

## Health Care Access and Affordability among Low- and Moderate-Income Insured and Uninsured Adults under the Affordable Care Act

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### At a Glance

- As of September 2015, low- and moderate-income adults with Marketplace coverage were more likely to have a usual source of care and less likely to have had unmet needs for general doctor and specialist care in the past 12 months than uninsured adults with such incomes.
- Low- and moderate-income adults with Marketplace coverage are no more likely to report problems paying medical bills or have high out-of-pocket costs than those with employer-sponsored insurance (ESI).
- Low- and moderate-income adults with Marketplace coverage are as satisfied with their health plans as those with ESI in terms of premiums charged, but are less satisfied with their choice of providers and the protection their plans provide against high medical bills.

The implementation of the key coverage provisions of the Affordable Care Act (ACA), including an expansion of Medicaid in 30 states and the District of Columbia<sup>1</sup> and the introduction of subsidized coverage through new health insurance Marketplaces, have contributed to a substantial increase in the number of adults with health insurance (Uberoi et al. 2016). Medicaid and the Children's Health Insurance Program (CHIP) enrollment increased by about 14.5 million between October 2013 and December 2015 (Centers for Medicaid and Medicare Services 2016). As of February 1, 2016, about 12.7 million people were enrolled in health plans through federal or state-based Marketplaces (Office of the Assistant Secretary for Planning and Evaluation 2016).

Despite gains in coverage, issues in health care access and affordability persist. Although affordability is unlikely to be an issue with Medicaid, which has no premiums or cost sharing in most states and nominal amounts in some others, provider payment rates that have historically been a problem in Medicaid can affect access to care, particularly specialist and dental care. Tax credits that provide the subsidies for Marketplace plans are linked to silver plans. Silver plans have an actuarial value of 70 percent; that is, they must pay for about 70 percent of the costs of covered services. As a result, silver plans typically come with high deductibles (Claxton et al. 2015), although those with incomes below 200 percent of the federal poverty level (FPL) receive additional subsidies that lower cost sharing and attenuate the effects of high deductibles.<sup>2</sup> In addition, intense competition within Marketplaces has led to limited network plans, and some physicians and hospitals may not be available to individuals with these plans (Blumberg et al. 2015; Polsky and Weiner 2015).

The key question we ask in this brief is whether those on Medicaid and in the Marketplace are better off than the uninsured. Second, are they as well off as those with employer-sponsored insurance (ESI) or those with non-Marketplace nongroup coverage? And finally, are those with Marketplace coverage better or worse off than those with Medicaid?

## What We Did

This brief draws on data from a sample of nonelderly adults ages 18 to 64 surveyed for the September 2015 round of the Health Reform Monitoring Survey (HRMS). We focus the analyses on adults from families with incomes below 400 percent of FPL, an income group making up over 80 percent of Marketplace enrollees and virtually all Medicaid enrollees but only about half of adults with other coverage (Blavin et al. 2016). This also reduces the impact of income and socioeconomic status that we cannot fully control for in our regression adjustment (discussed below). We examine measures of health care access and affordability among adults who were insured for all of the past 12 months and compare estimates for adults with different types of health insurance coverage at the time of the survey. We also compare full-year insured adults with each type of coverage with adults who were uninsured for part or all of the 12 months before the survey. In addition, we examine measures of plan satisfaction by type of coverage at the time of the survey but do not restrict our analysis to those who were insured for all of the previous year. Our four insurance coverage types are (1) nongroup coverage through a health insurance Marketplace; (2) ESI or coverage through the military; (3) Medicaid, Medical Assistance, or CHIP; and (4) non-Marketplace nongroup coverage.<sup>3</sup> We do not include adults with Medicare or other, unspecified coverage.

