

The State of Washington's Uninsured 2014-2015

An examination of the health insurance market before and
after the Affordable Care Act

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www.insurance.wa.gov

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1.0 EXECUTIVE SUMMARY

In January 2014, the Office of the Insurance Commissioner (OIC) issued a baseline report on the state of the uninsured in Washington state. Now, after implementation of the Affordable Care Act (ACA), we take a detailed look at how far the state has come in providing access to health insurance and the challenges that remain. The ACA expanded access to health insurance throughout our state, across all races and income groups, and in both urban and rural areas. Since 2012, more than 300,000 people have gained health insurance.

Key Findings

Washington state's uninsured rate was 8.2 percent in 2014 dropping from 13.9 percent at the end of 2012. The rate is expected to continue declining to 7.3 percent by the end of 2015. *(The estimate is preliminary and will be updated later this year when additional data become available).*

- The greatest gains were made in Adams, Yakima, and Grays Harbor counties.
- Kitsap county had the lowest uninsured rate at 5.6 percent while Kittitas county had the highest at 14.5 percent.
- Those who remain uninsured are more likely to be age 18 to 34, lower income, less educated, and predominantly Caucasian and Hispanic.
- The gains in coverage are tied to a number of provisions within the ACA, including most significantly:
 - Federal premium subsidies for nearly 120,000 Washingtonians.
 - The popular provision to keep young adults on their parents' health plan up to age 26.
- Specific decisions made in Washington state were instrumental to our success, such as:
 - The creation of Washington's state-based Exchange, Washington Healthplanfinder, which helped 157,500 people get covered.
 - Adopting Medicaid expansion which resulted in 680,000 people gaining coverage.
- The amount of uncompensated care costs decreased from \$2.35 billion in 2013 to \$1.2 billion in 2014.

Despite remarkable progress, many people still struggle to afford health insurance and some face significant barriers to accessing care. Insurers are taking a number of measures to keep premiums low, including increasing out-of-pocket costs. More must be done to improve consumer education about health insurance and the trade-offs that occur when selecting a health plan.

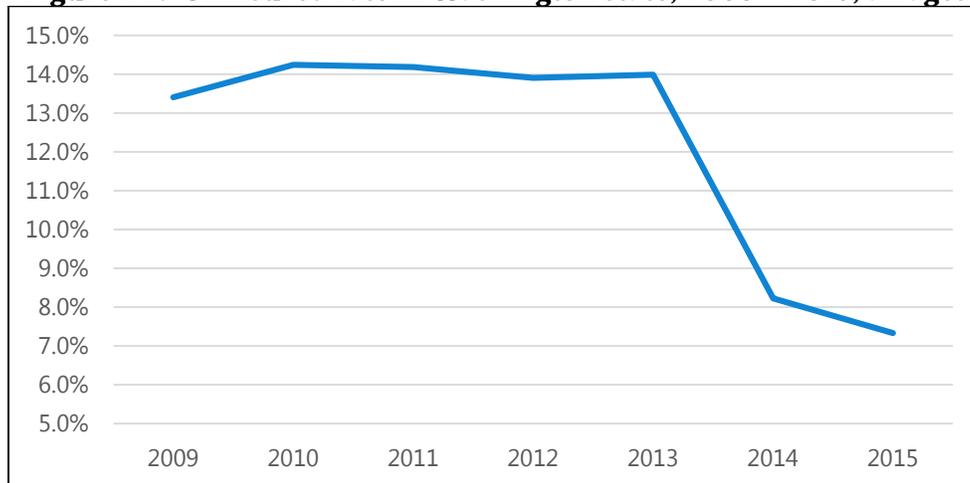
This report highlights critical areas for policymakers and stakeholders to consider when studying the changing health care landscape and the challenges that remain.

2.0 UNINSURED POPULATION

Before the Affordable Care Act took effect, nearly 1 million Washingtonians were uninsured. This trend was certain to continue as long as insurance companies could deny people coverage based on their health status; employers were not required to provide health coverage; and the individual market was prohibitively expensive for low- and middle-income consumers. Even if people could afford coverage, health plans often lacked meaningful benefits, such as prescription drug and maternity coverage.

The ACA and its reforms helped reduce the number of uninsured in Washington state from 13.9 percent at the end of 2012 to 8.2 percent in 2014. (See Figure 2-1). Preliminary data suggest that the uninsured rate dropped to 7.3 percent in 2015.

