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Health Insurance Marketplace Enrollment Rates by Type of Exchange

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Abstract
Because the ACA gave them choices in how to implement insurance coverage, health reform looks different state to state. 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 developed by researchers at the University of Pennsylvania that documents and codes state-level variation in the political setting, institutional structures, and operational decisions likely to affect outcomes on the marketplaces.

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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.

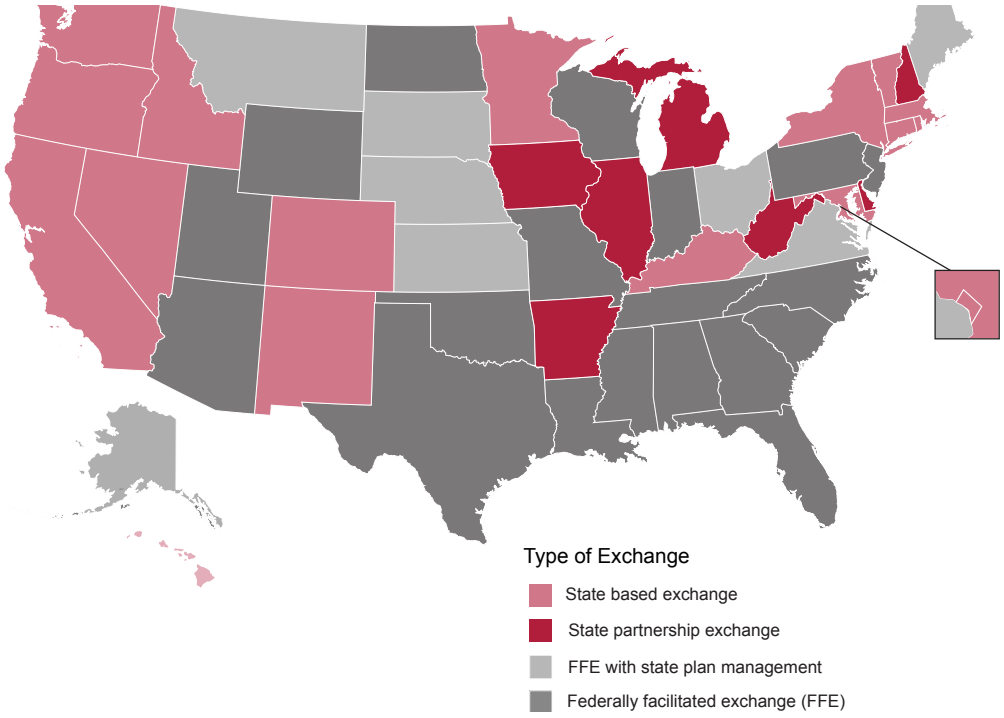
DID MARKETPLACE TYPE CORRELATE WITH ENROLLMENT RATES?

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).

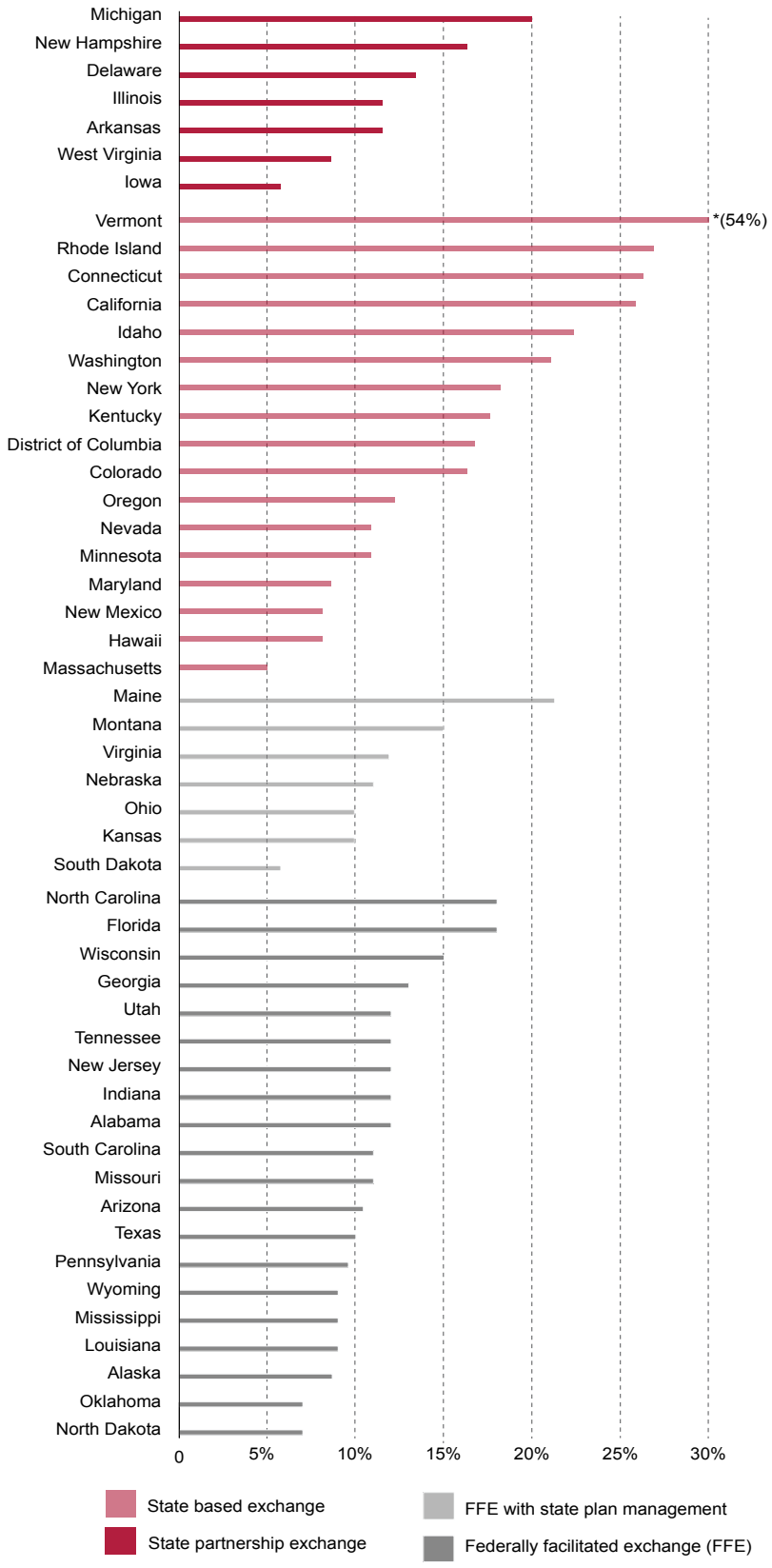
These averages, however, hide significant differences among the types, especially among the state-based marketplaces. Within the federally-run marketplaces, enrollment rates vary from 6% in South Dakota to 21% in Maine.