Some adults in these groups may have switched coverage type in the 12 months before the survey. However, more than 90 percent of respondents in each insurance group reported having the same plan or coverage type throughout the year. It is important to note that surveys have historically had difficulty identifying the type of coverage held by respondents, and recall error is likely to compound this problem when respondents are asked to report coverage over a long reference period (Pascale 2008). In addition, because many respondents in our sample reported more than one coverage type at the time of the survey, we impose a hierarchy of responses (ESI/military coverage; Medicare; Medicaid; nongroup coverage; and other, unspecified coverage) to assign coverage types. Our process for identifying likely Marketplace enrollees pulls people out of this hierarchy by assigning Marketplace coverage to some number of individuals reporting both public and nongroup coverage (but not ESI). The introduction of Marketplace-based nongroup coverage may exacerbate reporting challenges given the hybrid public-private structure of the Marketplaces and the close coordination of Marketplaces with Medicaid eligibility and enrollment systems. For instance, enrollment through the Marketplace is reported at higher rates in the HRMS and in the National Health Interview Survey than would be expected based on administrative enrollment totals (Blavin et al. 2016; Martinez et al. 2016). To address this challenge, we developed a process for identifying likely Marketplace enrollees in the HRMS that relies on multiple data elements, including reported coverage type or types, health plan or insurance company name, state of residence, and family income as a percentage of FPL.<sup>4</sup> This approach is described in detail in the technical appendix of a paper by Blavin et al. (2016).

Our measures of health care access include having a usual source of care; having had a routine checkup in the past 12 months; having had trouble getting a timely doctor's appointment in the past 12 months; and having had trouble finding a doctor as a new patient in the past 12 months.

Our measures of health care affordability are unmet needs for medical care, general doctor care, specialist care, prescription drugs, or tests, treatment, or follow-up care in the past 12 months because of affordability; problems paying family medical bills in the past 12 months; family out-of-pocket health care costs of \$1,500 or more in the past 12 months; and an annual per-person deductible of \$1,500 or more for current coverage (nongroup coverage or ESI only).<sup>5</sup>

Our measures of plan satisfaction are the shares of adults who report being very or somewhat dissatisfied with their choice of doctors or other providers, premium paid for coverage, and protection the plan provides against high medical bills. Because respondents had the option to report that they were “neither satisfied or dissatisfied” with aspects of their plan, the percentage that reported being very or somewhat dissatisfied does not imply that the remainder were satisfied. In addition, we recognize that collecting information about satisfaction with various health plan characteristics may be challenging because of widespread problems with health insurance literacy (Blumberg et al. 2013).

