated Medicaid.[6]

Importantly, it is not just alignment of previous programs and health reform goals with the ACA that motivates these decisions, but also the perception, and to some degree the reality, that those earlier efforts were homegrown state programs. This type of alignment between earlier efforts and the ACA is real, but so is the pragmatic appraisal that the ACA is not perfect, yet is a major resource to be tapped for the continuation of worthy state efforts.

Table 2 lists some of the major structural dimensions of the West's six state-run exchanges as of October 31, 2013 (see next page). It is clear that substantial financial and human resources have gone into the planning and development of information technology, training, outreach, communications, and other exchange functions. Each of these functions must not only be technically reliable and effective, but also be professionally managed to form a well-connected system so exchanges work in the long term. Although each new exchange requires similar resources, Table 2 describes different levels of financial and human investment and different choices about priorities and functions. The full state reports reveal the diversity of function and range of expertise. It will be instructive to review the functional specialties of exchange staffs to understand the public management collaboration challenge for the ACA.

Table 2. Exchange Structure in the Western States

CALIFORNIA
Exchange Name: Covered California
Form: Independent nonprofit, active purchaser, standardized insurance products.
Board: Five members appointed by the governor and state legislative leaders.
Staff: Board-appointed CEO; civil service exchange staff hired for range of functions; some in-kind assistance from state agencies.
Major funding: $910 million in federal grants through 2014; must be self-sustaining by 2015.
Principal contractor, system integration/project management: Accenture, CGI.

NEW MEXICO
Exchange Name: BeWellNM – New Mexico Health Insurance Exchange (NMHIX)
Form: Hybrid state-run health exchange that operates as a quasigovernmental nonprofit public corporation, clearinghouse.
Board: Twelve members appointed by the governor and legislature.
Major funding: $62,849,354 in federal grants though 2014.
Principal contractor, system integration/project management: GetInsured.

COLORADO
Exchange Name: Connect for Health Colorado.
Form: Independent nonprofit, clearinghouse.
Board: Twelve appointed members.
Staff: Executive director appointed by the board; three-member executive team; more than thirty staff in organization and more than 160 representatives in customer service center.
Major funding: $178 million in federal grants; one of ten states to receive technical assistance from the Robert Wood Johnson Foundation's State Health Reform Assistance Network.[7]
Principal contractor, system integration/project management: CGI

OREGON
Exchange name: Cover Oregon
Form: Quasigovernmental, clearinghouse
Board: Nine members appointed by the governor and confirmed by the legislature.
Staff: Executive director appointed by the governor; 185 full-time staff; 100 temporary; unspecified number of special functions contracted out; 400 temporary hires authorized in October to fill out paper applications in lieu of the IT system.
Major funding: $242 million in federal grants plus related Model Testing grant.
Principal contractor, system integration/project management: Oracle

WASHINGTON
Exchange name: Health Benefit Exchange (HBE)
Form: Quasigovernmental, public-private partnership exempt from certain state operating rules, clearinghouse.
Board: The eleven-member Board comprises health care industry experts and includes a chair, eight members appointed by the governor from among nominees chosen from each legislative caucus (Republican and Democratic causes in each house), and two ex-officio nonvoting members: the director of the Health Care Authority and the Insurance Commissioner.
Staff: The state Health Care Authority helped the HBE Board get started by providing staff and other resources; in 2013 HBE had nine leadership staff and 114 full time equivalents.
Major funding: $151 million in federal grants.
Principal contractor, system integration/project management: Deloitte, IBM

(Continued on the Following Page)

Table 2. Exchange Structure in the Western States

IDAHO
Exchange name: Your Health Idaho
Form: Quasigovernmental, clearinghouse. Officially, this is designated as a federally supported exchange, as opposed to a state-federal partnership or a federally facilitated exchange. It will become fully state run in 2014.
Board: Nineteen members appointed by the governor, confirmed by the state Senate.
Staff: At this early stage, one executive director and three directors of major divisions.
Major funding: $20.3 million in federal grants.

Early Starts Contributed Essential Development Time

Many states waited for the Supreme Court decision and the presidential election to make final implementation decisions. That did not allow much time, given the complexities of the ACA. Our out- front states moved more quickly, particularly in three areas.

1. Early political consensus — and consistent political leadership — allowed fast forward movement to develop, test, and learn about state-run exchanges and expanding Medicaid. California, Colorado, Nevada, Oregon, and Washington each benefitted from early decisions described in the state reports.
2. The early framework for implementation accepted the diversity of existing authority, the need for a new quasigovernmental, semi-independent entity to run the insurance exchange, and the need for high levels of coordination, communication, and executive leadership within and across sectors. Each of these states adapted the ACA to the state context. For example, public management of ACA implementation in Washington is spread across four state agencies and the new quasigovernmental independent exchange. We found intermittent concerns over the sometimes highly independent nature of the Health Benefit Exchange and occasional attempts by that agency to "go it alone." The major public management challenge in Washington was coordination. Despite a short timeframe, coordination was achieved through strong facilitation from the Governor's Office and leading state executives.
3. Key players in each of the Western states believed they were working under unrealistic time pressure. A major coping strategy was to accept this reality and develop strategic plans for assessment and reform when "the dust settles" after the first few years of the implementation.

Fiscal Federalism and Western Pragmatism

Much of the West can be viewed as fiscally conservative. California is the home of Proposition 13 and surrounding states have either copied that measure or invented more stringent approaches. Taxing, spending, and debt ceilings are in place in every state and in many municipalities. In this context, the 2008-11 recession amplified public spending limits and made the potential of federal funds for the ACA all the more enticing, despite conservative arguments to avoid the evils of dependency on federal money. In the end, debates about whether to accept federal funds have often ended with comments along the lines of those made by Colorado Governor John Hickenlooper:

> Everyone will have to pay something for health care. Colorado [gets] back way too few of the tax dollars we send to Washington. And so to suddenly say, we're not going to [accept] millions [in] grants to implement an exchange … to help lower costs for individuals and small businesses in Colorado, I think we'd be chumps not to do it.[8]

While there was ample discussion and debate about the implications of accepting ACA funds, Western states in the end were reluctant to reject revenue needed to restore programs, particularly Medicaid. While some Arizona leaders, including Governor Brewer , advocated rejection of Obamacare and the funds that came with it, the state accepted more than $30 million for planning a state-run exchange that never happened; then, after much political drama, they accepted Medicaid expansion funding.

Federalism Spawns Continuous Conflict and Innovation

In American federalism, public policy often develops within a robust mix of intergovernmental conflict and cooperation. The national government regularly cultivates broad domestic programs and legislation while relying on state and local governments and other local organizations to implement those efforts. Bargaining is continuous. State and local governments and organizations accept implementation roles that accompany incentives, though not always enthusiastically and often grudgingly. Some measure of political and policy conflict is almost certain. Representatives and staffs of national and state governments frequently appear leery of each other's motivations, intentions, and abilities.

Despite, and to some degree because of, frequent conflict, implementation of intergovernmental policy requires substantial cooperation, collaboration and coordination, and management beyond political rhetoric, particularly in operational matters. New major policy innovations such as the ACA require substantial collaboration among leaders and staff, and sometimes by people with little or no experience working with each other.

Implementation, Technology, and Learning Governance

In their classic study of a federal war on poverty program in Oakland in the 1970s, Jeffrey Pressman and Aaron Wildavsky generated important conclusions about the obstacles to and complexities of implementation. These conclusions apply to many major national public initiatives, including ACA in 2014.

> The experience of this program, which began with laudable intentions, commitment, and an innovative spirit, shows that *implementation* of a large-scale federal project can be very difficult indeed. Money was duly authorized and appropriated by Congress; the federal agency approved projects and committed funds with admirable speed. But the "technical difficulties" of implementation proved to be more difficult and more time-consuming than the federal donors, local recipients, or enthusiastic observers had ever dreamed they would be.[9]

In October 2013, the ACA ran headlong into this often-encountered flaw of intergovernmental implementation. The ACA was strongly impacted by technical problems of HealthCare.gov, the massive publicity and political gamesmanship associated with those problems, and the resulting effects on enrollment and state-level ACA resources.

State-run exchanges, including those in our Western sample, were not immune to these difficulties. Oregon has had a particularly difficult time with its Web site, which was not functional during most of 2013. This surprised some observers given that state's longstanding commitment to health care reform, its early start on building the exchange, and significant federal resources devoted to what some describe as visionary health reform.

Other fully aligned Western states also had problems with their exchanges and Web sites in October. California, Colorado, and Washington each experienced brief periods of technical failure despite relatively early starts and significant resources devoted to building their sites. Yet these state-run exchanges recovered quickly, allowing them to continue progress toward enrollment goals. Washington Associate Aaron Katz suggests what may be most surprising is the level of success these Western states have had in the face of huge obstacles: limited time and money, unreasonable expectations, technical complexity, and well-organized and active opposition. The history of state agency data systems gone awry is long, and the recent history of problematic federal IT projects is one of almost continuous crisis management.[10]

What accounts for this early measure of public management resilience among the leading Western states? What are the future implications of their efforts on state ACA development and the building of effective exchange Web sites? The month of October was insufficient time to determine precisely what went right and what went wrong in each case and pinpoint best measures of recovery. Yet we have clues from the field.

In general, Western states moved quickly to establish quasigovernmental, relatively independent exchanges. These exchanges were well funded by federal planning grants, and a large portion of the money was targeted to IT development. In each state, exchange boards and staff saw IT development as the absolute highest priority. Contractors with significant IT expertise were hired to develop exchange sites. Staff in Washington, California, and Colorado expressed concern that despite this substantial effort and the priority given to IT development, the merging of disparate intergovernmental systems and data and the limited time for building, testing and implementation would almost certainly result in some problems and necessary predictable fixes when the exchanges went live in October. This context would strain the feedback loop anywhere, although there were major differences in the magnitude of IT issues and state responses.