Figure 2-1. Uninsured rate in Washington state, 2009 – 2015, all ages



Source: OIC estimate; OFM, Population Estimates and ACS adjustment, 2016; U.S. Census Bureau, 1-Year ACS 2009-2014.

All demographic groups throughout the state saw a decrease in the number of uninsured, including rural and urban areas, young and elderly, and all races and ethnicities. Regional and demographic trends are discussed in Sections 2.1 and 2.2 of this report.¹

2.1 UNINSURED RATES BY COUNTY

Uninsured rates vary significantly from county to county, with urban counties generally having lower rates of uninsured than rural counties. Table 2-1 provides a county-by-county estimate of the uninsured rate as of 2014, the latest year for which county-level data are available.

¹ Because 2015 year-end company filings are not currently available, we are unable to fully analyze the health insurance marketplace in 2015 at this time. When data are available, this report includes 2015 estimates and analysis. In other instances, the report relies on 2014 data.

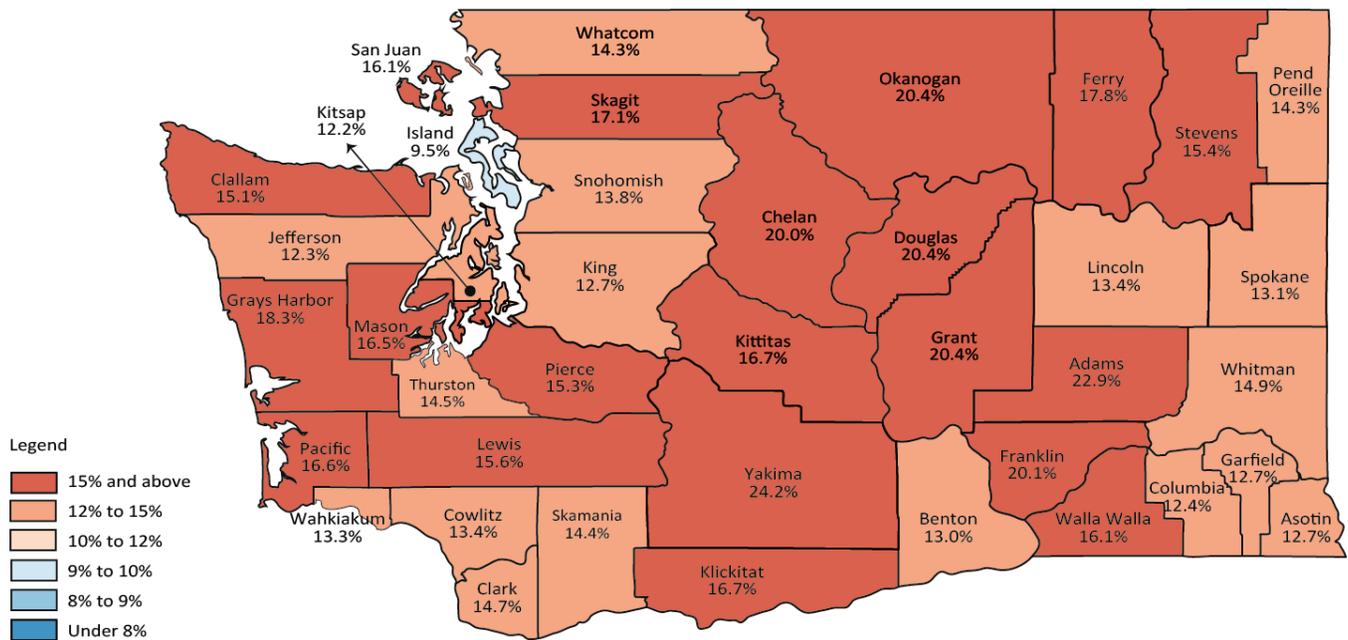
Table 2-1. Uninsured population by region and county, 2012 and 2014