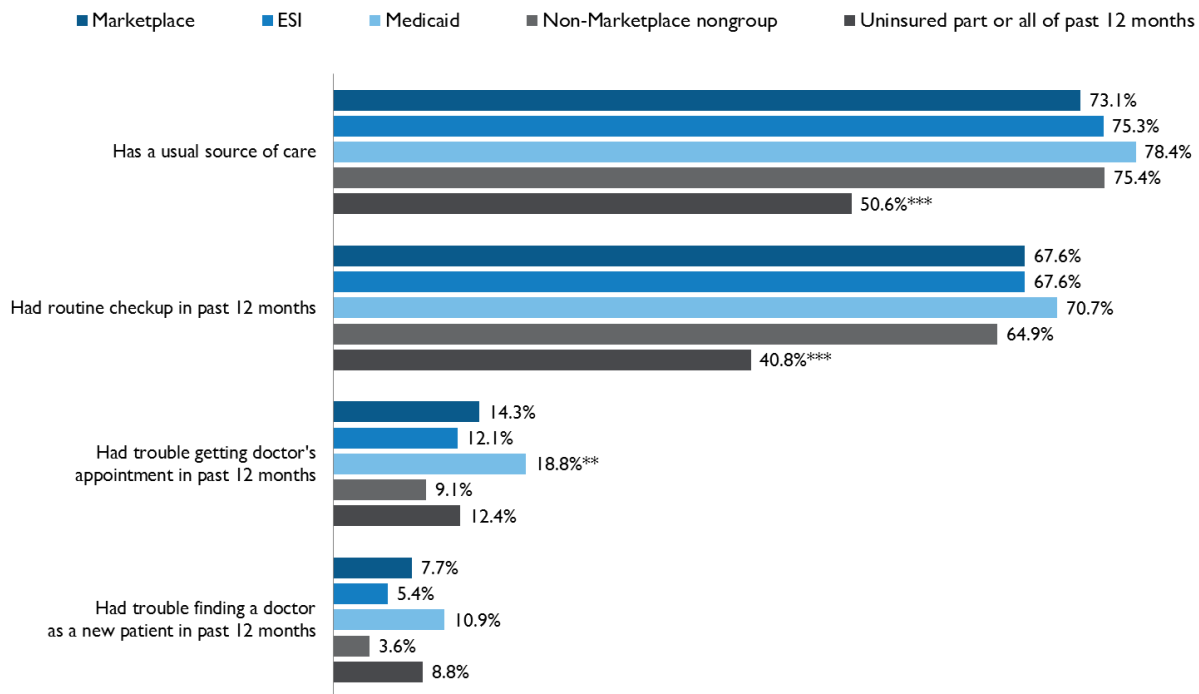
Comparisons across insurance groups are made for low- and moderate-income adults (adults in families with incomes below 400 percent of FPL). No data on those with incomes above 400 percent of FPL are reported in this analysis. The data are regression adjusted to control for income, age, gender, race/ethnicity, health status, educational attainment, marital status, homeownership status, and residence in a metropolitan area. However, 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), because there may still be unmeasured differences related to access, affordability, and plan satisfaction between insurance groups affecting who has a particular type of insurance.

## What We Found

Figure 1 shows that low- and moderate-income adults with any type of insurance coverage, including Medicaid and Marketplace coverage, are more likely to have a usual source of care or to have had a routine checkup in the past 12 months than people who were uninsured for part or all of the year. Among adults who were uninsured part or all of the past 12 months, only 50.6 percent had a usual source of care and 40.8 percent had received a routine checkup. Of those with Marketplace coverage, 73.1 percent had a usual source of care, not significantly different from adults with any other type of coverage. Similarly, the share of those with Marketplace coverage who had a routine checkup in the past year (67.6 percent) was not significantly different from those with ESI, Medicaid, or non-Marketplace nongroup coverage.

Low- and moderate-income adults with Medicaid reported more difficulty getting a timely doctor’s appointment than those with Marketplace coverage (18.8 percent versus 14.3 percent). Marketplace enrollees reported no more difficulty getting an appointment or finding a doctor as a new patient than those with ESI or other nongroup coverage. Although those with Marketplace coverage were no more likely to have trouble getting an appointment or finding a doctor as a new patient than those who were uninsured, the latter are far less likely to attempt to use the health care system. Figure 1 also shows that Medicaid enrollees had more trouble finding a doctor as a new patient than low-and moderate-income Marketplace enrollees (10.9 percent versus 7.7 percent), but this difference was not statistically significant.

**Figure 1. Health Care Access among Adults Ages 18 to 64 with Incomes below 400 Percent of FPL, September 2015**



Source: Health Reform Monitoring Survey, quarter 3 2015.

