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A Tale of Three Cities: How the Affordable Care Act is Changing the Consumer Coverage Experience in 3 Diverse Communities

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The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

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Introduction

With the close of the third open enrollment period for marketplace coverage under the Affordable Care Act (ACA), media and other observers have focused on the 12.7 million individuals who enrolled in coverage, noting that more than 90 percent of Americans are now insured. By this measure, the ACA has been a success in extending coverage to uninsured individuals and families. Since enactment of the health law, the number of uninsured has dropped from 49.9 million people in 2010[1] to 33.0 million people in 2014,[2] reflecting coverage gained through a number of ACA reforms, including the health insurance marketplaces that began offering coverage in 2014. But the enrollment numbers are just one measure of success. This next phase of ACA implementation must measure whether and how individuals are obtaining care with their new marketplace coverage, in order to answer the fundamental question of whether the ACA will improve people's overall health and financial security.

Prior to the ACA, uninsured individuals had to go without care or rely on safety net providers to obtain many health care services. Community-based safety net providers helped to fill gaps in a health care system that left many without insurance or unable to afford their care. With passage of the ACA, many health care experts expected that the gaps would narrow, with new coverage options, benefit requirements, and financial assistance that would extend affordable, comprehensive marketplace coverage to those who earn too much for Medicaid but couldn't obtain coverage on their own. The hope was that traditional safety net providers would help many of their clients gain insurance coverage through the marketplaces and become paying patients, while the safety net itself would be needed only by those excluded from eligibility for marketplaces, such as undocumented immigrants. However, after two full years of subsidized marketplace plans, respondents in three U.S. cities suggest that significant gaps still remain, and safety net providers and other charity care programs continue to be essential to helping people obtain affordable health care.

Background and Methodology

In 2013, 13.3 percent of the population was uninsured.[3] In order to receive health care, this population often relied on safety net programs within their local communities. Many uninsured were forced to cobble care together through local public hospitals, federally qualified health centers (FQHCs), free clinics, prescription drug programs, and other forms of charity care (see table).[4] But some communities went further and successfully built coordinated programs that allowed eligible patients relatively seamless access to a range of primary and specialty care services and prescription medicines. Even with the safety net, however, in 2013 less than half (46.6 percent) of the uninsured had a usual source of care (compared to 76.8 percent for those with private coverage), and only 39.3 percent had a routine check-up the previous year (compared to 67.2 percent with private coverage). [5] Many uninsured also sought care in local emergency rooms. A 1986 law requires hospitals to screen, treat and stabilize patients seeking emergency care, regardless of their ability to pay.[6] Although the law does not require hospitals to treat patients seeking non-emergency care, many go beyond the federal requirements and provide such care. A 2011 CDC survey found that 79.7 percent of adults who visited the emergency room did so because of a lack of access to other providers.[7]

Table: Safety Net Providers Interviewed for this Report

	Free Clinics	Federally Qualified Health Centers	Safety Net Hospitals, including Emergency Departments
Care Provided	Limited range of primary care services and medications; some provide limited specialty care services	More comprehensive array of primary care services; some provide limited specialty care; most make referrals for specialty care	Primary and specialty care, emergency services
Population Served	Mostly uninsured; clinics can set own eligibility rules (e.g., up to 200% of poverty)	Typically low income; may be uninsured, covered by Medicaid, CHIP or private insurance	Uninsured and insured patients (Medicaid, CHIP, and private insurance)
Cost-Sharing Help	Mostly provide services at no cost; some prescriptions available for low cost or free	Services generally available on sliding fee scale	Many hospitals offer cost-sharing assistance (e.g., for those up to 200% of poverty)
Funding	Mostly supported by charitable funding and services donated by volunteer providers; some receive limited state or local funding	Federal grants for clinic construction and operation; reimbursement through Medicaid and CHIP; many accept private insurance	Medicare, Medicaid, CHIP, and private insurance reimbursement for services; Medicaid and Medicare Disproportionate Share Hospital (DSH) and other funding for uncompensated care
Changes Expected as a Result of the ACA	Coverage expansions were expected to reduce number of eligible (uninsured) patients; remaining patients were expected to be those in Medicaid gap and undocumented individuals	Increased grants for clinic construction and operation; increased share of patients with private or Medicaid coverage available to pay for services	Reductions in Medicare and Medicaid DSH funding; increased share of patients with coverage/compensation for care

NOTE: The above factors vary based on state and local requirements and funding, as well as by each organization's specific mission, eligibility requirements, and role in community.