States such as Washington, California, and Colorado that charted a smoother course built simpler sites and did not attempt to create the ultimate system from scratch. Each of these states planned to add to these systems incrementally. That is, these states planned to use "learning governance" to allow time for repeated testing, repair, and redesign. As mentioned above, Oregon, on the other hand, may have attempted to do too much with its initial system design.

Ultimately, the technical implementation progress of several Western states, although incomplete, is a function of planning to learn from web development, moving ahead on a steady professional basis, getting beyond political battles that each state faced early on, and placing public management and governmental competence ahead of political debates. Such essential pillars of public management as oversight and accountability are particularly challenging in quasi-independent arrangements like many of the state exchanges and specialized Medicaid departments. Public oversight and management is especially daunting given the need to manage advanced technologies and the centrality of IT to the exchange mission.

Our affirming Western states appear to have established the necessary independence, experience, and time to craft reasonably effective feedback and oversight. As a group, these states have had strong public leadership and coordination. They are deploying teams of skilled professionals on boards and in high-level staff positions to interact with the systems designers as well as each other and counterparts in other states. These states have done more testing followed by needed interventions. They have issued clear and objective descriptions of problems and fixes, and of course have had the advantage of some degree of political cover, including agreement over needed health reforms and requisite focus on long-term capacity building and problem solving.

The Future

Compared to many other states, this cluster of Western states is off to a fast start in the implementation of the ACA. Yet questions remain. Will the quick start and alignment with the goals of the ACA be sustainable? Will Western states develop and meet higher performance standards leading to desired health outcomes and more complete development of affordable care? The challenge is achieving full reform of the American health care system through intergovernmental cooperation. As one observer put it, "You know what's relatively easy? Fixing a Web site. You know what's really hard? Ensuring access to affordable, quality health care for every single American and improving our broken health system in the process."[11]

Operational Versus Rhetorical Federalism

It is still quite early in the history of ACA-stimulated health care reform and there are many obstacles to overcome. It is possible that a mix of political challenges, bad publicity, unmet expectations, and general public dissatisfaction could derail, dilute, or even ultimately defeat the ACA. That scenario is one potential outcome of rhetorical federalism.

Our Western state sample, however, seems pointed in another direction. The majority of these states have adopted structures and changed institutions and rules to enable development of state health reforms that complement those of the ACA. These states are aligned with the national ACA policy in the following ways:

- Created largely independent exchanges governed by diverse, highly qualified state boards.
- Recruited and deployed diverse, talented staff to design state health care reform.
- Began building virtual state health insurance exchanges by linking public and private interests and data with increasing success.
- Trained and developed large outreach efforts to canvass states and facilitate expansion of health insurance for all qualified residents.
- Expanded Medicaid.
- Passed legislation to aid in funding these efforts following federal grants.

This capacity, in place and being augmented now, is operational federalism. Western states are in front because they were already on the path to health care reform. They are likely to push ahead just as they did with universal public education in the last century. In the West it appears, at least for now, that the health care reform train has left the station.

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The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Understanding Special Enrollment Periods, Part 1: A Look at Some Who Will be Out of Luck

Posted on **March 31, 2014** by **JoAnn Volk**

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As part of our Robert Wood Johnson Foundation-funded Navigator Technical Assistance project, we've had the opportunity to hear the range of questions navigators and assisters are fielding from consumers trying to understand their coverage options. Many of these questions have helped fill out our Navigator Resource Guide, which has 270 FAQs ranging from "what is the individual mandate" to "how do I qualify for financial help?"

Some of the questions we've heard point to the complexity of Affordable Care Act (ACA) rules. Others point to the complexity of family situations that can make it difficult to sort through coverage options and eligibility rules. And still others point to areas where the rules can be improved to work better for consumers. An example of this last category of questions is one we've heard repeatedly: If an individual falls into the so-called Medicaid coverage gap and later gets a job with income that would qualify them for premium tax credits, can they get a special enrollment period to sign up for coverage? Unfortunately, the answer is no, unless they take early steps to make that option possible.

Who falls into the Medicaid coverage gap?

To be eligible for premium tax credits, individuals and families must have income between 100 percent and 400 percent of poverty. Below the 100 percent poverty threshold, the ACA assumes individuals would be covered by Medicaid under the law's mandatory expansion of Medicaid. Since the U.S. Supreme Court made that decision optional for states, 25 states have opted not to expand Medicaid, leaving the poorest individuals – those under the poverty level – with no coverage option. It is estimated that 4.8 million people fall into this coverage gap.

Can these individuals qualify for premium tax credits later in the year if their income changes?

Under the current rules, individuals whose change in income would qualify them for premium tax credits can

get a special enrollment period – but only if they are already enrolled in a marketplace plan. That means if an individual's income was so low that they couldn't get a marketplace plan with a premium tax credit, they don't qualify for an opportunity to enroll in a plan until the next open enrollment period. So even if their luck changes and they get a job with enough income to qualify for premium help, they are out of luck when it comes to affordable coverage. An individual in that case may qualify for a hardship exemption from the mandate penalty, since coverage without a premium tax credit is likely to be unaffordable for that person. Or they may qualify for an exemption because their income falls below the tax filing threshold. But that's small consolation when you really just want to get covered.

However, individuals can preserve the right to a special enrollment period later if they take specific steps before their income changes. Individuals who fall into the Medicaid gap can obtain an exemption from the individual mandate penalty. But these individuals have to apply for Medicaid and be found ineligible before they can obtain that exemption. If later the individual's income rises to more than 138% of poverty, he or she will lose their hardship exemption based on being ineligible for Medicaid; losing a hardship exemption then triggers a special enrollment period that will allow them to apply to the marketplace for premium tax credits.

So it's possible that individuals who fall into the Medicaid gap can have a path to coverage if their luck changes and their income rises. But they need to take the right steps to preserve that right to a special enrollment period, before their income changes: First, they must apply for coverage under Medicaid, knowing they won't be found eligible. Second, upon receiving their denial from the state Medicaid agency, they must apply for a hardship exemption. Third, once their income changes, they must notify the Marketplace, and apply for a special enrollment period based on the loss of their hardship exemption. Needless to say, this path to coverage requires extra steps, foresight, and a sophisticated ability to navigate the eligibility and enrollment process.

The exchange rules didn't start out this way. Originally, the rule for special enrollments allowed anyone gaining eligibility for financial assistance because of a change in income to qualify. But HHS, in subsequent rulemaking, limited that option to those already enrolled in a marketplace plan. Because most people under 100 percent of poverty can't afford to enroll in a marketplace plan without financial help, this change significantly limits access to coverage for these individuals, even if later in the year they experience an increase in income that would qualify them for premium tax credits. Many will have to wait for the next open enrollment period to enroll in a plan.

It's not clear why the administration made this change – it could be that insurers were concerned about adverse selection (the greater the opportunity to enroll outside of open enrollment season, the greater likelihood healthy people will defer doing so). However, this limit seems particularly unfair for the millions of individuals who were too poor to qualify for premium tax credits and have the misfortune to live in a state that hasn't expanded Medicaid – and didn't know about the steps to take to preserve their right to a special enrollment period. On the other end of the spectrum, those who bought coverage outside the marketplace because their income was too high to qualify for premium tax credits are also locked out if their fortunes change and their income drops mid-year.

In the coming months, we may see rules change and enrollment processes made smoother in anticipation of the next open enrollment period, which will begin November 15, 2014. This is one rule we hope is on the list for review. Stay tuned to CHIRblog for updates on the rules and more on special enrollment periods.

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NationalJournal

HEALTH CARE

Obamacare's Invisible Victory

Why the total enrollment number is actually bigger than you think.

(Helder Almeida/Shutterstock)

By Sophie Novack

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March 28, 2014

Obamacare friends and foes alike are eagerly watching the law's insurance-enrollment tally, ready to trumpet every success or pounce on every failure.

But as the final figures before the end of open enrollment are posted, a significant chunk of people who bought insurance under the law will be missing from the official tally.

That's because people who bought insurance directly from insurers, and not through the law's exchanges, will not be included. And just how many people that represents is a figure that will not be available in time for the big enrollment-total reveal—and likely not for a long time after.

Off-exchange enrollment is the forgotten piece of the Affordable Care Act, but it could represent millions of people who are also getting covered as a result of the health care law—many of whom are the young, healthy customers the administration is so aggressively pursuing.

Unfortunately for the White House, no one really knows what those numbers are, and few are talking about them at all.

People who enroll outside of the exchanges are simply using a different means to buy what are often the same ACA-compliant plans available inside the exchanges. They are part of the same risk pools and have the same impact on premiums.

When *HealthCare.gov* was not functioning in first month or two of open enrollment, officials encouraged consumers to enroll in coverage off the exchanges—an option that bypassed the glitchy enrollment sites and allowed consumers to work directly with insurance companies. The administration then made the option even easier by making the law's premium subsidies available to people who signed up directly with an insurer.

The number of people who have actually taken that approach remains a mystery, but anecdotal reports suggest it could be significant.

In Washington state—one of the only states to release this information—more people have signed up outside the exchange than inside of it. The state insurance commissioner's office says 183,618 people had enrolled in private plans outside of the exchange as of the end of February, compared with 125,000 paid enrollments the state exchange is reporting as of March 23.

Insurers' data paint a similar picture. WellPoint has reported that as of the end of January, 20 percent of its 500,000 new customers did not enroll through the ACA's exchanges.

Highmark said that as of mid-February, about one-third of the over 110,000 people who bought ACA-compliant plans enrolled directly with the company. The insurer offers plans in Delaware, Pennsylvania, and West Virginia.

Neither WellPoint nor Highmark responded to requests for updated numbers.

The Blue Cross Blue Shield Association, America's Health Insurance Plans, and the National Association of Insurance Commissioners all said they do not have direct-enrollment data available. Several state exchanges and state insurance commissioners said they do not collect that information.