County	2012			2014			Change in Percent Uninsured
	Population	Uninsured	Percent Uninsured	Population	Uninsured	Percent Uninsured	
Adams	19,050	4,356	22.9%	20,334	2,052	10.1%	-12.8%
Asotin	21,700	2,746	12.7%	22,040	1,992	9.0%	-3.7%
Benton	180,000	23,397	13.0%	182,713	21,258	11.6%	-1.4%
Chelan	73,200	14,625	20.0%	74,854	9,297	12.4%	-7.6%
Clallam	72,000	10,868	15.1%	72,266	8,087	11.2%	-3.9%
Clark	431,250	63,427	14.7%	441,902	38,446	8.7%	-6.0%
Columbia	4,100	507	12.4%	4,060	347	8.6%	-3.8%
Cowlitz	103,050	13,805	13.4%	104,595	9,532	9.1%	-4.3%
Douglas	38,900	7,919	20.4%	40,237	4,913	12.2%	-8.2%
Ferry	7,650	1,362	17.8%	7,638	987	12.9%	-4.9%
Franklin	82,500	16,621	20.1%	85,892	10,941	12.7%	-7.4%
Garfield	2,250	286	12.7%	2,246	193	8.6%	-4.1%
Grant	91,000	18,582	20.4%	94,724	12,843	13.6%	-6.8%
Grays Harbor	73,150	13,401	18.3%	73,581	6,888	9.4%	-8.9%
Island	79,350	7,526	9.5%	80,197	7,771	9.7%	0.2%
Jefferson	30,175	3,707	12.3%	30,569	2,970	9.7%	-2.6%
King	1,957,000	248,414	12.7%	1,991,383	133,102	6.7%	-6.0%
Kitsap	254,500	31,096	12.2%	259,582	14,501	5.6%	-6.6%
Kittitas	41,500	6,912	16.7%	42,584	6,194	14.5%	-2.2%
Klickitat	20,600	3,443	16.7%	20,741	2,262	10.9%	-5.8%
Lewis	76,300	11,913	15.6%	77,555	9,451	12.2%	-3.4%
Lincoln	10,675	1,433	13.4%	10,743	908	8.4%	-5.0%
Mason	61,450	10,165	16.5%	62,780	5,560	8.9%	-7.6%
Okanogan	41,425	8,451	20.4%	42,232	5,172	12.2%	-8.2%
Pacific	20,970	3,489	16.6%	21,092	1,783	8.5%	-8.1%
Pend Oreille	13,100	1,868	14.3%	13,267	1,497	11.3%	-3.0%
Pierce	808,200	123,761	15.3%	822,561	68,453	8.3%	-7.0%
San Juan	15,925	2,566	16.1%	15,962	1,241	7.8%	-8.3%
Skagit	117,950	20,165	17.1%	120,831	12,834	10.6%	-6.5%
Skamania	11,275	1,624	14.4%	11,315	1,299	11.5%	-2.9%
Snohomish	722,900	99,902	13.8%	741,005	57,579	7.8%	-6.0%
Spokane	475,600	62,203	13.1%	484,973	36,782	7.6%	-5.5%
Stevens	43,700	6,731	15.4%	44,270	5,127	11.6%	-3.8%
Thurston	256,800	37,182	14.5%	263,213	18,819	7.1%	-7.4%
Wahkiakum	4,025	534	13.3%	3,959	273	6.9%	-6.4%
Walla Walla	59,100	9,543	16.1%	59,784	7,773	13.0%	-3.1%
Whatcom	203,500	28,999	14.3%	208,030	14,846	7.1%	-7.2%
Whitman	45,950	6,842	14.9%	45,945	5,677	12.4%	-2.5%
Yakima	246,000	59,431	24.2%	253,045	29,228	11.6%	-12.6%
Washington State	6,817,770	989,802	14.5%	6,954,702	578,876	8.3%	-6.2%

Source: OFM, Population Estimates, 2013; U.S. Census Bureau, 1-Year ACS 2012; U.S. Census Bureau, SAHIE 2011; OFM County Population Estimation Model, January 2016 update using the 2014 American Community Survey, adjusted for Medicaid undercount