As ACA implementation began in 2014, safety net program administrators understood they would have to adapt, as millions of their patients would be newly insured and the mechanisms for financing their care would change.[8] Hospitals in particular braced for the ACA's required annual reductions in both Medicaid and Medicare Disproportionate Share program (DSH) payments, which have helped finance the uncompensated care they provide to low-income individuals.[9] But they hoped that as their patients gained insurance coverage, fewer would require uncompensated care.

At the same time, drafters of the ACA recognized a continuing role for a health care safety net. In order to accommodate millions of newly insured seeking health services, the ACA established an $11 billion Community Health Center Fund to support continued operation and expansion of FQHCs, as well as the construction of new health centers.[10] FQHCs receive enhanced funding from Medicaid and Medicare and must serve underserved areas, provide comprehensive services, and offer a sliding fee scale for patients with limited income; many accept private health insurance reimbursement.

However, the need for safety net funding may be greater than drafters of the ACA anticipated, and not just because of those who fall into the Medicaid gap in states that have failed to expand Medicaid.[11] Many who are potentially eligible for marketplace subsidies remain uninsured and cite affordability as the reason, although surveys have found that most are unaware they may be eligible for financial assistance to buy a marketplace plan.[12] Still others have marketplace coverage but struggle with "underinsurance," in which they must spend considerable amounts out-of-pocket in order to obtain health care services and medicines. A study of marketplace enrollee health care spending found even those with income that qualifies them for relatively generous cost-sharing subsidies face considerable out-of-pocket costs.[13] For those with income less than 200 percent of poverty and health care spending that puts them in the top ten percent of marketplace enrollees, premiums and out-of-pocket costs can total 18.5 percent of income.[14] These populations – eligible for or enrolled in marketplace

plans with financial assistance – may continue to rely on safety net providers for free or low cost health care.

This paper explores how three communities and their safety net programs and providers are responding to a changing consumer coverage experience for those with marketplace plans. We conducted three site visits to Tampa, Florida; Columbus, Ohio; and Richmond, Virginia in the weeks leading up to the ACA's third open enrollment period. We chose these communities because they are geographically diverse mid-size cities with community-wide health systems. Although all are in states with federally facilitated marketplaces, they vary in their state's response to the Medicaid expansion provisions of the ACA. Ohio expanded Medicaid coverage to individuals under 138 percent of the federal poverty level.[15] Florida and Virginia have not.

In order to better understand the consumer experience with marketplace coverage, we spoke to various community stakeholders who interact directly with consumers, including navigators and other in-person assisters (hereinafter collectively referred to as "assisters"), insurance brokers, free clinics and FQHC staff, hospital and physician representatives, and health insurance regulators. Interviews explored issues currently facing consumers as they enroll in and use their marketplace coverage. In total, we conducted 25 interviews across the three cities. These interviews, while not representative, provide a window into the experience of marketplace consumers in three communities through the eyes of those who work most closely with them.

Observations

We heard from stakeholders that the law has benefited many of the people they serve. Respondents spoke with pride about the people they have helped enroll in marketplace coverage, particularly those who were previously denied coverage because of a health condition or who had been unable to afford coverage without substantial financial assistance. Our respondents reported that many of those gaining coverage for the first time felt a tremendous sense of relief that they can now obtain care more easily and affordably. In addition, the ACA's requirement that insurers cover preventive services without cost sharing is one of the most popular "selling points" assisters use to encourage people to enroll in marketplace plans.

At the same time, our interviews with stakeholders in the three communities confirmed that many consumers are still facing the same widely reported challenges from the first two years of Marketplace enrollment:

- Premiums and cost sharing – even for those who qualify for financial help – can be daunting, turning some consumers away from enrolling in coverage and deterring others from obtaining care.
- Provider networks in many places have been narrowed to respond to price-conscious consumers which has lengthened travel and wait times for consumers and reduced provider choice, relative to employer-based health plans.
- Consumers struggle with health literacy. Their difficulty grasping basic insurance terms and concepts makes choosing a plan and understanding how to use their coverage difficult.

What has been less recognized, though, is how various community stakeholders are responding to these known factors to provide help in the form of both counseling and financial assistance to meet these substantial challenges. Furthermore, the ways in which consumers are obtaining care has changed, but not always to the degree or in the ways many observers had anticipated at the time of the ACA's passage.