Information released by eHealth—an online broker that predates the health care law—indicates that the coveted young-adult demographic is signing up outside of the exchanges. About 45 percent of people applying for ACA-compliant plans through eHealth are between 18 and 34, the company said—compared with roughly 25 percent in the exchanges.

Brian Mast, vice president of communications for eHealth, says the company has historically had a high portion of young enrollees—around 50 percent—since young people are particularly inclined to favor completing tasks quickly and online.

Roughly 170,000 people applied for insurance plans through eHealth during the first three months of ACA open enrollment—a 50 percent increase from the same quarter the year before. Mast attributes the increase to the health care law.

"The purpose of our releases [Tuesday] and in late February was to draw attention to the fact that there is a robust market outside the exchanges," Mast says. "It would be great if there were an aggregate number for on and off [exchanges], because it would give a clearer picture of how enrollment is going."

There is still a fair amount we don't know about Obamacare enrollment—the final tally from the Health and Human Services Department will likely be skewed by the number of individuals that the White House is counting as enrolled, but who have not yet paid their premiums; and the health status of the risk pool is still largely a question mark.

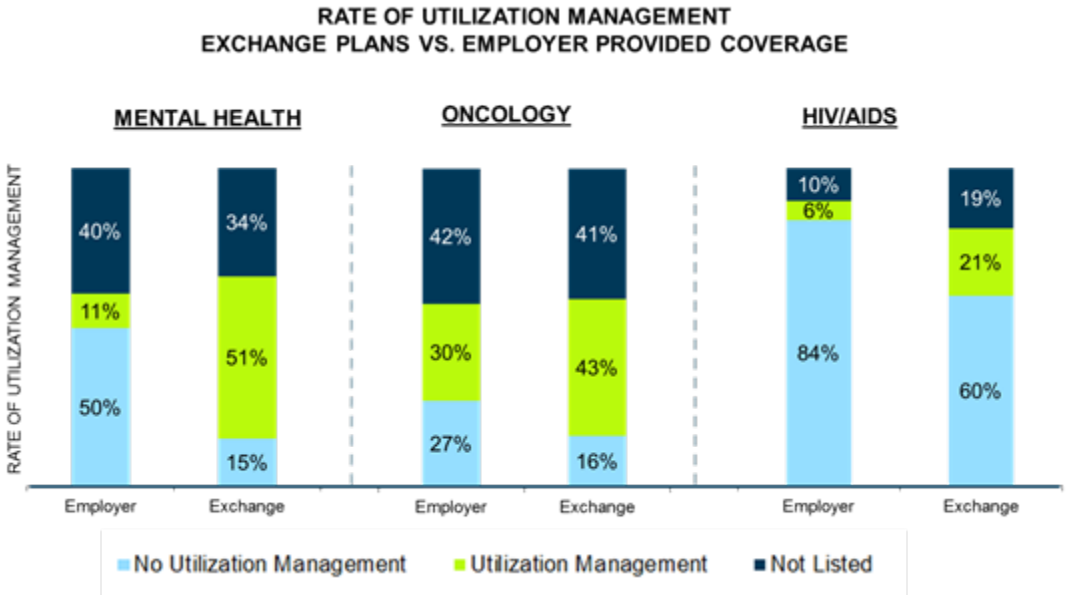
But in the conversation of what remains a mystery, off-exchange enrollment is largely left out. It's quite possible this number would more than balance out the premium payment discrepancy—but unfortunately for HHS, we might not know for a very long time.

AVALERE ANALYSIS: CONSUMERS FACE MORE HURDLES TO ACCESSING DRUGS IN EXCHANGE PLANS COMPARED TO EMPLOYER COVERAGE

A new analysis from Avalere Health finds that consumers purchasing insurance through exchanges are twice as likely to face utilization management controls on prescription medications compared to people enrolled in employer-sponsored insurance plans. Utilization management controls, including prior authorization and step therapy, are administrative steps that patients and their physicians must complete to demonstrate appropriate use of the drugs. These tools are used by health plans to limit access to specific medications and, in some cases, reduce costs.

Branded mental health and oncology medications were extremely likely to be subject to step therapy or prior authorization, with more than 70 percent of covered drugs (excluding not listed) requiring utilization management in exchange plans. HIV/AIDS drugs had the lowest incidence of utilization management, with more than half of exchange plans providing open access to these medications.

"This is one more reminder that consumers shopping on the exchange need to look beyond premium costs when picking a plan," said Caroline Pearson vice president at Avalere Health. "Patients may be better off selecting a plan that includes open access for drugs they use regularly, and they will need to work closely with their physicians to fulfill utilization management requirements where they exist."



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Source: Avalere Health PlanScape,™ a proprietary analysis of exchange plan features. Data as of October 31, 2013. Percentages represent presence of utilization management across all plans and all medications analyzed. See methodology for more details.

Health plans rely on utilization management tools to encourage use of lower cost or generic drugs, as well as to ensure that the drugs prescribed are appropriate to a patient's medical condition. However, those tools may also be a barrier to accessing needed medications, particularly for vulnerable populations like severely mentally ill patients. Utilization management for mental health drugs is over four times more common for exchanges compared to employer coverage.

"Insurers offering exchange products are trying balance access and cost to ensure that consumers are getting value," said Matt Eyles, executive vice president at Avalere. "The utilization management tools we profiled are not as widely used in commercial insurance settings, so they need to be closely monitored for their effects on consumers and on the clinicians responsible for their administration."

Methodology

Avalere Planscape™ evaluated 84 formularies from bronze- and silver-level plans in 15 largest states. Plans included in this analysis represent plans from over 90% of plan sponsors offering exchange plans in the largest city in each of these states, including: 5 national carriers, 14 regional carriers, 2 national Medicaid MCOs, and 5 local Medicaid MCOs—several of these carriers participate across multiple states in the sample. Avalere's analyzed 2014, exchange-specific formularies publicly available at the time of this analysis (November 2013). Avalere captured all coverage, tiering, and utilization management data available in public documents.

Analysis includes single-source branded drugs across 84 plans. Products analyzed generally encompass the most commonly used, branded medications within a class. To develop the list of drugs per class, Avalere consulted the United States Pharmacopeia (USP) Medicare Model Guidelines v5.0 to obtain a listing of the USP Category, USP Class, and Example Drugs. Avalere reviewed 21 drug classes as part of this analysis. Mental health drugs include the following USP classes: Serotonin/ Norepinephrine Reuptake Inhibitors, 2nd generation/Atypical Antipsychotics, Bipolar Agents, and Antidepressants-other. Cancer drugs include: Emtogenic Therapy Adjuncts, Metabolic Bone Disease Agents, Alyklating Agents, Antiangiogenics, Molecular Target Inhibitors, and Selective Estrogen Receptor Modifying Agents. HIV/AIDS drugs include: Non-Nucleoside Reverse Transcriptase Inhibitors, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors, Protease Inhibitors, and HIV-Other (includes Enfuvirtide, Maraviroc, and Raltegravir).

Employer-sponsored insurance (ESI) data sample comes from formularies utilized by the five following plans: Largest federal employee health benefits plan (FEHBP); large publicly-traded, self-insured employer plan; large, self-insured employer plan; national carrier plan sponsored by a large employer; and national carrier plan sponsored by a mid-size employer.

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MERRILL EDGE

The contraception case is big, but another challenge could really hurt Obamacare

BY JASON MILLMAN March 24 at 11:39 am

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REUTERS/Gary Cameron

Obamacare faces two separate court challenges on Tuesday, but only one could deliver a major knockout blow to the law.

The case getting the most attention is tomorrow's Supreme Court challenge to the health care law's requirement for employers to provide birth control to their workers. At the same time Tuesday morning, the District of Columbia's Circuit Court of Appeals will consider whether Obamacare allows premium subsidies to flow through federal-run health insurance exchanges. That case has been called "the greatest existential threat" to the survival of the health care law by one of Obamcare's staunchest supporters.

First, the contraception case

The Supreme Court will hear oral arguments Tuesday morning in Sebelius v. Hobby Lobby Stores Inc. and Conestoga Wood Specialties Corp v. Sebelius. The challenges are similar – both companies' owners argue that the law's contraception mandate is unconstitutional because it violates their religious liberty. My college Jamie Fuller has a good roundup of what you need to know about the cases.

Should the Obama administration lose on the contraception requirement, the impact on its signature health care law would be minimal. A loss would essentially give employers the opportunity to refuse contraception coverage if they have a religious exemption, but the rest of the law wouldn't be touched.

About four dozen lawsuits have been filed by for-profit companies against the contraception mandate in the past two years, but advocates for the requirement say it's hard to measure what the real-life effect would be if the Supreme Court sided with the plaintiffs.

"It's difficult to read the minds of other employers in the future to determine who might want to assert some kind of religious belief to deny this benefit to others," said Marcia Greenberger, founder and co-president of the National Women's Law Center.

"Because this is really quite a new argument that is being put forward, I think these kind of estimates are difficult," she continued. "There's no doubt that millions of women are now entitled to this benefit that didn't have it before."

The contraception case is significant for other reasons concerning religious liberty and the rights of corporations. It could also have a much broader impact on anti-discrimination laws, Adam Liptak of the New York Times points out.

Federal subsidies are the bigger deal for the law

If we're just thinking about what these cases could mean for Obamacare's future, the cases related to federal subsidies are a much bigger deal. Opponents to the law are challenging the IRS interpretation that Congress authorized individuals in states with federal-run exchanges to access premium subsidies.

If the opponents' challenge is successful – and the law's supporters say the cases are a real longshot – it would deal a major blow to the law in the 36 states with federal-run exchanges. According to latest monthly enrollment report from HHS, 85 percent of those signing up for health plans in federal exchange states have received federal subsidies. Without those subsidies, coverage would be less affordable for many, and therefore a much less attractive option to those who consider themselves healthy. That would mean the mix of people participating in the program would be sicker, which would drive up insurance costs and threaten Obamacare's future.