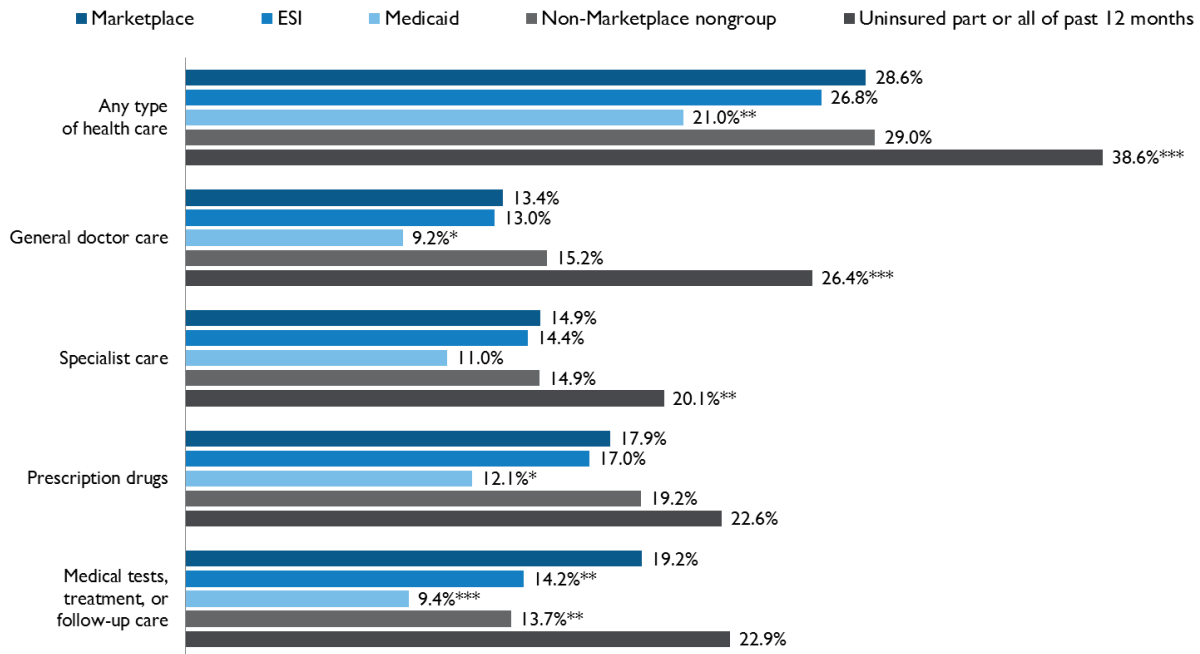
Notes: FPL = federal poverty level; ESI = employer-sponsored insurance. For each coverage type, estimates are shown only for those who had insurance for all of the past 12 months, though some may have switched coverage types during that period. Estimates are regression adjusted.

\*/\*\*/\*\* Estimate differs significantly from adults with Marketplace coverage at the 0.10/0.05/0.01 levels, using two-tailed tests.

Figure 2 shows that rates of unmet need because of affordability over the last year did not vary much among low- and moderate-income adults with some kind of insurance, but rates were typically higher for the uninsured. Those with Marketplace coverage were no more likely to report unmet need for any type of health care because of affordability than those with ESI, with the exception of medical tests, treatment, or follow-up care. Within this category of care, 19.2 percent of Marketplace enrollees had unmet need because of affordability, compared to 14.2 percent of those with ESI.

Relative to Marketplace enrollees, those with Medicaid coverage were significantly less likely to report unmet need for any type of health care because of affordability (21.0 percent versus 28.6 percent), which held true for specific measures such as general doctor care, prescription drugs, and medical tests, treatment, or follow-up care. Marketplace enrollees were significantly less likely to report any type of unmet need because of affordability than those who were uninsured for part or all of the past 12 months. Differences between Marketplace enrollees and the uninsured in unmet need were significant for any type of health care (28.6 percent versus 38.6 percent), general doctor care (13.4 percent versus 26.4), and specialist care (14.9 percent versus 20.1).

**Figure 2. Unmet Health Care Needs in Past 12 Months Because of Affordability among Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, September 2015**



Source: Health Reform Monitoring Survey, quarter 3 2015.

