Pre-Reform Access and Affordability for the ACA's Subsidy-Eligible Population

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At a Glance

- Those uninsured for part or all of the prior year report significant access and affordability problems relative to those with private coverage and will have clear benefits from enrolling in Marketplace coverage.
- Those in the pre-reform private market are relatively healthy, but report affordability problems.
- Those with pre-reform public coverage have more serious health problems and more difficulty obtaining care than those with private coverage.

Perhaps the most innovative provision of the Affordable Care Act (ACA) is the establishment of health insurance Marketplaces to facilitate the purchase of health coverage for individuals and small businesses. The ACA imposes a mandate on individuals to obtain health insurance if affordable coverage is available. To reduce the burden of this mandate, the ACA also provides income-related subsidies through tax credits for many adults with family incomes between 138 percent and 400 percent of the federal poverty level (FPL) who purchase individual coverage in the Marketplaces. In this brief, we examine pre-reform access to and affordability of health care for the population now eligible for Marketplace subsidies. The goal is to identify current problems with access and affordability and to suggest potential gains for adults likely to be affected by the ACA.

Marketplace subsidies will be available for people who do not have access to affordable employer-sponsored insurance (ESI), defined as coverage with premium costs to the employees less than 9.5 percent of income. Most individuals with ESI are expected to keep ESI coverage. The subsidy-eligible people fall into several groups, depending on their pre-reform health insurance status. Almost all of those with nongroup coverage will move into the Marketplaces and, if their incomes are below 400 percent of FPL, be subsidy eligible. Many in this income range, both uninsured and those with public coverage, will also likely move into the Marketplaces.[1]

What We Did

The analysis draws on data collected in June–July 2013 from the Health Reform Monitoring Survey (HRMS), using a sample of nonelderly adults age 18–64. In addition to providing data on insurance coverage at a point in time, the HRMS has information on whether individuals had coverage over the prior year. Thus, respondents can be placed into four categories based on the type of their pre-reform insurance coverage:

1. those with public coverage (either Medicare or Medicaid) who had insurance coverage (either public or private) over the entire prior year;
2. those uninsured for all or part of the prior year;
3. those with ESI who had some type of coverage during the entire prior year; and

4. those purchasing coverage directly who had some type of coverage during the entire prior year.

We compare each insurance category's access and affordability to that of those with ESI. This is because coverage in the Marketplaces is modeled after ESI, with the benefits in most states based on the small group plan with the largest enrollment. Though private ESI plans typically cover a somewhat higher share of costs than Marketplace products, we consider current private ESI coverage a reasonable proxy for comparisons of health care access and affordability.[2]

Compared with individuals with ESI, the characteristics of those in the different pre-reform insurance categories vary. The individuals with nongroup coverage are slightly healthier and younger (see table 1). Those with public coverage are much more likely to report fair or poor health and are considerably older, less likely to be white, and considerably less educated. Those uninsured for all or part of the prior year are considerably younger, less likely to be white, more likely to be Hispanic, less likely to have graduated from college, and far more likely to report being in fair or poor health. Because differing characteristics can affect both access and affordability, we use multivariate models to control for these and other factors and present both unadjusted and regression-adjusted differences.[3] We compare potentially subsidy-eligible adults with the different kinds of pre-reform insurance coverage on several measures of access and affordability (table 2). The access questions ask respondents 1) whether they have a usual source of care, had a routine check-up in the prior year, or had difficulty obtaining care, and 2) specific questions about the type of difficulty in obtaining care. The affordability questions ask whether respondents experienced an unmet need because care was not affordable and whether they had problems paying medical bills. Again, we compare those in each pre-reform insurance category to those with ESI.

Table 1. Health Status and Demographic Characteristics of Adult Subsidy-Eligible Marketplace Target Population, by Health Insurance Coverage and Prior-Year Coverage Status (percent)

		Coverage Type at Time of the Survey, and Full-Year Insurance Status							
	Total	Private, employer-sponsored insurance, full-year insured		Private, non-group coverage, full-year insured		Public, full-year insured		Uninsured, part or all of year	
Self-reported health status									
Fair/poor	12.2	9.1		9.1		39.4	***	13.8	**
Good	36.0	36.5		28.2	**	39.1		36.7	
Very good/excellent	51.8	54.4		62.6	**	21.4	***	49.5	
Age									
18–30	29.5	24.4		35.2	**	18.3		41.9	***
31–49	41.1	45.3		34.8	**	31.2	***	35.6	***
50–64	29.5	30.3		30.1		50.5	***	22.5	***
Gender									
Male	50.3	49.8		44.3		47.5		54.1	
Female	49.7	50.2		55.7		52.5		45.9	

Race/ethnicity							
White, non-Hispanic	66.3	73.2	71.5	47.9	***	53.0	***
Other race/ethnicity, non-Hispanic	19.4	16.9	18.1	35.6	***	21.8	
Hispanic	14.3	9.9	10.4	16.6		25.2	**
Education							
Less than high school	7.4	4.2	4.9	15.2	*	13.8	***
High school graduate or some college	66.5	64.8	62.1	75.2	*	69.6	**
College graduate	26.1	31.1	33.0	9.6	***	16.6	***
Sample size	**3,192**	**2,016**	**286**	**188**		**702**	

Source: Health Reform Monitoring Survey, quarter 2 2013.