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.

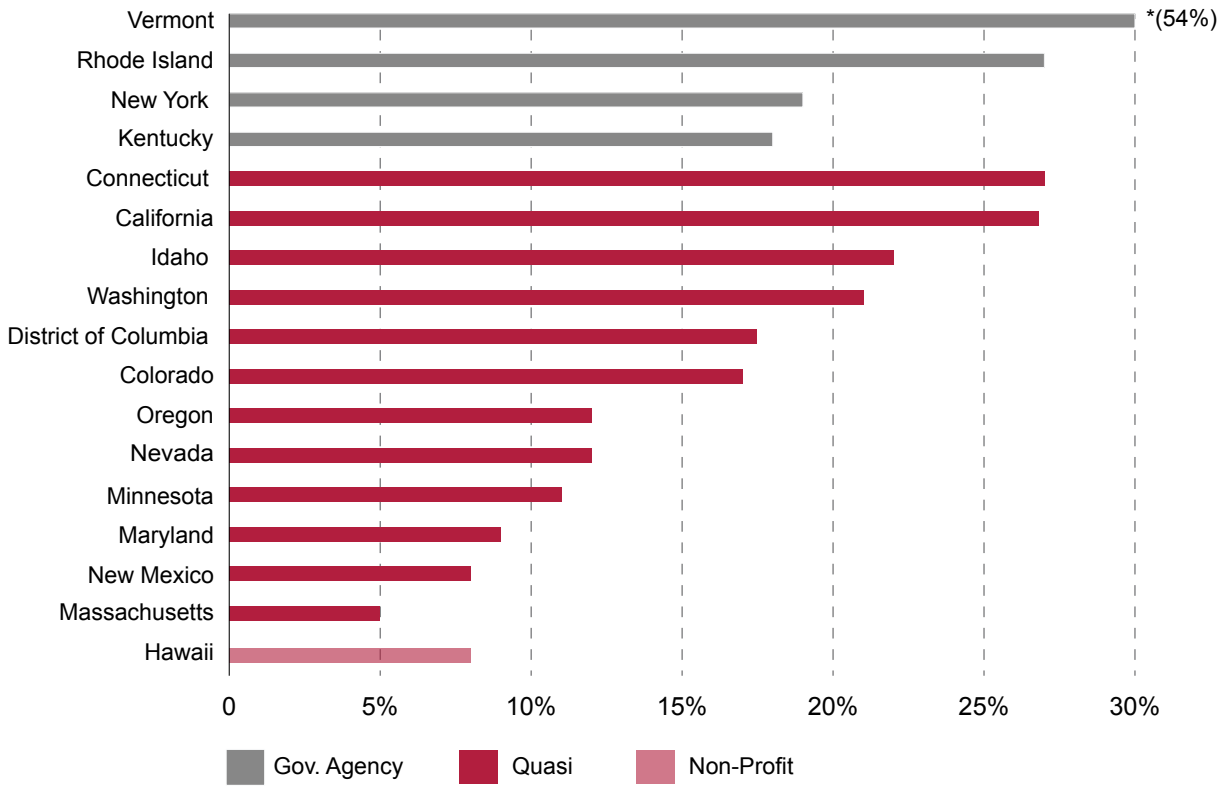
Each state choosing to run its own marketplaces decided on a formal governance structure, and that decision seems to have made a difference in enrollment rates. Each option had its potential advantages and disadvantages. Housing a marketplace in a state agency might allow the state to use its existing 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

This Data Brief was written by Daniel E. Polsky, PhD, MPP, Janet Weiner, MPH, Christopher Colameco, and Nora Becker.

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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