The law's opponents argue that Congress never authorized subsidies in federal-run

exchanges, and they claim this was done on purpose. They say Congress wanted to incentivize states to run their own exchanges, an option that only 14 states and the District of Columbia chose in 2014.

The law's supporters argue that the law doesn't differentiate between federal-run and state-run exchanges, so people should be able to receive subsidies no matter who's administering the insurance marketplaces. Further, they say the broad purpose of the law is to expand access to affordable insurance regardless of who runs the exchange.

There are four pending cases in federal court challenging the subsidies. In Tuesday's case, Halbig v. Sebelius, a lower federal court in January upheld the IRS rule allowing subsidies in federal-run exchanges.

"The Court finds that the plain text of the statute, the statutory structure, and the statutory purpose make clear that Congress intended to make premium tax credits available on both state-run and federally-facilitated Exchanges," District Court Judge Paul Friedman wrote in his decision.

A separate challenge in Virginia federal court has also been rejected, and the plaintiffs have also appealed that decision. Two similar cases are also pending in Indiana and Oklahoma.

Jason Millman covers all things health policy, with a focus on Obamacare implementation. He previously covered health policy for Politico. He is an unapologetic fan of the New York Yankees and Giants, though the Nationals and Teddy Roosevelt hold a small place in his heart. He's on Twitter.

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Mission Advanced But Not Accomplished:

Four Years of Health Reform in California

CA's Past & Future Work to Implement & Improve the Affordable Care Act (March 20, 2014)

- *Over 3 Million In New Coverage in Medi-Cal and Covered California*
- *Millions More Getting New Help from ACA and CA's Additional Efforts*
- *Next Steps on Health Reform Needed, by Bills, Budget, and Ballot Box*
- *"Phase 2" Includes Improved Customer Service, Consumer Protections, Cost and Quality, and Extending Coverage for All Californians.*

Due to California's efforts to both implement and improve upon federal health reform in the four years since the enactment of the Affordable Care Act (ACA), California now leads the nation, providing new financial help for new coverage choices for over 3 million Californians, as well as new consumer protections and financial relief for millions more. This report details the impact of the Affordable Care Act in the last four years, the positive expansions of coverage, but also those components where the Act was insufficient and/or more work at the state level is needed.

What is notable about the progress in California is the urgency of the health care crisis prior to the ACA. California had the seventh highest uninsured rate in the nation: Californians were more likely to be uninsured than residents of all but six states. Californians were more like not to get coverage at work, more likely not able to afford coverage, and more likely to be denied coverage due to pre-existing conditions than in many other states. The severity of the health care crisis is a key reason California has "embraced" reform, as Governor Jerry Brown stated this month, and makes this progress all the more compelling. Even though California is the only state of those with the top ten highest uninsured rates with a Democratic Governor, it is an example for those other states that are similarly situated in terms of health care needs if not of like mind politically.

Even with the significant progress, much more work is needed to fully realize the promise of health reform, from providing world-class customer service; to offering additional financial help to fellow Californians that need it; to requiring strong oversight to ensure timely access and strong consumer protections when dealing with an insurer; to putting in place additional policies to reduce costs and increase quality, and encourage a healthier California.

This report tallies the impacts of the Affordable Care Act in California to date; details how California has taken a leadership role in implementing and improving the law; and also lays out the important next steps needed to be taken by state policymakers so Californians can take full advantage of their new rights, options, and benefits. This report and its appendices serve as a list of state legislative actions taken, as well as a "to-do" list of those still awaiting action.

COUNTING THE BENEFITS

Many nationally are focused on enrollment in the new Exchanges, and California is doing impressive work, with over **1 million** enrolled in Covered California as of March 15th with two weeks left in open enrollment. Around 85% are likely to pay at least the first month's premium; 85% are also eligible for subsidies to afford care. Covered California's original goal, projected by leading experts and academics, was 1 million Californians in subsidized coverage by the *end* of 2014 and the second enrollment period. California is on track to surpass that figure by the end of the first enrollment period in March, showing the strong demand for the new coverage options and benefits. This is in addition to over **2 million** in Medi-Cal and **nearly a half-million** young adults on their parents plan, all the result of the ACA.

The Affordable Care Act has already made a difference for millions of Californians who have new consumer protections, from the removal of lifetime limits and arbitrary caps on coverage to the required coverage of preventative services without co-payments or cost-sharing. Hundreds of thousands of Californians have new financial help to make care more affordable, including seniors on Medicare getting prescription drugs, and small businesses getting tax credits to continue to offer coverage to their workers.

OVER 3.5 MILLION CALIFORNIANS ENROLLED IN NEW ACA OPTIONS

The biggest impact has come from expanding coverage—getting people the care they need and providing economic security from financial ruin. The most recent estimates by March 15th, 2014 are that **over 3 million Californians have been able to get coverage** through Medi-Cal and Covered California.

- Over **1.1 million** **Californians selected a plan in Covered California**, with 85% eligible to get a subsidy under the ACA.
- Over **652,000** Californians in 53 (of 58) counties got **coverage through Low-Income Health Programs (LIHPs)** – the most expansive early expansion of coverage under the Affordable Care Act in the country, before being switched on January 1, 2014
- **Over 1.1 million more Californians determined eligible for Medi-Cal** through Covered California portals, and **another 185,000 through county offices.**
- Over **135,000** Californians signed up for Medi-Cal through the **"express lane" connection with CalFRESH,** with **another 600,000 able to easily sign up** after being identified as eligible but unenrolled in Medi-Cal.

Beyond over 1 million in Covered California and 2 million in Medi-Cal, many more have new coverage or new financial assistance under the law.

- Over **435,000** **young California adults up to age 26** who otherwise would have been uninsured have coverage through their parent's health plan, under the ACA and state conforming legislation.

- Other Californians with pre-existing conditions are buying coverage outside Covered California, but still in a reformed, guaranteed-issue individual insurance market with new consumer protections and essential benefits in place.
- Other provisions that have helped more people stay and become insured are the **tax credit for small employers** who cover their workers**, the early retiree reinsurance program**; and the **financial relief and savings for the state budget** and maintenance of effort requirements that prevented additional state cuts to eligibility and enrollment.

NEW CONSUMER PROTECTIONS AND FINANCIAL ASSISTANCE

Over **12 million** insured Californians, whether getting insurance as an individual or from employer-based coverage, gained new consumer protections, such as the **removal of lifetime limits on their coverage**. The **over 3 million** Californians who buy coverage as individuals (and the estimated **16 million** Californians who have pre-existing conditions, even if they aren't in the individual market at the moment) now have the security that **insurers are no longer permitted to rescind coverage**, and especially after the patient gets sick. And no one can be denied coverage due to a pre-existing condition. [i]

Some of the ACA provisions provided direct financial assistance, to allow patients and policy-holders, seniors and small businesses, to get relief when paying premiums or obtaining care. Here are specific ways that the ACA has helped consumers better afford the cost of health care:

- ***No-Cost Preventative Care:*** Over **8 million** Californians had their coverage improved to include preventative care without cost sharing, so there is no financial barrier between them and these screenings and services. [ii]
- ***Rebates:*** Over **1.4 million** Californians got a total of about **$65.6 million** in rebates in 2013 because their insurance companies did not spend enough of their premium dollars on providing health care, under the ACA's "medical loss ratio" provision. [iii] [iv]
- ***Rate Oversight:*** Over **1,507,532** Californians saved over **$175.2 million** in 2012 as a result of the rate review process when Anthem, Blue Shield, and Aetna from rate hikes that were retracted, rolled back, or withdrawn.[v,vi,vii]
- ***Prescription Drug Help in Medicare:*** Around **300,000** California seniors and people with disabilities in 2012 saved over **$183 million** in prescription drug costs, under the ACA provision that begins the process to close the Medicare prescription drug "donut hole." [viii]
- ***Small Business Tax Credit:*** In the 2011 tax year, over **375,000** California small businesses in California (70% of the total) were eligible for the tax credit to help pay for the cost of coverage of their **2,442,900** California workers. [ix] While it will take more time for all eligible small businesses to take advantage, the incentive is big, as the average credit is $752 per worker. For the 158,000 businesses who are eligible for the maximum assistance, their average credit is $1000 per worker.

There are other benefits to the Affordable Care Act that may be less visible to Californians in their everyday lives. They include the state budget savings yielded in the recent Medicaid waiver, which helped prevent further budget cuts during the recession.

Another help to California's health system, and to our economy, were the federal grants, such as those where California community clinics got an estimated **$509 million** to build capacity. Other grants were to enhance public health and prevention efforts, to set up Covered California, and to improve consumer assistance programs.

CALIFORNIA LEADS AND IMPROVES

These impacts and improvements were not by accident, but part of a concerted effort to take full advantage of all the opportunities for a beleaguered health system that needs all the help it can get.

The biggest difference has been the politics: California's efforts have seen less of the political opposition of the law that has characterized many other states and within the federal government. The federal government has seen legislative challenges including 50 votes to repeal all or part of the ACA; judicial challenges leading all the way up to the Supreme Court; a government shutdown, and political challenges, including a presidential campaign between two candidates with starkly different positions on whether to move forward with reform. This level of opposition is in stark contrast to California, where every statewide elected official supports the ACA, as do two-thirds of those elected to the legislature. The first bill in the nation to set up an exchange under the ACA was signed in California by a Republican Governor; many other implementing bills to expand Medi-Cal and reform the insurance market receive bipartisan support, with at least one or two GOP votes. A lesson from California for other states is that the ACA can work, if the political leaders allow it to.