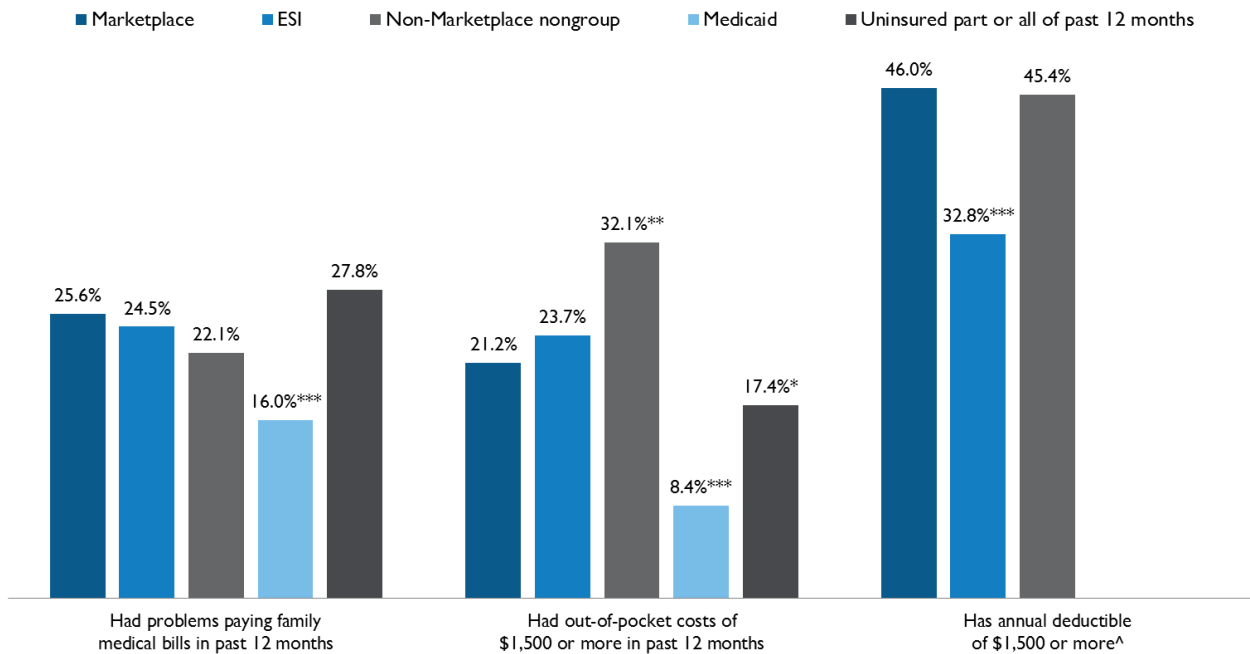
Notes: FPL = federal poverty level; ESI = employer-sponsored insurance. For each coverage type, estimates are shown only for those who had insurance for all of the past 12 months, though some may have switched coverage types during that period. Unmet need for any type of care includes medical care; general doctor care; specialist care; prescription drugs; or tests, treatment, or follow-up care. Estimates are regression adjusted.

\*/\*/\*\* Estimate differs significantly from adults with Marketplace coverage at the 0.10/0.05/0.01 levels, using two-tailed tests.

Figure 3 shows the share of each group that had problems paying family medical bills.<sup>6</sup> Of low- and moderate-income adults with Marketplace coverage, 25.6 percent reported problems paying medical bills in the past year. This is not statistically different from adults with ESI or those with non-Marketplace nongroup coverage, but it was higher than those with Medicaid (16.0 percent). However, the estimated share of adults with Marketplace coverage who reported problems paying medical bills was not statistically different than the share for those who were uninsured part or all of the past 12 months. This may be because the uninsured are less likely to use health care services.

Of adults with Marketplace coverage, 21.2 percent reported having out-of-pocket health care expenses (not including premiums) of over \$1,500 in the previous 12 months. This is not statistically different than those with ESI but is less than those with non-Marketplace nongroup coverage, presumably because of cost-sharing reductions available in the Marketplace. In addition, some adults with non-Marketplace nongroup coverage are covered by non-ACA-compliant plans (i.e., “grandfathered” and “grandmothered” plans), which typically have higher cost sharing. Not surprisingly, out-of-pocket costs for Marketplace enrollees were substantially higher than for adults with Medicaid, with only 8.4 percent of those with Medicaid reporting out-of-pocket costs of more than \$1,500.<sup>7</sup>

**Figure 3. Problems Paying Family Medical Bills, Out-of-Pocket Health Care Costs, and Annual per Person Deductibles among Adults Ages 18 to 64 with Incomes Below 400 Percent of FPL, September 2015**



Sources: Health Reform Monitoring Survey, quarter 3 2015.