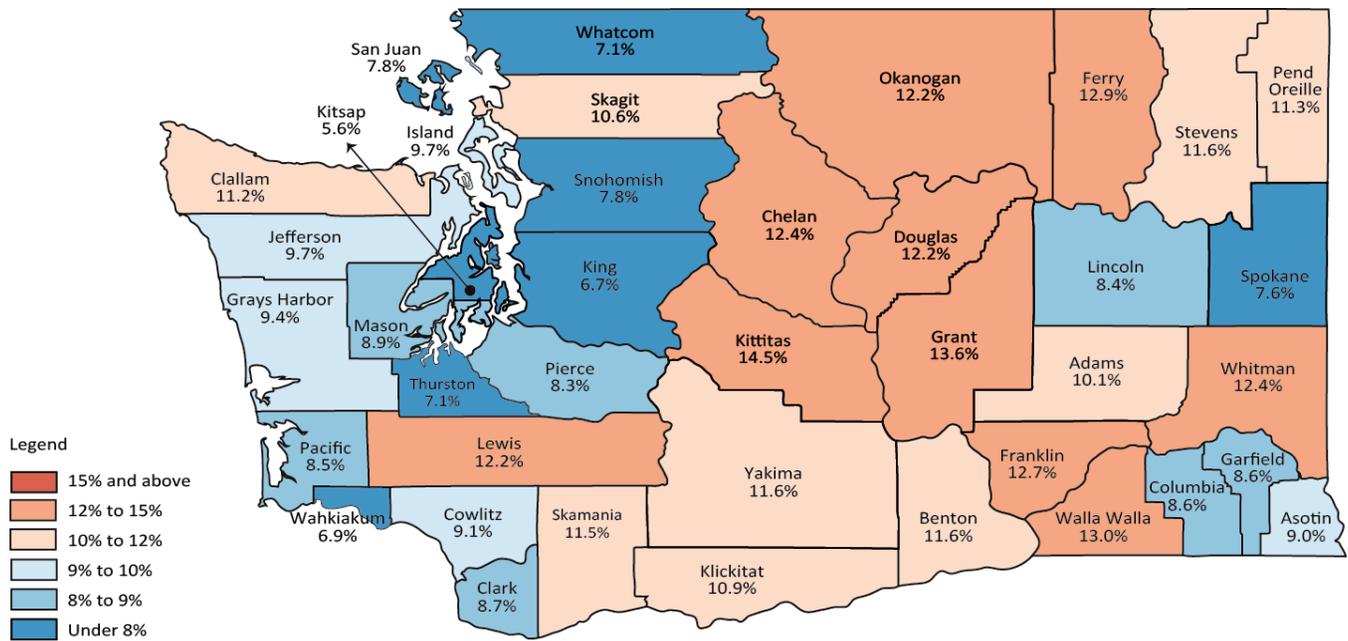
State maps showing the change in the uninsured rate also depict county-by-county gains in health coverage due to the ACA (Figures 2-2 and 2-3).

Figure 2-2. Uninsured population by county, 2012



Source: OFM, Population Estimates, 2013; U.S. Census Bureau, 1-Year ACS 2012; U.S. Census Bureau, SAHIE 2011.

Figure 2-3. Uninsured Population by County, 2014



Source: OFM County Population Estimation Model, January 2016 update using the 2014 American Community Survey, adjusted for Medicaid undercount

As noted above, all counties saw significant improvements in health coverage. In 2014, the state’s lowest uninsured rate was in Kitsap County at 5.6 percent while the highest rate was in Kittitas County at 14.5 percent.

2.2 WHO ARE THE UNINSURED?

The remaining uninsured in Washington state represent a wide range of demographics and socioeconomic statuses. The ACA took an incremental approach to expanding health coverage options, filling in gaps in the existing insurance system versus providing universal coverage. If the trends continue, we expect the uninsured rate to continue to drop over the next several years and likely plateau to a level representing those who are unable or choose not to enroll in health insurance.