California has not just implemented the law, but improved upon the Affordable Care Act, working to plug loopholes, make adjustments, and to ultimately ensure the promise of the law is kept to better maximize the benefits. Here are some examples of how California has led efforts to take advantage of the ACA's benefits, either early, or in the case of those items highlighted in blue, ongoing:

1. COVERED CALIFORNIA: Our state was the **first in the nation to establish a insurance marketplace** after passage of the ACA, and only one of a handful to give it the **negotiating power to bargain for the best value** for consumers, which has led to more competitive rates. (The board also has strong conflict-of-interest rules so the health industry is not on both sides of the bargaining table.)

2. STANDARDIZED APPLES-TO-APPLES COMPETITION: Covered California used its authority to **standardize benefit packages so consumers can make apples-to-apples comparisons,** to allow for easier selection and foster head-to-head competition on cost and quality. (Benefit standardization authority is separate from active purchaser though each facilitates the other.)

3. BENEFITS: Alongside the new **"essential benefits"** standards for coverage required by the ACA and passed by the California legislature, California had **mandated maternity coverage as a basic benefit** 18 months early, in July 2012, which revived a benefit that insurers were no longer providing in the individual insurance market. The adoption of essential health benefits meant that insurers could no longer sell "skinny" benefits to individuals or small businesses, benefits with limits on doctor visits or hospital stays or generic-only drug formularies.

4. CHILDREN WITH PRE-EXISTING CONDITIONS: California quickly implemented the ACA provision that **banned denials for children with pre-existing conditions** starting early in 2010. When insurers started withdrawing child-only coverage, state law made it clear that insurers who refused to offer policies to children would be barred from covering adults as well—bringing the major insurers back into the market. The state law also went further than federal law, to also limit what children with pre-existing conditions can be charged to no more than twice any other child for the same policy.

5. EARLY MEDICAID EXPANSION: California was one of only a few states to **expand coverage early**, getting federal matching funds to cover nearly 700,000 Californians county-run Low Income Health Programs. In addition to getting a medical home that includes primary and preventative care, these enrollees were automatically shifted to full Medi-Cal coverage in January 2014.

6. EXPRESS LANE: in the last few months, California has identified over 600,000 adults and 150,000 children in the CalFRESH food assistance program who were eligible for Medi-Cal, and pre-qualified them for "express lane" enrollment. Those identified were sent **easy-to-read-and-respond notices allowing them to sign up for Medi-Cal by phone, mail, or Internet**. California expects to continue this "horizontal integration" of human services, so when someone is linked to one program, they have easy access to others.

7. INCLUSIVE EXPANSION FOR LEGAL IMMIGRANTS: California continued its policy of **immigrant inclusion, extending affordable coverage to a broader category of legally residing immigrants beyond what is required by federal law**. California's Medi-Cal expansion includes recent legal immigrants less than five years; those persons residing under the color of law (PRUCOL), and those who got deferred action (DACA) including DREAM Act students.

8. LGBT INCLUSION: The ACA is a major law against discrimination—whether for those with pre-existing conditions from being denied, or women from being charged more. California has taken additional steps to ensure LGBT inclusion, from **enabling domestic partners to buy family coverage**, directing all insurers to cover **necessary care for transgender patients**, funding outreach to LGBT communities, and other steps.

SOME CALIFORNIANS NEED MORE HELP TO SELECT AND AFFORD PLANS

While the Affordable Care Act is dramatically expanding coverage and reducing the numbers of uninsured, for some the help is not enough. Many of the problems that have been spotlighted by opponents of the ACA are issues that have plagued the health care system for decades: health insurance price spikes; limited networks of providers; insurers cancelling plans and transferring patients to more profitable products; and overall affordability. In many cases, the problem isn't with what the ACA did, but that it didn't do enough or for enough people.

For example, when insurers "cancelled" substandard plans for about a million Californians in the individual market, transitioning them into new health plans, a majority were able to get improved coverage and/or at a reduced cost. California took additional action to help: The Legislature passed SB369(Pan), to ensure continuity of care for those who were in a course of treatment with a provider even if they were now in a different network. The Insurance Commissioner also negotiated the ability of many to stay in their plans for an added three months. Covered California provided a special hotline to help them figure out the best plan. But while the ACA's subsidies protected many, there's around 250,000 Californians that may have faced a premium increase in their plan switch, who were just over 400% of the poverty level and in a high health cost region, who may need more help.

The ACA has improved the health system and made getting coverage for many cheaper and easier, but there are Californians that need greater assistance to select and afford the health coverage they need. If Congress won't make the needed improvements, in many instances California can and should.

IMPROVING THE CONSUMER EXPERIENCE FOR ELIBILITY AND ENROLLMENT: Although California's successful numbers surpassing its goals show the great demand for more affordable coverage the enrollment process still does not work as well as it should for many Californians. . While some issues can be explained as the glitches that come from the first year of any venture, or the need to ramp up to the scale sufficient to California's size, and those issues need to be addressed in the next several months, other barriers require thoughtful re-examination of the enrollment process. These problems need fixing by the next open enrollment period, if not before (as folks enroll through the year in Medi-Cal and in Covered California because of life changes such as weddings, graduations, a new baby or the loss of a job.) The challenges include:

- A smoother, glitch-free website experience, in English and Spanish at a minimum and eventually in other languages.
- A call center with the capacity to answer inquiries quickly, by the set standard of 80% in 30 seconds, rather than the 15-45 minute waits or more consumers experience now.
- More community enrollment counselors, aided by increased reimbursement and streamlined certification procedures.

- A more concerted campaign to educate and enroll harder-to-reach populations, including Latino and low-English proficient communities.
- Improved tools to help consumers to select plans and make comparisons beyond price, including improved quality ratings, and a working and accurate provider search tool.
- More effort to make Covered California choices easier to understand and the best value, by ditching confusing "co-insurance" options and requiring a high standard for network adequacy.

EXTENDING HELP TO ALL CALIFORNIANS: Beyond the accessibility and overall experience of signing up for a health plan, there's also the issue of whether people can afford coverage. Estimates of the remaining uninsured could be as high as 3 million. There are four specific populations where the ACA may not provide enough help:

- Undocumented immigrants are explicitly excluded from getting financial help for coverage from the ACA, and even from using a state marketplace like Covered California to purchase health coverage using their own money. And while many of the most populous California counties serve undocumented in their safety-net, many counties do not.
    - These **undocumented Californians** are key parts of our community and economy, and should be included in our health system as well. County systems should reconsider covering the remaining uninsured, including the undocumented, and state funding formulas should take that into account. We recommend a statewide solution for California to set up state structures to help enroll this population: both state-only Medicaid and a mirror marketplace alongside Covered California to provide coverage for the undocumented. One such bill, SB1005 (Lara), follows this approach.
- The ACA allows workers whose out-of-pocket premium costs are more than 8% of income to be able to get subsidies in a state marketplace. But a federal interpretation of the law states that if worker coverage is less than 8% but family coverage is more than 8% then subsidies are unavailable for the family—leaving some spouses and children without an affordable offer of coverage.
    - This **"family glitch"** can and should be remedied at the federal level legislatively. Until then, California should explore providing some help as well.
- The ACA states that all who spend more than 8% of their income on coverage are exempt from the requirement to have coverage; moreover, it provides protection from most that they won't have to pay more than 9.5% percent of income for a basic "silver" plan. But subsidies for coverage, rather than exemptions from the mandate, are only available up to 400% of the poverty level. There are consumers, mostly ages 50-64 in high-cost health care areas who are just above the 400% threshold and who now face premiums higher than 9.5% of their incomes. These folks without such income-based protection were among the less-than-1% of California that was negatively impacted by the plan cancellations and price spikes of late last year.
    - Federally, or perhaps statewide for a high cost-of-living state like California, it would be good to provide modest **relief for those having to spend more than 10% or 12% of income, regardless of their FPL**. It would make the ACA's affordability guarantee universal.

- For those below 400% of poverty, the question is whether the financial help provided is enough. Even with lots of sign-ups, and the influx of subsidies with hundreds or thousands of dollars for low-income families, there are some families that won't be able to afford the premium required. We are concerned that some might fall off coverage due to lack of affordability.
    - States like Massachusetts and Vermont have supplemented the federal subsidies, in order to help families make ends meet. San Francisco is looking at something similar for those in Healthy San Francisco. After some experience, California should consider extending **more help and/or affordable options for low-income families**.

ONCE COVERED, GETTING CARE

PUTTING IN PLACE PROTECTIONS FOR WHEN THEY USE THEIR COVERAGE: Once Californians have coverage, that is merely the entry point to the health system, but getting care and using it wisely is another question. Some are concerned about access to doctors, specialists and other medical providers in both Medi-Cal and Covered California, for which some plans have "narrow networks." California can go a long way to alleviate these concerns:

- California already has strong consumer protections that require that managed care plans networks are adequate to provide needed care in-network in your geographic region in a timely manner—no more than 10 business days. While narrow networks aren't necessarily a problem for consumers, their prevalence make the need for vigilance on these protections even more urgent. One bill, SB964(Ed Hernandez), would make surveys by the Department of Managed Health Care more frequent, and segmented by Medi-Cal, commercial, and Covered California line of business.
- Insurance Commissioner Dave Jones is currently drafting a new "start from scratch" network adequacy rule for those plans regulated at the Department of Insurance.
- For those in Medi-Cal, especially those in fee-for-service outside a managed care plan, a legitimate issue is the reimbursement rates, which are some of the lowest in the nation, and which are just implementing a 10% provider cut from the 2009-10 budget crisis. Given California had moved from deficit to surplus, we should at the very least cancel that cut, as proposed by AB1759(Pan)/AB1805(Skinner).

As Californians are in new coverage, they continue to need **new consumer support and protections**.

- We need to increase capacity to consumer assistance hotlines as more Californians are covered and many experience coverage for the first time. Trainings and added outreach will be necessary to help the newly insure people learn how to use the health system.
- California's consumer protections need to be adapted to the ACA framework. Measures in the legislature would help patients dealing with high-cost prescription drugs (AB1917 Gordon), provide continuity of care when switching plans (SB1100 Ed Hernandez), and prevent more folks for falling for "junk" insurance (AB2088 Roger Hernandez).