Notes: FPL = the federal poverty level; ESI = employer-sponsored insurance. For each coverage type, estimates are shown only for those who had insurance for all of the past 12 months, though some may have switched coverage types during that period. Estimates are regression adjusted.

<sup>^</sup> Estimates not shown for adults with Medicaid or who were uninsured for part or all of the past 12 months.

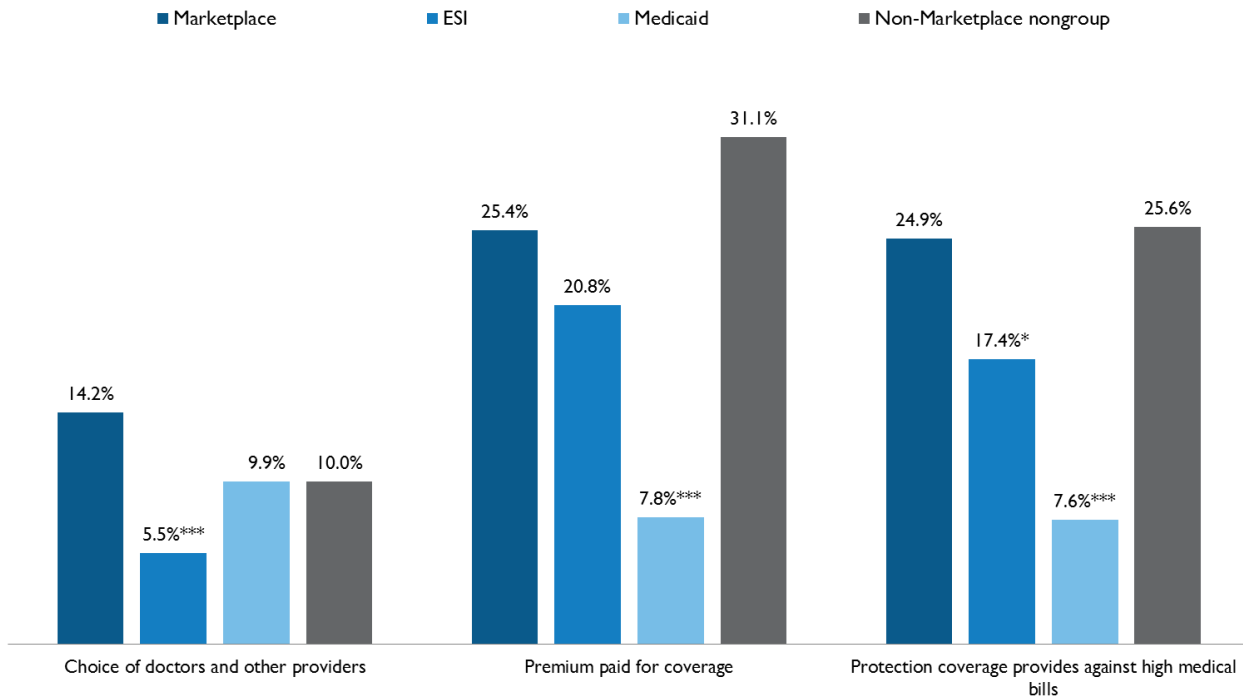
\*/\*/\*\*/\*\*\*\* Estimate differs significantly from adults with Marketplace coverage at the 0.10/0.05/0.01 levels, using two-tailed tests.

Finally, adults with Marketplace coverage were more likely than those with ESI to report facing a deductible of more than \$1,500 (46.0 percent versus 32.8 percent); this would seem to reflect the higher deductibles in silver and bronze Marketplace plans. The typical ESI plan is more similar to a gold Marketplace plan.