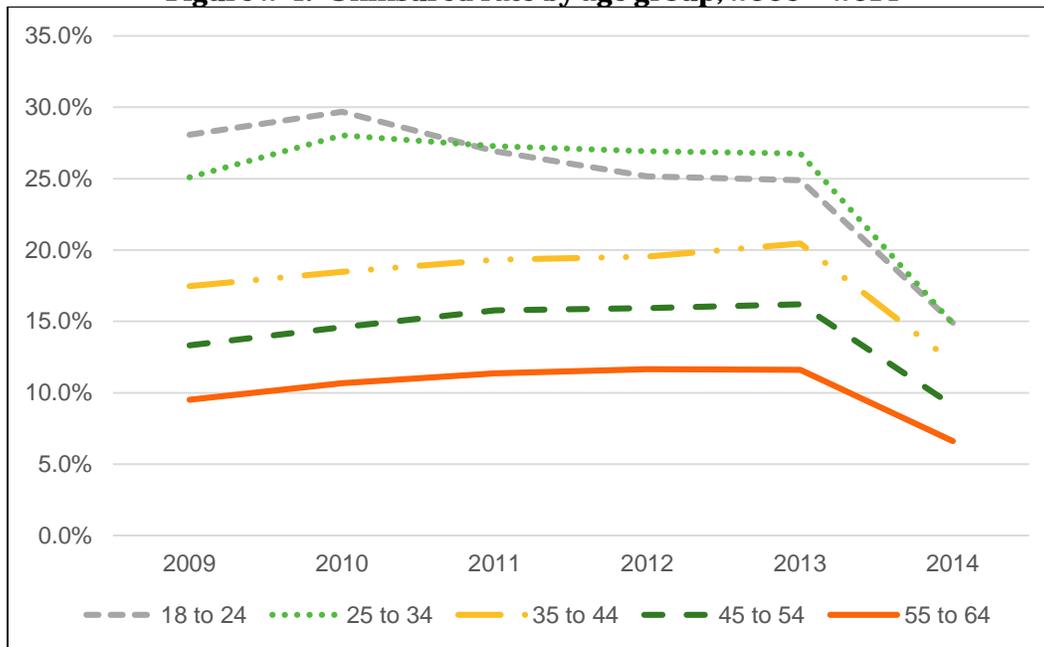
By Age

In 2014, the uninsured rate declined significantly for all age groups. (Figure 2-4). From 2010 to 2014:

- The 18-24 age group showed the largest drop from a high of 29.7 percent to 14.9 percent.
- The 25-34 age group experienced a decline of 13.2 percent to 14.8 percent.
- The 55-64 age group dropped by 4 percent.

While they had the greatest declines, the 18-24 age group and 25-34 age group still have a high combined number of uninsured at 14.9 percent. This is 6.6 percentage points higher than the uninsured rate for *all* age groups.

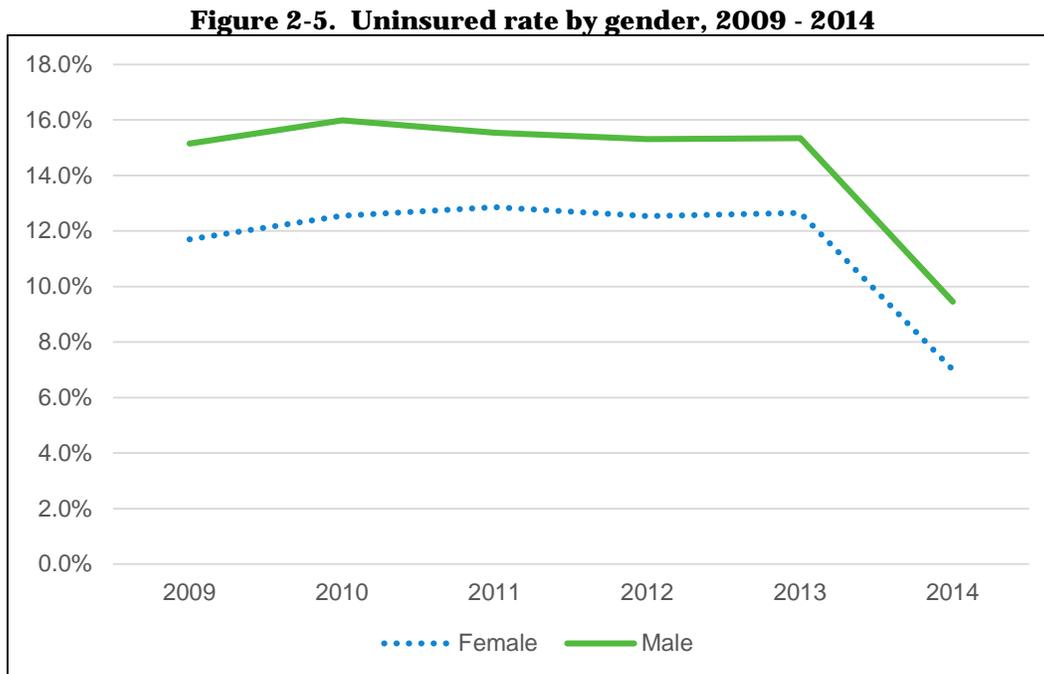
Figure 2-4. Uninsured rate by age group, 2009 – 2014



Source: U.S. Census Bureau, 1-Year ACS 2009 – 2013; OFM: 2014 American Community Survey, adjusted for Medicaid undercount, January 2016

By Gender

Figure 2-5 displays the uninsured rates by gender between 2009 and 2014. Women have historically had higher rates of coverage than men. However, between 2009 and 2014, the coverage gap declined from 3.4 percent to 2.5 percent. This reflects improvements in the economy as well as increased availability of health coverage under the ACA.