CONTROLLING COST AND IMPROVING QUALITY: Health insurance is expensive enough that some families will need direct financial help to pay for coverage, but there is certainly more to do to control the cost of health care while improving the quality and reducing health disparities.

Progress has already been made in controlling costs: The ACA's various cost containment elements have helped get the nation the slowest growth of health care costs in 40 years. The increased review of insurer rates has resulted in hundreds of millions of dollars in rate retractions, reductions, and rebates. While not enough, these are promising signs that some elements of the reform are working. The ACA provides new tools for additional work in the area of cost, quality, and public health.

- We propose efforts to increase transparency in our health system, so we can "follow the money" at the insurer, provider, drug company, and doctor level. Some bills are pending that would advance **greater transparency on cost and quality**. We support further industry oversight and regulation to monitor costs and improve quality.
- **Ballot measure voters** will get a say on health care costs this November: one ballot measure will allow the Insurance Commissioner to reject unjustified health insurance rate increases; another ballot measure currently pending would cap excessively inflated hospital charges.

CONCLUSION

While the implementation of the Affordable Care Act in California has not been perfect, and there is more to do, the stories below, among many collected by Health Access and partners like Consumers Union, demonstrate the dramatic help it has provided to Californians to get more affordable health care and financial security:[x]

- **LARRY IN LOS ANGELES:** "I am a 60-year old man with the typical chronic conditions of someone my age." He buys his own insurance as a freelance consultant, and before 2014, he paid $750/month for a $5000 deductible "with some limits on various areas of coverage." Blue Cross sent him a letter in late 2013, saying he would need to change plans but they could switch him to a similar policy for $450/month. "So, I would save $300/month without even switching to an exchange plan, but just keeping the same private coverage. Not bad, but it gets better." Larry looked online at Covered California and found that "a comparable PPO Bronze plan will cost me less than $100/month with the subsidies I am eligible for. Or I could upgrade to a Silver plan, with a much lower deductible and better coverage for about $250/month, or a savings of $500."
- **RICHARD FROM SACRAMENTO:** After graduation from college, Richard said health insurance was a top priority, but on a tight budget, he couldn't see an affordable way to get covered and went a year and a half uninsured. "I looked into private health insurance because it was worrisome to be without healthcare coverage. It was $150 a month, which was not worth it to me. I am very healthy and don't take any medications – but what would happen if I got into an accident?" Richard has a part-time job and has discovered he's now eligible for Medi-Cal, like many recent college grads in part-time work or internships which may not provide employer-sponsored health insurance. "I work with a lot of people who are transitioning to new careers, changing careers,

training, etc. It's good to have options for coverage in those in-between times." The process was confusing at times, Richard says, "It was totally worth it. In my opinion, the amount of information required was minimal for something as important as health care – I'm thrilled."

- **MIA FROM OAKLAND:** Mia is a self-employed mom from Oakland, California. "We had a terrible plan with a $12,500 deductible. The costs were going up every year – and in the past few years, they'd gone up every 6 months. Meanwhile, our benefits were getting cut." Mia's insurance didn't provide the security she and her family needed, since it was so hard to meet the deductible. "I had to keep a credit card exclusively for health emergencies in my wallet," she says. But that plan was all they could afford. Mia and her husband were able to purchase a Covered California plan with a much lower deductible – $500 per person. Their co-payments for doctor's office visits are just $15. "It's real health insurance. Everything is affordable." Their new plan did not cover all of the doctors they saw under the old plan, but that wasn't a dealbreaker for Mia's family. "Most of our doctors did not join our Covered California plan, but we do have coverage at UCSF and Children's Hospital Oakland. That was more important to us, to know that if we really got sick we'd have good options. " She adds: "This is the first time I've had health insurance, *real* health insurance, since my oldest daughter was born," said Mia. "It's such a relief."

California had led in the implementing of health reform; we need California to continue to be a leader work to implement and improve the Affordable Care Act, to fulfill the promise and give all Californians the coverage they need at the cost they can afford.

APPENDIX I: Future Work to Implement and Improve the Affordable Care Act

CALIFORNIA ACA-RELATED LEGISLATION PENDING FOR 2014

- ***Coverage Expansion***

SB1005 (Lara) seeks to extend access to affordable coverage to all Californians, without regard to immigration status, by offering the same financial help as the ACA provides to Californians excluded under the federal law. The bill creates a state-only Medi-Cal program for those who are barred from Medi-Cal by reason of immigration status, covering kids up to 266%FPL and adults up to 138%FPL through state-only Medi-Cal. It also creates a parallel Exchange or "mirror marketplace" that would provide immigrants with the same coverage options and subsidies as those covered through Covered California. STRONG SUPPORT.

- ***Insurance Consumer Protections***

NETWORK ADEQUACY OVERSIGHT OF HEALTH PLANS: SB964 (Ed Hernandez) requires the Department of Managed Health Care (DMHC) to conduct surveys of health plans for timely access and network adequacy to be done more frequently, and by book-of-business, separately for Medi-Cal managed care and Covered California plans, to ensure access to care for patients in those programs. It also requires separate surveys until five years after implementation of major Medi-Cal managed care transitions, including those of Healthy Families, seniors and persons with disabilities, dual eligibles (both Medicare and Medi-Cal) and the rural transition. SPONSORED by Health Access California.

PRESCRIPTION DRUG COST SHARING: AB1917 (Gordon) spreads out the cost of expensive prescriptions over a year, to better help those with HIV/AIDS, cancer, MS, and other diseases manage out-of-pocket expenses. Consumers would still have the annual out of pocket limit of no more than $6,350 for an individual or $12,700 for a family under the ACA, but the cost of any one drug can't be more than 1/24th of the annual limit or about $265 per copay. This means multi-tier drug formularies in which some high-priced drugs are on a tier with 20% co-insurance won't burden patients all at once; a patient might still end up owing the annual out of pocket limit but at least the cost will be spread out over a year. SPONSORED by Health Access California.

JUNK INSURANCE FOR LARGE EMPLOYERS: AB2088 (Roger Hernandez), while not banning limited benefit plans, makes them supplemental to employer-based coverage. While California's Insurance Code allows the sale of "insurance" that provides very limited benefits, such as cancer-only policies and hospital fixed amount indemnity policies that pay $100 or $200 a day when someone is hospitalized, current California law allows it only as supplemental to essential health benefits in the individual and small employer markets. This bill extends this consumer protection to large employer coverage, closing a loophole for employers to possibly avoid compliance with the full intent of the ACA. SPONSORED by Health Access California.

CONTINUITY OF CARE: SB1100 (Ed Hernandez) will be amended to provide continuity of care protections for consumers who change their individual coverage—something that was not possible for many until the ACA. While Californians with employment-based coverage now have the right to continuity of care if in the midst of treatment or had a serious condition when their coverage changed, this bill extends this protection to those

with individual coverage including in Covered California. *(AB369 Pan, sponsored by Health Access California and pending on the Governor's desk, would provide continuity of care protections specifically for consumers with policies cancelled Dec. 1, 2013-March 31, 2014.)* SUPPORT.

SB959 (Ed Hernandez) is the clean-up bill for the individual and small group market reform legislation to implement the ACA enacted in 2012 and 2013. SUPPORT.

SB1034 (Monning) would delete 60 day waiting period for California insurance. California law would not permit any waiting period as a result of a pre-existing condition. Federal law would permit employers to impose a waiting period of as much as 90 days for workers and dependents. SUPPORT.

AB1962 (Skinner) would impose on dental-only plans a requirement that a percentage of premium that must be spend on patient care. It requires specialized dental-only plans to have the same "medical loss ratios" as for medical coverage: 85% for large group and 80% for individual and small group coverage. Specialized health plans such as dental or vision are now exempt from many federal and state consumer protections. The bill is sponsored by the California Dental Association. SUPPORT IF AMENDED.

SB1053 (Mitchell) would implement and improve provisions of the ACA related to contraceptive benefits into state law. Amendments needed to reconcile with state law. It is co-sponsored by NHELP and many family planning clinics. SUPPORT IF AMENDED.

- ***Cost/Quality Transparency***

AB1558 (Roger Hernandez) would provide claims data to the University of California so that UC can do studies on cost and quality. SUPPORT.

SB1182 (Leno) would implement large group rate review for rate increases in excess of 5%. It also provides claims data or other detailed data to large purchasers. SUPPORT.

- ***Medi-Cal***

AB1759 (Pan)/AB1805 (Skinner) would restore the remaining 10% reimbursement rate cuts to fee-for service Medi-Cal providers, a cut made in 2009-10 that was delayed by legal actions but is just being implemented this year, at the same time of the ACA Medicaid expansion. At a time of surplus, it would be less than $250 million to cancel this cut that was made in the worst moments of California budget crisis. SUPPORT.

SB1124 (Hernandez) will be amended to address and limit Medi-Cal estate recovery. California is one of only ten states that impose estate recovery on more than long term care services, where the state, for those over 55, recovers the cost of care from the estate of an individual after death. This has discouraged some from signing up for Medi-Cal coverage. Co-sponsored by Western Center on Law and Poverty (WCLP) and California Advocates for Nursing Home Reform. SUPPORT.

AB2025 (Dickinson) would change Medi-Cal income eligibility for seniors and persons with disabilities, not updated in decades. Sponsored by WCLP. SUPPORT.

APPENDIX II: Past Work to Implement and Improve the Affordable Care Act

CALIFORNIA ACA-RELATED LEGISLATION ENACTED 2010-13

The passage of the Affordable Care Act at the federal level was not the end but the beginning of legislative activity to reform our health system. Since passage, California has enacted over two dozen pieces of legislation listed below so Californians can take advantage of the ACA's new options, benefits, and consumer protections.