Premiums and Out-of-Pocket Costs

Many safety net programs in existence before enactment of the ACA were expected to become less necessary once the ACA coverage expansions took effect. And respondents report that has indeed been the case. But what was deemed affordable under the ACA for those with income too high for Medicaid eligibility is not necessarily perceived to be affordable to the individuals enrolling in the marketplace health plans, particularly when health care spending must compete with other pressing household expenses. For example, a Columbus insurance broker shared his

experience helping a client gain substantial financial assistance and cost-sharing help for a marketplace health plan, only to have her balk at the $18 per month premium. Even after he explained to her the benefits of being insured and avoiding the tax penalty for not having coverage, she ultimately concluded she could not afford to enroll.

In addition to challenges with premiums, some marketplace plans come with substantial cost sharing. A recent survey found that 40 percent of adults in marketplace plans with income up to 250 percent of poverty had deductibles of $1,000 or more.[16] In our interviews, stakeholders have found a continued need for safety net providers to fill gaps for those marketplace enrollees who cannot afford care. As a result, safety net program directors and funders that originally believed they would see a decline in uninsured patients and an increase in insured, paying patients in the wake of the ACA are finding that the new law's impact is not that clear or settled.

For example, free clinics that serve only uninsured patients expected to see a decline in the number of patients seeking care as a result of the ACA coverage expansions. However, in some cases, patients who gained coverage and no longer needed charity-based care have begun to "drift back." Free clinics in Columbus and Richmond found that the number of patients dropped in the wake of the ACA's open enrollment period, but by the fall, these patients returned for free care because they had dropped their marketplace plans. Staff believe this is because they could not afford to continue paying their premiums. In other cases, patients decline to enroll in coverage in the first place. A Tampa free clinic survey of patients found three out of four patients decided not to enroll in a marketplace plan because they perceived coverage to be unaffordable, although it is not clear if they were aware of the financial assistance that is available. For these patients the choice may be a rational one, particularly because they know that, to the extent they need health care services, they can continue to receive them from the free clinic.

Among hospitals that serve both insured and uninsured patients, many respondents noted with some surprise the degree to which insured patients still need help with out-of-pocket costs, even those who qualify for cost-sharing help in marketplace plans (up to 250 percent of poverty).[17] For example, although hospitals in all three communities report a reduction in the number of uninsured patients in their service areas, they also report increased participation in their charity care programs that provide assistance with hospital bills, as well as an increase in revenue lost to "bad debt." [18]

Staff at a Tampa hospital system report an increase, since 2014, in the number of people applying for the hospital's financial assistance program, which targets patients with incomes up to 250 percent of poverty. However, it is not clear if the increase reflects a greater need for cost-sharing help or if there are just more people now aware of the program. The ACA imposed new requirements on non-profit hospitals, including a requirement to include a summary of the hospital's charity policy on every statement provided to patients. In addition, the Tampa hospital system staff report that some higher income patients – those above the eligibility threshold for the hospital's financial assistance program and marketplace cost-sharing subsidies – are unable to afford the required cost sharing for a procedure. Depending on their particular circumstances, patients in that case may also qualify for the financial assistance from the hospital system.

Hospital respondents have also had to adjust their expectations about state and federal funding for uncompensated care under the Medicaid DSH Program as well as Medicare DSH payments. For example, the safety net hospitals in Columbus receive funding from Ohio's DSH program, the Hospital Care Assistance Program (HCAP). Under the program, four hospitals in Columbus provide charity care to anyone earning between 138 and 200 percent of the poverty level, including both uninsured and underinsured individuals, but excluding those who are eligible for Medicaid.

As more people were slated to gain coverage through Medicaid and the marketplace, state leaders anticipated DSH program funding would become less necessary. However, Columbus stakeholders report a continued need for DSH funding. The ACA has not reduced the need for the safety net, observed one Ohio provider, "the changes have just shifted who needs [it]."

Similarly, a coalition of providers and other community leaders in Richmond recognized during the first year of the ACA's roll out that consumers would continue to need help from the safety net to defray out-of-pocket costs for health care services and medications.

With some funding from an outside foundation, the coalition began exploring the development of a new program to supplement the government cost-sharing assistance consumers receive through the ACA's marketplaces. Although program staff are still assessing the feasibility of such a program, they intend to start with a more modest initiative, in which patients receive a $200 prescription drug voucher and one-on-one insurance literacy coaching. Through this effort, program staff hope to gather better data on enrollees' experiences with cost sharing and access to care under their marketplace health plans, while also examining the feasibility of providing assistance with out-of-pocket costs.

Access to providers

Prior to the ACA, some of the uninsured found a way to "create their own network" of clinics and hospital-based charity care where they could obtain care. Primary care was often available from safety net providers; however, access to specialists was usually more challenging and largely dependent on volunteer physicians providing services on a pro bono basis.