Notes: Adult subsidy-eligible Marketplace target population is adults age 18–64 with family incomes between 139 and 399 percent of the federal poverty level. Estimates for subpopulations with fewer than 50 observations are not reported.

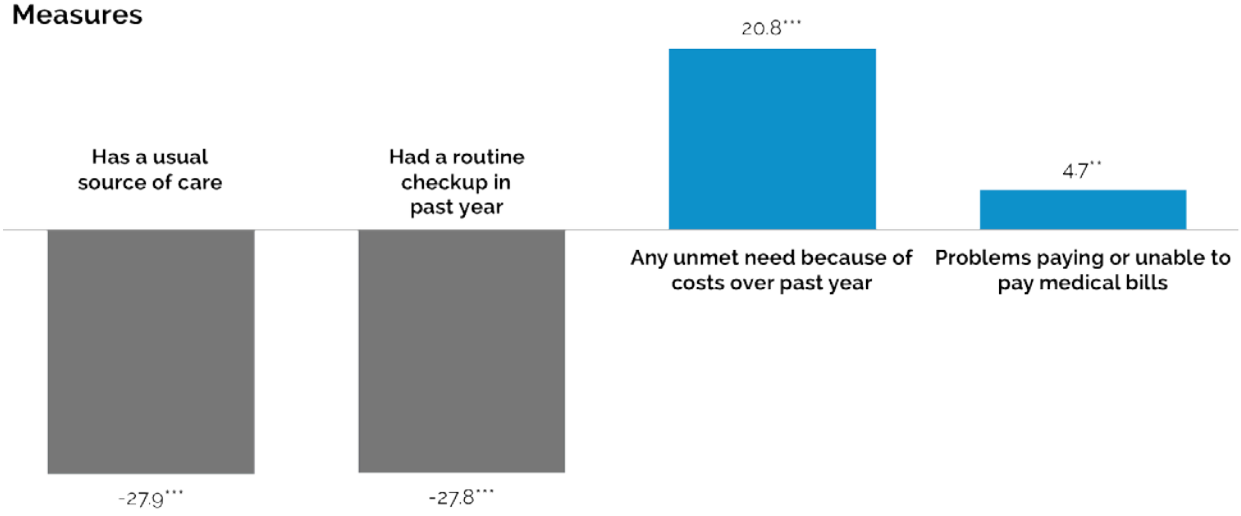
*/**/*** Estimate differs significantly from private, full-year insured at the 0.10/0.05/0.01 level, using two-tailed tests.

What We Found

Those uninsured for part or all of the prior year report significant access and affordability problems relative to those with ESI and will have clear benefits from enrolling in Marketplace coverage. Those who were uninsured for all or part of the prior year were less likely to have a usual source of care than those with ESI (49.7 percent versus 79.2 percent) and less likely to have had a routine check-up in the prior year (38.4 percent versus 67.3 percent). The uninsured were also somewhat more likely than those with ESI to have difficulty obtaining care in the prior year (19.5 percent versus 17.7 percent).

Adults who were uninsured part or all of the prior year were more likely to report one or more unmet needs because of cost in the prior year than those with ESI (54.0 percent versus 31.8 percent) for needs that include medical care, dental care, mental health care, and prescription drugs. Almost one-third of the uninsured adults (30.4 percent) report problems paying medical bills, compared with about one-quarter of those with ESI (23.4 percent). All these differences remain statistically significant when regression-adjusted (table 2; figure 1). Because some of this population had coverage for only part of the prior year, their responses may reflect expectations that could not be met once they lost coverage.

Figure 1. Among Adult Subsidy-Eligible Marketplace Target Population, Regression-Adjusted Percentage-Point Differences between Part- and Full-Year Uninsured and Those with Employer-Sponsored Insurance on Selected Access and Affordability Measures



Source: Health Reform Monitoring Survey, quarter 2 2013.
Note: Adult subsidy-eligible Marketplace target population is adults age 18–64 with family incomes between 139 and 399 percent of the federal poverty level.
/* Estimate differs significantly from the employer-sponsored full-year insured at the .05/.01 level, using two-tailed tests.
No estimate differs significantly at the .10 (*) level.