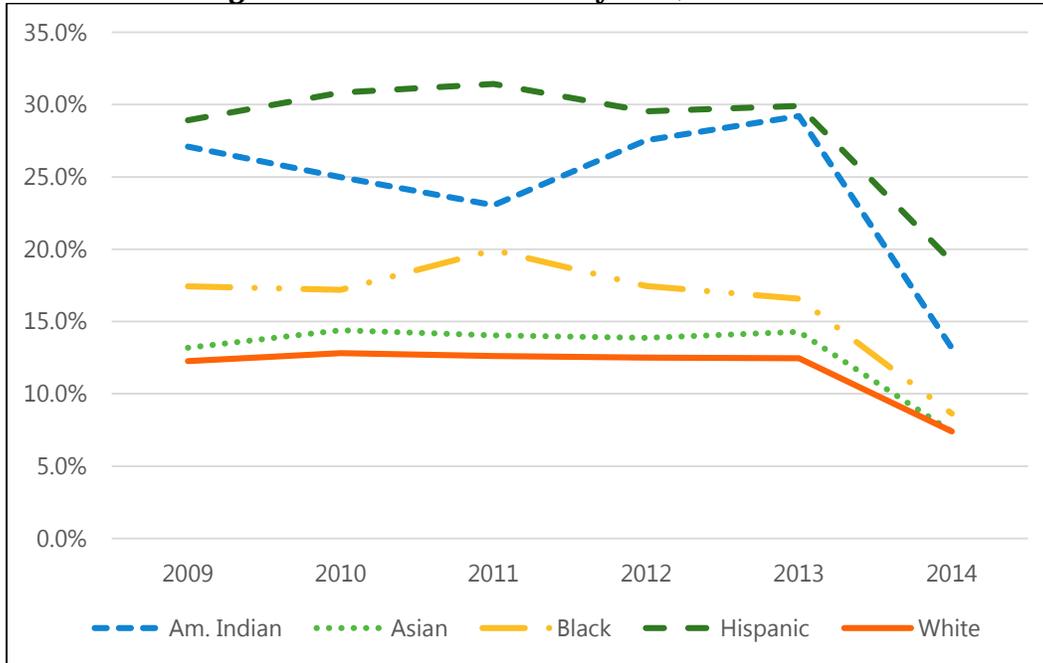


Source: U.S. Census Bureau, 1-Year ACS 2009 – 2013; OFM: 2014 American Community Survey, adjusted for Medicaid undercount, January 2016.

By Ethnicity/Race

Figure 2-6 displays the uninsured rate by ethnicity between 2009 and 2014. There have been significant improvements among all races, but disparities remain. For example, Hispanics continue to have a high uninsured rate of 19.2 percent, compared to the uninsured rate for Caucasians which has dropped to 7.4 percent.