Some communities established programs such as the one in Richmond, called AccessNow, which has worked to connect uninsured patients to specialist providers willing to deliver care on a pro bono basis since January 2008. Also, some hospitals, such as a major hospital system in Richmond, created "insurance-like" programs for patients seen in the hospital, with the goal of reducing unnecessary use of hospital services. Hospital executives report that they had initially expected that demand for this program would shrink, as would the need to support it financially. However, after two years of marketplace coverage, these executives report continued high demand.

In all three communities, safety net providers report that significant numbers of their newly insured patients continue to obtain health care services at the safety net providers they used prior to 2014, even though their new health plans offer the opportunity to seek care from a broader network of providers. In some cases, this was due to the marketplace plans' reliance on safety net providers to meet ACA marketplace plan network standards that require inclusion of "essential community providers," many of whom are FQHCs. But enrollment assisters also noted that some patients sought out networks that included the clinic or hospital where they had been getting free or low-cost care prior to enrolling in coverage. Clinic staff in Columbus and Richmond report that few of their patients wanted to leave, and if they did, it was to see a specialty physician or for services the clinic could not provide.

Consistent with federal policymakers' intent to enlist providers in enrollment efforts, safety net providers in all three communities have engaged in robust efforts to enroll uninsured patients in marketplace or Medicaid coverage and reach out to the communities they serve to educate residents about the ACA and the new coverage options available. For the various types of safety net providers, the enrollment efforts have different implications. Free clinics have conducted enrollment outreach and assistance while recognizing that by gaining coverage, the patients they serve may lose eligibility for the free or discounted primary care and medicines they had been receiving through their facility or other community providers. Free clinics in Richmond provide newly insured patients with referrals to community providers and a supply of drugs to cover the time until they see those providers. On the other hand, FQHCs and hospitals have sought to enroll uninsured patients knowing that they may gain paying patients through Medicaid or insurer reimbursement for care previously provided at no or low cost.

One place where patients can often obtain primary and specialty care, with insurance or without, is a hospital emergency department (ED). The ACA was expected to reduce the use of EDs for primary care services or other non-urgent care. Although data is lacking, stakeholders provided anecdotal reports of some reduction in the use of EDs for non-urgent care, but many newly insured still rely on EDs as a regular source of care. A Tampa ED physician reports that most of his patients, including those with non-urgent needs, have a primary care physician. Stakeholders in all three communities discussed ongoing education efforts to persuade consumers to use an appropriate site of care for non-emergency services, both to save money and obtain the benefits of having a usual source of primary care. But stakeholders across all three communities report continued heavy reliance on local emergency

departments. For the most part, they attribute this to "convenience." Patients asked to avoid the ED and instead use a primary care physician must make and wait for an appointment. If any follow up services are needed, they must make appointments and arrange for travel to those. When they compare that to a hospital emergency department – where all services, including labs, imaging, and pharmacy are on site – the "one-stop-shop" of an emergency department becomes a rational choice for many.

Education

Stakeholders in all three communities have found that previously uninsured consumers have difficulty understanding key insurance terms, such as coinsurance and deductible, and must often be instructed on how to use provider directories and drug formularies. For example, assisters in Columbus noted that they spend far more time educating consumers about their plan choices than they spend preparing and submitting eligibility applications, a shift from the first open enrollment season when technical glitches caused long delays in obtaining eligibility determinations from the marketplaces. Enrollment assisters feel they must be a "walking glossary" and help consumers understand how insurance works, a task made more complicated by the different ways health insurers describe plan terms and benefits. While we identified no organized community effort in Columbus to address consumer health literacy challenges, educating consumers about how insurance works has become a primary focus for marketplace assisters when helping consumers compare plans and enroll in coverage.

However, merely defining the terms to help consumers compare plans when shopping for coverage is just a small piece of the work underway. Consumers also need intensive help after they have enrolled, as they obtain care and pay medical bills. For example, a hospital-based physician in Tampa said the newly insured he sees have never before seen – and don't know how to read – a hospital bill. In response, providers in both Tampa and Richmond have developed programs to help meet consumers' education needs.

A Tampa hospital system has trained staff to meet with patients at the bedside, regardless of insurance status, to answer questions they may have about their insurance and how it works. In the process, they are discovering that trouble with health insurance literacy is not unique to new marketplace enrollees; almost all consumers, even those with long-standing coverage, need considerable help understanding the terms and benefits under their health plans.