Those in the pre-reform nongroup market are relatively healthy but report some affordability problems and worse access problems relative to those with ESI (table 2, figure 1). Those with private nongroup coverage have somewhat lower levels of access than those with ESI, with 67.3 percent having a usual source of care (versus 79.2 percent for those with ESI) and only 48.9 percent having had a routine checkup in the prior year (versus 68.3 percent for those with ESI). These results could reflect higher cost-sharing structures in nongroup plans. The regression-adjusted differences between those with ESI and those with nongroup coverage for these measures are 11.4 percentage points and 18.7 percentage points, respectively. Regression adjustment also shows that adults with nongroup coverage in this income range are more likely to have unmet needs for medical care because of costs and to have more trouble finding a doctor or other health care provider. There are no significant regression-adjusted differences in having problems paying medical bills.

Those with pre-reform public coverage have more serious health problems and more difficulty obtaining care than those with ESI. Those with public coverage are four times more likely to report being in fair or poor health than those with ESI (table 1), making them more likely to need health care services. Those with public coverage are more likely to have had a routine checkup in the past year (79.4 percent) than those with ESI (67.3 percent), and, this difference remains significant after regression adjustment. Still, they are much more likely to report difficulty in obtaining care in the past year (29.8 percent versus 17.7 percent) and they reportedly had more trouble finding a doctor who would accept their insurance than those with ESI (20.0 percent versus 3.6 percent), differences that remain significant after regression adjustment. There was no difference in problems paying medical bills, reflecting the comprehensive nature of public insurance.

Table 2. Health Care Affordability for Adult Subsidy-Eligible Marketplace Target Population, by Coverage Type and Full-Year Insurance Status (percent)

									Adjusted Percentage-Point Differences					
	Total	Private, employer-sponsored insurance, full-year insured	Private, non-group coverage, full-year insured		Public, full-year insured		Uninsured, part or all of prior year		Between private, nongroup coverage, full-year insured, and private, employer-sponsored insurance, full-year insured		Between public, full-year insured and private, employer-sponsored insurance, full-year insured		Between uninsured, part or all of prior year, and private, employer-sponsored insurance, full-year insured	
Has a usual source of care	70.8	79.2	68.3	***	83.2		49.7	***	-11.4	***	3.6		-27.9	***
Had a routine check-up in the past year	59.0	67.3	48.9	***	79.4	***	38.4	***	-18.7	***	7.1	**	-27.8	***
Difficulties obtaining care in the past year	19.0	17.7	19.2		29.8	***	19.5		0.7		7.6	*	-1.0	
Trouble finding a doctor or other health care provider	5.1	3.4	6.9	*	6.0		8.2	***	3.8	*	0.9		3.8	***
Trouble finding a doctor as a new patient	4.8	3.3	6.1	*	9.2	*	6.6	***	2.7		4.1		2.5	***
Trouble finding a doctor who would accept insurance type	5.6	3.6	3.7		20.0	***	7.4	***	-0.2		13.3	***	2.2	
Trouble getting an appointment with a doctor	13.5	13.7	13.4		18.5		11.8		-0.9		1.1		-3.7	***
Any unmet need because of costs over the past year	38.5	31.8	35.8		41.9	***	54.0	***	5.5		3.9		20.8	***
Medical care, general doctor care, specialist care, medical tests, treatment, or follow-up care	25.6	18.9	23.4		19.0		43.0	***	5.5	*	-6.2		22.7	***
Dental care	27.3	22.3	24.5		29.2	*	39.1	***	3.8		1.7		15.2	***
Mental health care or counseling	9.0	6.5	7.4		9.0		15.1	***	0.4		0.2		7.6	***
Prescription drugs	18.2	14.2	16.8		19.6	*	27.6	***	3.3		-0.1		12.7	***
Problems paying or unable to pay medical bills	25.0	23.4	19.9		24.9		30.4	***	-2.6		-5.7		4.7	**