In figure 4, we see that low- and moderate-income Marketplace enrollees were more likely to be dissatisfied (14.2 percent dissatisfaction among enrollees) with their choice of doctors and other providers than adults with ESI (5.5 percent). Dissatisfaction with choice of providers among Marketplace enrollees was not statistically different from levels of dissatisfaction among those with Medicaid (9.9 percent) or non-Marketplace nongroup coverage (10.0 percent).

About one-quarter of Marketplace enrollees (25.4 percent) reported being very or somewhat dissatisfied with the premiums they paid, not statistically different from adults with ESI (20.8 percent) and non-Marketplace nongroup coverage (31.1 percent) and substantially more than adults with Medicaid (7.8 percent).<sup>8</sup> In terms of protection against high medical bills, 24.9 percent of these Marketplace enrollees reported being very or somewhat dissatisfied, comparable to those with other nongroup coverage (25.6 percent) but more than those with ESI (17.4 percent) or Medicaid (7.6 percent). Overall, Marketplace enrollees seem generally as satisfied as those with other nongroup coverage but not as satisfied as adults with ESI or Medicaid.

**Figure 4. Share of Insured Adults Ages 18 to 64 with Incomes below 400 Percent of FPL Who Are Very or Somewhat Dissatisfied with Aspects of Their Health Plans, by Coverage Type at Time of Survey, September 2015**



Source: Health Reform Monitoring Survey, quarter 3 2015.  
 Notes: FPL = the federal poverty level; ESI = employer-sponsored insurance. Estimates are regression adjusted.  
 \*/\*\*/\*\* Estimate differs significantly from adults with Marketplace coverage at the 0.10/0.05/0.01 levels, using two-tailed tests.

## What It Means

The intent of the ACA was to expand coverage and reduce the number of uninsured. ACA provisions give states the option of expanding Medicaid eligibility to those with incomes at or below 138 percent of FPL. In all states, the ACA provides subsidized coverage through Marketplaces for those with incomes between 100 and 400 percent of FPL who are not eligible for Medicaid and do not have an affordable offer of ESI. Marketplace plans with the greatest enrollment are not as generous as those offered by employers. Subsidies are tied to the silver tier, which is intended to pay 70 percent of the cost of covered services (not counting cost-sharing reductions); this is less than the typical employer-based plan, which pays for about 80 percent of the cost of covered services.

This brief shows that low- and moderate-income adults with Marketplace coverage seem to be doing as well as might be expected. They fared as well as those with ESI, Medicaid, or non-Marketplace nongroup coverage on having a usual source of care and having had a routine checkup, and they did considerably better than the uninsured on those measures. Their ability to get a timely doctor’s appointment and find a doctor as a new patient over the past 12 months was comparable to those with ESI and non-Marketplace nongroup coverage.

In addition, Marketplace enrollees reported no more unmet need because of affordability for general doctor care, specialist care, and prescription drugs than adults with ESI or non-Marketplace nongroup coverage. They do however report more unmet need because of affordability for medical



tests, treatments, or follow-up care than those groups. Compared with the uninsured, adults with Marketplace coverage were considerably better off by most measures of unmet need because of affordability. Adults with Marketplace coverage were also no more likely to report problems paying medical bills in the past 12 months than those with ESI or non-Marketplace nongroup coverage. They were also no more likely to have out-of-pocket costs above \$1,500 in the past 12 months than those with ESI and less likely to have high out-of-pocket costs than those with non-Marketplace nongroup coverage.

The data also show that adults with Medicaid had similar access and affordability profiles as adults with other types of insurance coverage along several dimensions, including having a usual source of care and having had a routine checkup in the last 12 months. They also had low levels of unmet need because of affordability for medical care, general doctor care, specialist care, prescription drugs, and medical tests, treatments, or follow-up care. Adults on Medicaid also reported relatively low levels of trouble paying medical bills in the past 12 months as well as out-of-pocket costs exceeding \$1,500. Those on Medicaid, however, were more likely than other insured low- and moderate-income adults to have trouble getting a doctor's appointment.