Similarly, the provider-led coalition in Richmond has funding from local foundations and hospital systems to run a new education program for marketplace consumers, after they've enrolled in coverage. To be eligible for the program, participants must be enrolled in a marketplace plan and obtain care from an FQHC. Once enrolled in the new program, patients will receive one-on-one coaching to help prepare them for out-of-pocket costs, such as deductibles, copayments, and coinsurance, as well as advice on how to improve communication with their primary care physician.

Local Efforts to Better Understand Consumer Coverage Experiences

Changes brought about by the ACA are prompting providers in all three communities to collect data in order to better understand how patients are obtaining and paying for care. A Tampa physician noted that Medicare efforts to reduce hospital re-admissions have prompted his hospital to expand its data collection to better understand how patients access care in the hospital and community, including where they get care and what services they are getting, from preventive services to hospital admissions.

A hospital system in Tampa is collecting data on the number of patient visits covered by marketplace plans, noting that the number almost doubled in the second year of marketplace coverage. The hospital system is also tracking "new business," marketplace enrollees who hadn't visited the hospital previously. Similarly, hospitals in Columbus are collecting data to better assess how their uncompensated care may have changed as a result of the ACA coverage expansions. Although their report was not yet published at the time of this writing, a hospital official there expects it to show that providers' share of uncompensated care has declined, but not the bad debt they incur when insured patients cannot pay their hospital bills. Such a finding would be consistent with anecdotal reports from other provider respondents, as well as a recent report from a major national hospital chain.[19]

In Richmond, staff developing the provider-led educational initiative intend to gather data about the

patients enrolled in order to better understand what assistance consumers need. If they ultimately expand the program to provide more cost-sharing assistance, they hope to use the data they collect to better target their efforts.

Policy Discussion

In the three communities we studied, we found that the need for a safety net is shifting, not shrinking. Safety net providers are adapting to the new coverage and health system landscape ushered in by the ACA. Many are working to enroll uninsured patients in Medicaid or marketplace coverage, gaining insured, paying patients as a result. But about 27 million people in this country are expected to remain uninsured, including undocumented immigrants.[20] Many who are eligible for marketplace coverage face a Hobson's choice. If they enroll in a marketplace plan, they lose eligibility for the free or low-cost care they were able to get when they were uninsured. Yet the marketplace plans that are most affordable to them often come with very high deductibles and other cost sharing that can make it more difficult to access care than when they were uninsured. As one assister put it, these individuals are "arguably worse off" if they enroll in marketplace coverage. Policymakers should be cautious about reducing funding for safety net providers and programs without further data on the need for free or low cost care, for uninsured as well as for those who are eligible for marketplace subsidies.

Respondents also emphasized how much of their time is absorbed in helping consumers understand how their coverage works – not just when comparing plan options but also when they use their coverage to get care. Federal rules recognize the role of assisters in educating consumers on health insurance. An update to those rules adds an additional obligation to their duties, one many are already fulfilling, to help with post-enrollment questions.[21] Other changes to federal rules and actions in many state-run marketplaces will also help consumers understand their plan choices and use their coverage. For example, the out-of-pocket cost calculator and provider and drug search tools made available on federal marketplaces for the third open enrollment are an improvement. Many state-based marketplaces have similar decision support tools. But the education challenges of newly covering millions more individuals require continued attention and a greater investment in health literacy and decision support tools.

Although there are ad hoc efforts by local organizations in all three communities to collect and analyze data about consumers' experiences, a more organized, national effort is needed to understand how consumers are using and paying for health care services under their new coverage options. The ACA authorizes state and federal regulators to collect and make public data on a comprehensive range of information from insurers about enrollment, benefit design, and problems or complaints.[22] Those data would help regulators, researchers, and consumers better understand whether and how health plans are meeting consumers' needs.[23] For example, federal regulators could request data on the out-of-pocket spending requirements in marketplace plans and the implications for obtaining care. However, to date, federal regulators have required only limited collection of data from marketplace plans and no data that would help answer the important question of whether enhanced coverage has translated to improved access to affordable care.

Conclusion

The ACA has considerably expanded the number of people with insurance coverage and improved their ability to access and pay for health care services. But our site visits to three American cities demonstrate that significant challenges remain. These challenges include unaffordable premiums and cost-sharing associated with health care services and drugs, as well as huge gaps in consumers' knowledge about how to choose an optimal health plan and how and where to obtain covered health services once enrolled. However, we found in these three communities that local efforts, often led by safety net providers, have emerged or evolved to help meet the changing needs of newly insured consumers. The need for these local efforts does not appear likely to abate, even as the marketplaces gain in enrollment, and could benefit from a more comprehensive approach to data collection as envisioned in the ACA.

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