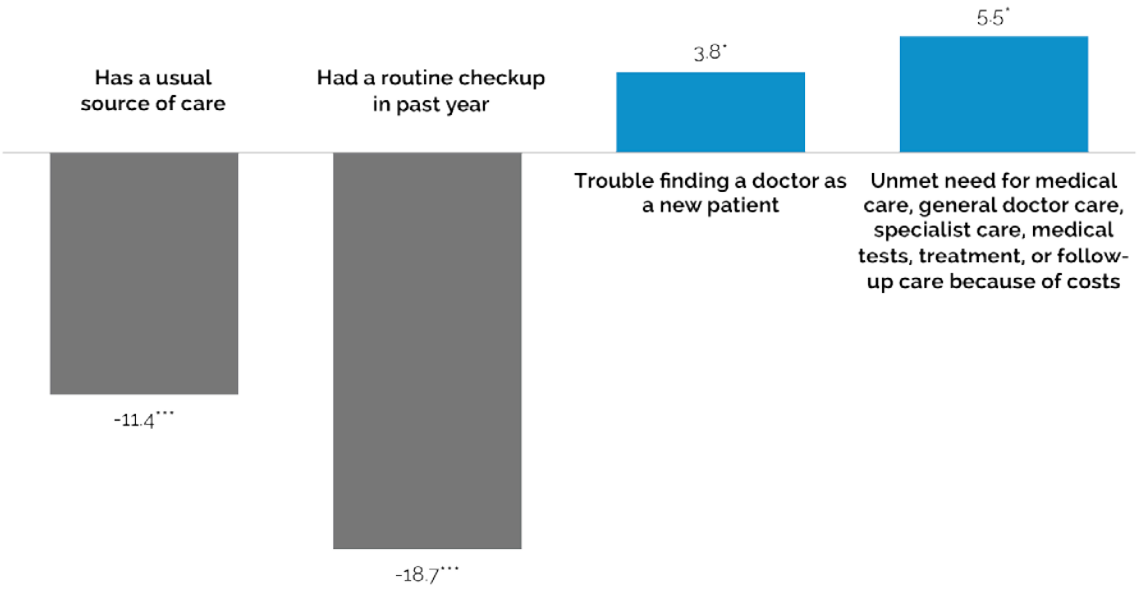
Sample size	**3,192**	**2,016**	**286**		**188**		**702**							

Source: Health Reform Monitoring Survey, quarter 2 2013.

Note: Estimates for subpopulations with fewer than 50 observations are not reported. Control variables in the regression-adjusted estimates are age, gender, race/ethnicity, health status, education, homeownership, marital status, and urban/rural indicator. Adult subsidy-eligible Marketplace target population is adults age 18–64 with family incomes between 139 and 399 percent of the federal poverty level.

*/**/*** Estimate differs significantly from private, full-year insured at the 0.10/0.05/0.01 level, using two-tailed tests.

Figure 2. Among Adult Subsidy-Eligible Marketplace Target Population, Regression-Adjusted Percentage-Point Differences Between Those with Private, Nongroup and Employer Sponsored Insurance on Selected Access and Affordability Measures



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*/*** Estimate differs significantly from the employer-sponsored full-year insured at the .10/.01 level, using two-tailed tests.
No estimate differs significantly at the .05 (**) level.

What It Means

These results suggest that adults in these pre-reform insurance groups could benefit from coverage offered in the Marketplaces, depending on plans available to them. Adults who were uninsured for all or part of the prior year have the most to gain, because they are much less likely to have a usual source of care, have had greater difficulty in obtaining care in the prior year, and have had more unmet needs because of cost. Those with nongroup coverage at the time of the survey are less likely than those with ESI to have had a usual source of care or a routine checkup, both of which should be mitigated with Marketplace coverage. Those with public coverage have had more difficulty finding a doctor who accepts their insurance, which should also be mitigated under Marketplace coverage. Whether those with public coverage will be better off in the Marketplaces depends on the Marketplace plans. If access to providers improves, it may counterbalance the effect of higher cost sharing.

About the Series

This brief is part of a series drawing on the Health Reform Monitoring Survey (HRMS), a quarterly survey of the nonelderly population that is exploring the value of cutting-edge Internet-based survey methods to monitor the Affordable Care Act (ACA) before data from federal government surveys are available. The briefs provide information on health insurance coverage, access to and use of health care, health care affordability, and self-reported health status, as well as timely data on

important implementation issues under the ACA. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation, and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

About the Authors

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Notes

[1] The exceptions to this are uninsured undocumented immigrants, those uninsured who are exempt from the mandate and penalty (e.g., people who would be required to pay more than 8 percent of income and, even with subsidies, coverage would be unaffordable), those uninsured who choose not to comply with the law and pay the penalty, and those in states that expand Medicaid eligibility to groups with incomes above 138 percent of FPL. However, states do not have financial incentives in the ACA to continue these prior Medicaid expansions.

[2] Although some states expanded Medicaid coverage to individuals with incomes above 138 percent FPL before the ACA, most will not continue to do so. Therefore, comparing access and affordability for those with current public coverage to those with ESI shows how access might change for those in pre-ACA Medicaid expansions.

[3] The regressions control for age, gender, race and ethnicity, health status, education, marital status, home ownership, and an indicator of residence in a metropolitan area. The regression-adjusted differences should not be interpreted as the impact of having one type of insurance as opposed to another (or of having no insurance). There may be unmeasured differences between insurance groups that affect who has a particular type of insurance and relate to access and affordability.