NEW ACCESS FOR CALIFORNIANS WITH PRE-EXISTING CONDITIONS

*** AB1887 (Villines)/SB227 (Alquist), 2010**

FEDERAL FUNDING FOR A HIGH-RISK POOL: Authorizes MRMIB to apply for federal funding for, and to create, a new "high-risk" Pre-Existing Condition Insurance Program (PCIP) to provide coverage to people denied for pre-existing conditions.

*** AB2244 (Feuer), 2010**

ACCESS AND AFFORDABILITY FOR CHILDREN WITH PRE-EXISTING CONDITIONS: Requires guaranteed issue, eliminates all pre-existing condition exclusions, and limits premium increases based on health status, phasing in modified community rating for children under age 19 in the individual market. Improving on federal reform: Rating rules of 2 to 1 in open enrollment, providing additional affordability to children with pre-existing conditions.

*** AB151 (Monning), 2011**

GUARANTEED ISSUE FOR SENIORS: Assures that those who previously covered by Medicare Advantage plans have guaranteed issue for Medi-Gap coverage.

***AB1x2 (Pan); SB1x2 (Hernandez), 2013**

BAN ON PRE-EXISTING CONDITIONS AND OTHER INDIVIDUAL INSURANCE MARKET REFORMS: Prevents insurers from denying or discriminating for pre-existing conditions, and institutes other market rules/consumer protections for those who purchase health coverage on their own. Limits different premiums on age to 3:1.

NEW OVERSIGHT ON INSURER PREMIUMS

*** SB1163 (Leno), 2010**

PROVIDING TRANSPARENCY ON RATES: Requires 60 days public notice of rate hikes and requires health plans to provide to the public information about their rate methodology. Improving on federal reform: Requires review of all rate hikes in individual and small group market, rather than just "unreasonable" increases. Also, collects additional information on underlying cost increases.

*** SB51 (Alquist), 2011**

REQUIRING PREMIUM DOLLARS TO BE SPENT ON HEALTH CARE: Allows state regulators to enforce the Medical Loss Ratio provision of the Affordable Care Act that requires insurers in the large group market to spend 85% of premium dollars on health care and insurers in the small group and individual markets to spend 80% of health care dollars on actually providing health care rather than for administration or profit.

*** AB1083 (Monning), 2012**

REFORMING THE SMALL GROUP MARKET: Conforms new insurance market reforms for small businesses to prior state law as well as the Affordable Care Act, particularly so small employers don't get additional premium spikes based on the health of their workers.

BETTER BENEFITS

* AB2345 (De La Torre), 2010

COVERING PREVENTIVE SERVICES: Requires insurers to eliminate cost-sharing for some preventive services such as pap smears, mammograms, other cancer screenings, and immunizations. Conforms to federal reform.

* SB222 (Evans/Alquist) & AB210 (Hernandez), 2011

GUARANTEEING MATERNITY COVERAGE: Requires that health plans sold in the individual and small group markets, respectively, stop discriminating against women and provide as a basic benefit, maternity care and maternity-related care. Ensures Californians get needed care, preventing them from falling onto taxpayer-funded programs. Improving on federal law: Starts in July 2012, eighteen months earlier than the maternity requirement as part of the federal essential benefits package in 2014, allowing for a smoother phase-in.

* SB 951 (Hernandez) & AB1453 (Monning), 2012

ESSENTIAL HEALTH BENEFITS: Protects consumers from underinsurance and junk insurance by requiring that health plans and insurers cover a minimum set of essential health benefits, including ten categories of benefits defined in the ACA. The bill sets the minimum floor for benefits to be equivalent to the Kaiser small group HMO.

SECURITY TO STAY ON COVERAGE

* AB2470 (De La Torre), 2010

REGULATING RESCISSIONS AND MEDICAL UNDERWRITING: Sets standards for rescission, the insurance industry's practice of terminating coverage as if the coverage had never been issued. Improves on federal reform by continuing coverage pending determination of rescission, and providing more notice.

* SB1088 (Price), 2010

ALLOWING YOUNG ADULTS TO STAY ON THEIR PARENTS' COVERAGE: Requires group health, dental, and vision plans to allow dependent children to continue on their parents' coverage through age 26.

*AB36 (Perea), 2011

ALIGNING TAX CODE FOR YOUNG ADULTS STAYING ON PARENTAL COVERAGE:

Aligns state tax code to conform to federal law related to parents covering young adult children.

MEDI-CAL EXPANSIONS AND REFORMS

* AB342 (Perez), 2010

MEDI-CAL WAIVER: EARLY EXPANSIONS FOR LOW-INCOME ADULTS: Expands county-based "coverage initiatives" using federal matching funds to provide better access for low-income Californians, as a bridge to full expanded Medicaid under health reform in 2014. Improving on federal reform: Allows hundreds of thousands of Californians to get coverage prior to 2014, and to be ready for full Medi-Cal coverage on day one.

* SB208 (Steinberg), 2010

MEDI-CAL WAIVER: SYSTEM CHANGES: Implements a new Medicaid waiver with the federal government, in order to draw down new federal funds, to encourage better coordinated care, including shifting seniors and people with disabilities to mandatory managed care, with certain consumer protections.

* 1296 (Bonilla), 2011

STREAMLINING ELIGIBILITY AND ENROLLMENT: Requires the California Health and Human Services Agency establish a standardized single application form and related renewal procedures for Medi-Cal, Healthy Families, the Exchange, and county programs. Sets a framework so that millions of Californians gain meaningful and easy access to coverage under the ACA. (Modified by Assemblywoman Bonilla's AB1580 in 2012).

***AB1x1 (Speaker Perez); SB1x1 (Hernandez/President Pro Tem Steinberg**

MEDI-CAL EXPANSION AND STREAMLINING: Expands Medi-Cal to all legal residents up to 133% of the poverty level, including over one million adults without children at home. Puts in place eligibility and enrollment reforms to make it easier to get on and stay on Medi-Cal coverage.

***AB1x3 (Hernandez)**

BRIDGE PLAN OPTION: Allows those in Medi-Cal to stay in the Medicaid managed care plan as their incomes fluctuate and qualify them for Covered California. Conceptual goal is to improve continuity of care, affordability for lower-income families, and more stability for safety-net health providers.

SETTING UP NEW SYSTEMS TO BETTER ASSIST CONSUMERS IN 2014 AND BEYOND

*** AB1602 (Speaker Perez), 2010**

CREATING A NEW EXCHANGE: Establishes the operations of the California Health Benefit Exchange which would be an independent state agency tasked in negotiating for the best prices and values for consumers and providing information regarding health benefit products. Improving on federal reform: The California Exchange will be an active purchaser, with protections against adverse selection.

*** SB900 (Alquist/Steinberg), 2010**

RUNNING A NEW EXCHANGE: Establishes the governance of the Exchange by a 5 member board appointed by the Governor Schwarzenegger and Legislature. The board will serve the individuals and small businesses seeking health care coverage through the Exchange. Improving on federal reform: Creates independent state agency with conflict of interest protections.

*** AB922 (Monning), 2011**

IMPROVING CONSUMER ASSISTANCE: Improves the Office of Patient Advocate to provide better assistance to California health care consumers by providing a central, enhanced center to handle consumer questions and complaints, and for them to be triaged to the appropriate agencies, whether regulatory or administrative, state or federal, etc. The bill also transfers the Office of Patient Advocate, and the Department of Managed Health Care, to the Health and Human Services Agency.

*** AB174 (Monning), 2012**

SYSTEMS INTEGRATION: Establishes funding for Office of Systems Integration to establish information-sharing between the Franchise Tax Board and the Employment Development Department to specified health care agencies and county departments to verify applicant eligibility for state health care programs as well as claims data information.

*** AB792 (Bonilla), 2012**

NOTICE OF COVERAGE OPTIONS DURING LIFE CHANGES: Requires insurers to provide information to consumers who are dropping off group coverage about their coverage options including at Covered California. Also provides notice at family court, when adoption, divorce, and other life changes are key moments when consumers should seek coverage options.

*** AB1761 (Speaker Perez), 2012**

DECEPTIVE MARKETING: Prohibits any individual or entity from falsely representing themselves as the Exchange, Covered California.

This report was compiled by Anthony Wright, executive director of Health Access Foundation, the statewide health care consumer advocacy coalition, working for quality, affordable health care for all Californians for over 25 years.

To follow up, contact Anthony Wright at **awright@health-access.org**.

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More information is available on our website at **www.health-access.org**, including our daily blog on health policy issues at **blog.health-access.org**.

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[i] http://www.hhs.gov/healthcare/facts/bystate/ca.html
[ii] http://www.hhs.gov/healthcare/facts/bystate/ca.html
[iii] http://www.hhs.gov/healthcare/facts/bystate/ca.html
[iv] http://www.hhs.gov/healthcare/facts/bystate/ca.html
[v] http://www.insurance.ca.gov/0400-news/0100-press-releases/2012/subject.cfm#Health Care
[vi] http://www.dmhc.ca.gov/library/reports/news/rrc1.pdf
[vii] http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/release016-13.cfm
[viii] http://www.whitehouse.gov/files/maps/aca/aca-map-v6.html
[ix] http://familiesusa2.org/assets/pdfs/health-reform/CA-Small-Business-Health-Care-Tax-Credit.pdf
[x] Thanks to Consumers Union for Mia's and Richard's stories. Media outlets wishing to talk with them and other consumers can contact Geraldine Slevin at Consumer Union's West Coast Office, 415-431-6747. To speak with Larry or many other individual Californians with stories are available to talk to the media, contact Health Access..