Overall, low- and moderate-income adults enrolled in a Marketplace health plan are considerably better off in terms of access to and affordability of health care than those who are uninsured. They fare as well as adults with ESI or non-Marketplace nongroup coverage on most measures. Low- and moderate-income adults with Medicaid are better off than those with Marketplace coverage in terms of affordability of care, not surprising because of the general absence of premiums and cost sharing, but they do report more trouble getting a doctor's appointment. Further improvements to the ACA would likely require higher provider payment rates in Medicaid and more generous premium and cost-sharing subsidies in Marketplaces.

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## About the Series

This brief is part of a series drawing on the HRMS, a quarterly survey of the nonelderly population that explores the value of cutting-edge Internet-based survey methods to monitor the ACA before data from federal government surveys are available. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit [www.urban.org/hrms](http://www.urban.org/hrms).

## About the Authors

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## Notes

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<sup>1</sup> In addition to the states that have already expanded Medicaid, Louisiana is planning to expand eligibility for Medicaid by mid-2016, and Wisconsin has used state funding to expand eligibility to nonelderly adults with incomes up to 100 percent of FPL. Several states, including California, Connecticut, and Minnesota, as well as the District of Columbia, expanded Medicaid under the ACA before 2013.

<sup>2</sup> Marketplace enrollees with incomes between 200 and 250 percent of FPL also receive cost-sharing reductions that are much more limited than the reductions received by enrollees with lower incomes.

<sup>3</sup> Estimates for adults with non-Marketplace nongroup coverage are relatively imprecise because of a lower sample size for this group.

<sup>4</sup> The income measure used in the HRMS is not the same as the measure of modified adjusted gross income used to determine eligibility for Medicaid and Marketplace tax credits; therefore, estimated levels of family income as a percentage of FPL only provide an approximation of whether respondents are in the income ranges targeted by the Medicaid expansion and Marketplace tax credits.

<sup>5</sup> Some of the measures we examine—problems paying family medical bills and out-of-pocket health care costs of \$1,500 or more in the past 12 months—may be related to family members other than the insured adult whose type of coverage is used in this brief.

<sup>6</sup> Our measure of problems paying family medical bills includes bills for dental care, which may not be a covered service for adults with Medicaid depending on their state of residence.

<sup>7</sup> Although Medicaid beneficiaries are subject to little or no cost sharing, the measure of out-of-pocket health care costs for the previous year used in this analysis is reported for the entire family and not only the respondent reporting Medicaid. Therefore, reported out-of-pocket costs may have been incurred by another family member who was covered by a different type of insurance or who did not have coverage. In addition, some adults reporting Medicaid at the time of the survey may have had other coverage during the previous year when they incurred high out-of-pocket costs. In some instances, adults with another form of coverage may spend down their income on health care to the point where they

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qualify for Medicaid based on criteria for being medically needy. Adults reporting family out-of-pocket health care costs for the previous year may also be subject to recall error and other forms of measurement error, which may be exacerbated by limited understanding of basic health insurance terms among lower-income adults. Finally, the regression-adjusted share of Medicaid beneficiaries with high out-of-pocket costs is higher than the unadjusted share. In order to assess the validity of our estimated share of adults with Medicaid, we benchmarked these results to a similar measure using the March 2015 Current Population Survey and found the estimates from the two surveys to be comparable.

<sup>8</sup> Most Medicaid beneficiaries are not subject to premiums, and those that are have their premiums capped at a low level. Although it was surprising that 7.8 percent of low- and moderate-income adults with Medicaid were very or somewhat dissatisfied with their premiums, 71.8 percent of Medicaid beneficiaries were satisfied and 19.6 percent were neither satisfied nor dissatisfied. The remaining 0.9 percent did not report their level of satisfaction with their premiums. In addition, about one-third of adults with Medicaid reported they were not too confident or not at all confident in their understanding of premiums (data not shown).