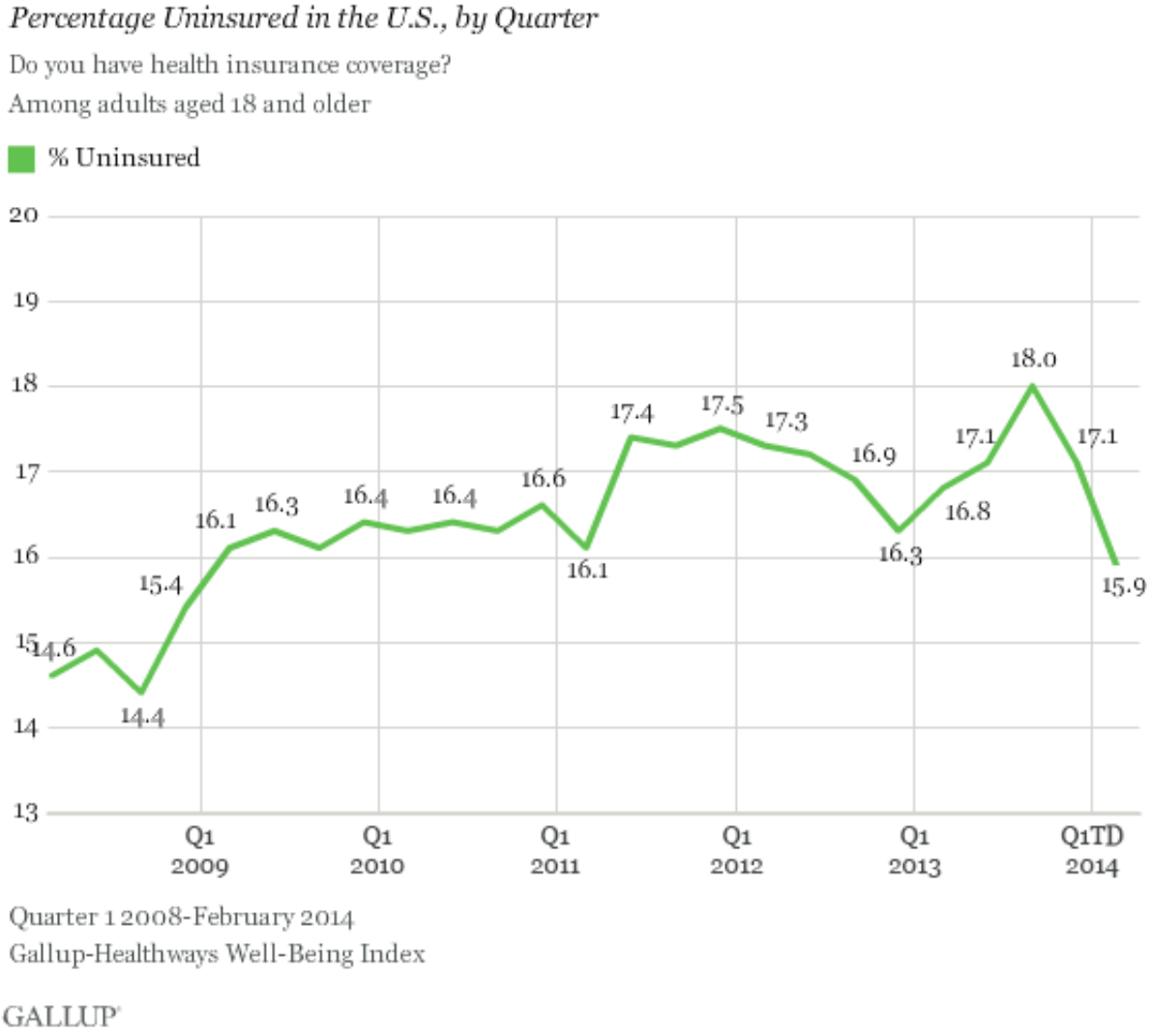
March 10, 2014

U.S. Uninsured Rate Continues to Fall

Uninsured rate drops most among lower-income and black Americans

by Jenna Levy

WASHINGTON, D.C. -- The percentage of Americans without health insurance continues to fall, measuring 15.9% so far in 2014 compared with 17.1% in the fourth quarter of 2013.



These data are based on more than 28,000 interviews with Americans from Jan. 2-Feb. 28, 2014, as part of the Gallup-Healthways Well-Being Index. With only a few weeks remaining in the first quarter, the uninsured rate is on track to be the lowest quarterly level that Gallup and Healthways have measured since 2008.

The uninsured rate has been declining since the fourth quarter of 2013, after hitting an all-time high of 18.0% in the third quarter. The uninsured rate for the first quarter of 2014 so far includes a 16.2% reading

for January and 15.6% for February.

Uninsured Rate Declines Most Among Lower-Income and Black Americans

The uninsured rate for almost every major demographic group has dropped in 2014 so far. The percentage of uninsured Americans with an annual household income of less than $36,000 has dropped the most -- by 2.8 percentage points -- to 27.9% since the fourth quarter of 2013, while the percentage of uninsured blacks has fallen 2.6 points to 18.3%. Hispanics remain the subgroup most likely to lack health insurance, with an uninsured rate of 37.9%.

The percentage of uninsured has declined across all age groups this year, except for those aged 65 and older. The uninsured rate for that group has likely remained stable because most Americans aged 65 and older have Medicare.

The uninsured rate among 26- to 34-year olds and 35- to 64-year olds continues to decline -- now at 26.6% and 16.3%, respectively. The February Enrollment Report released by the Department of Health and Human Services (HHS) highlighted no significant changes in young adults' enrollment in the health exchanges since its December report, with the cumulative total enrollment rate among 18- to 34-year-olds hovering at 25%. The Obama administration has made young adults' enrollment in a health insurance plan a top priority, as healthcare experts say 40% of new enrollees must be young and healthy for the Affordable Care Act to be successful.

Percentage of Uninsured Americans, by Subgroup

	Quarter 4 2013 %	Jan. 2-Feb. 28, 2014 %	Net change (pct. pts.)
National adults	17.1	15.9	-1.2
18-25 years	23.5	23.0	-0.5
26-34 years	28.2	26.6	-1.6
35-64 years	18.0	16.3	-1.7
65 years and older	2.0	2.2	+0.2
White	11.9	10.9	-1.0
Black	20.9	18.3	-2.6
Hispanic	38.7	37.9	-0.8
Less than $36,000	30.7	27.9	-2.8
$36,000-$89,999	11.7	10.9	-0.8
$90,000+	5.8	5.0	-0.8

Gallup-Healthways Well-Being Index

GALLUP

Fewer Americans Get Primary Coverage Through Employer

The percentage of Americans who get insurance through a current or former employer fell nearly two

points so far in the first quarter of 2014 to 43.4%. More Americans now say their primary health insurance coverage is through a plan fully paid for by themselves or a family member compared with at the end of 2013 -- 18.1% vs. 17.2%. The percentage who say they are covered primarily through Medicaid is also up slightly, likely because some states have chosen to expand Medicaid coverage.

Type of Primary Health Insurance Coverage in the U.S.

Is your primary health insurance coverage through a current or former employer, a union, Medicare, Medicaid, military or veteran's coverage, or a plan fully paid for by you or a family member?
Among those who have health insurance

	Quarter 4 2013 %	Jan. 2-Feb. 28, 2014 %	Net change (pct. pts.)
Current or former employer	45.5	43.4	-2.1
Medicare	20.1	20.3	+0.2
Plan fully paid for by you or a family member	17.2	18.1	+0.9
Medicaid	6.6	7.4	+0.8
Military or veteran's	4.4	4.5	+0.1
A union	2.6	2.6	0
(Something else)	1.9	2.0	+0.1

Gallup-Healthways Well-Being Index

GALLUP

Implications

The uninsured rate continues to decline after the requirement to have health insurance went into effect on Jan. 1, 2014. This drop could be a result of the ACA, which aims to provide healthcare coverage to more Americans through multiple provisions, including federal and state healthcare marketplaces where Americans can purchase health insurance coverage at competitive rates.

At the end of February, HHS reported 4 million people have signed up for health insurance coverage through the marketplaces established under the ACA. With the open enrollment period scheduled to close on March 31, the uninsured rate in the U.S. will likely continue to fall. Additionally, healthcare aides in the Obama administration announced on Wednesday that Americans will be able to renew old health insurance plans for up to three years, even if the plans do not comply with ACA policies. Other provisions of the healthcare law have not yet gone into effect, such as the requirement for employers to provide health insurance to their employees by 2015 or 2016. These provisions also may affect the uninsured rate over time.

Gallup will continue to track the U.S. uninsured rate in the weeks and months ahead.

Survey Methods

Results are based on telephone interviews conducted as part of the Gallup-Healthways Well-Being Index survey Jan. 2-Feb. 28, 2014, with a random sample of 28,396 adults, aged 18 and older, living in all 50 U.S. states and the District of Columbia.

For results based on the total sample of national adults, the margin of sampling error is ±1 percentage points at the 95% confidence level.

Interviews are conducted with respondents on landline telephones and cellular phones, with interviews conducted in Spanish for respondents who are primarily Spanish-speaking. Each sample of national adults includes a minimum quota of 50% cellphone respondents and 50% landline respondents, with additional minimum quotas by time zone within region. Landline and cellular telephone numbers are selected using random-digit-dial methods. Landline respondents are chosen at random within each household on the basis of which member had the most recent birthday.

Samples are weighted to correct for unequal selection probability, nonresponse, and double coverage of landline and cell users in the two sampling frames. They are also weighted to match the national demographics of gender, age, race, Hispanic ethnicity, education, region, population density, and phone status (cellphone only/landline only/both, and cellphone mostly). Demographic weighting targets are based on the most recent Current Population Survey figures for the aged 18 and older U.S. population. Phone status targets are based on the most recent National Health Interview Survey. Population density targets are based on the most recent U.S. census. All reported margins of sampling error include the computed design effects for weighting.

In addition to sampling error, question wording and practical difficulties in conducting surveys can introduce error or bias into the findings of public opinion polls.

For more details on Gallup's polling methodology, visit www.gallup.com.

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