Figure 2-6. Uninsured rate by race, 2009 – 2014

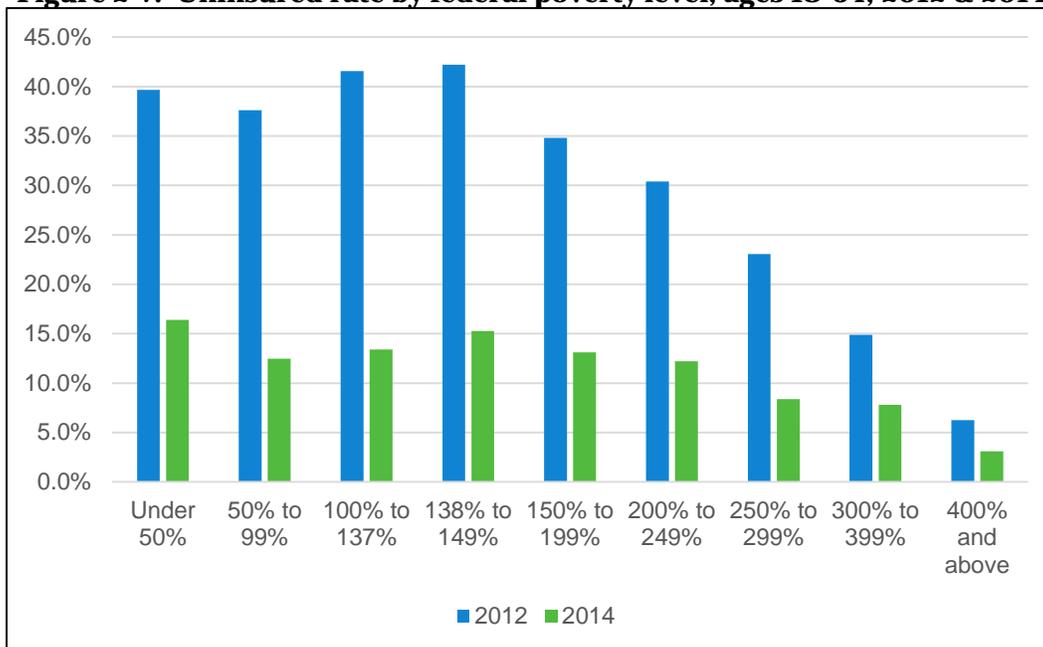


Source: U.S. Census Bureau, 1-Year ACS 2009 – 2013; OFM: 2014 American Community Survey, adjusted for Medicaid undercount, January 2016.

By Income

Figure 2-7 displays the uninsured rate by income for 2012 and 2014. Individuals with all income levels experienced an improvement in the uninsured rate. However, those earning between 100 percent to 137 percent of the Federal Poverty Level (FPL) saw the biggest drop at 28.2 percent due to the expansion of Medicaid.

Figure 2-7. Uninsured rate by federal poverty level, ages 18-64, 2012 & 2014



Source: U.S. Census Bureau, 1-Year ACS 2009 – 2013; OFM: 2014 American Community Survey, adjusted for Medicaid undercount, January 2016.

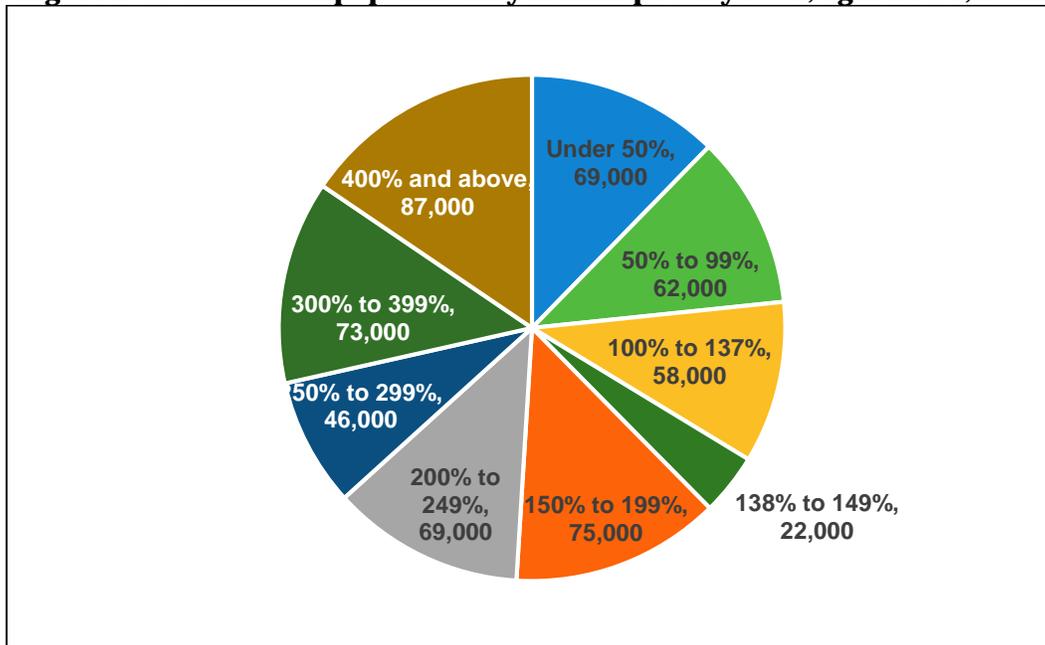
For reference, the FPL levels for a household of four are noted in Table 2-2.

Table 2-2. Federal poverty level for a family of four, 2014

FPL	Household Income
50%	\$11,925
100%	\$23,850
138%	\$32,913
150%	\$35,775
200%	\$47,700
250%	\$59,625
300%	\$71,550
400%	\$95,400

Figure 2-8 provides another way to understand the remaining uninsured population, broken out by percentage of the FPL.

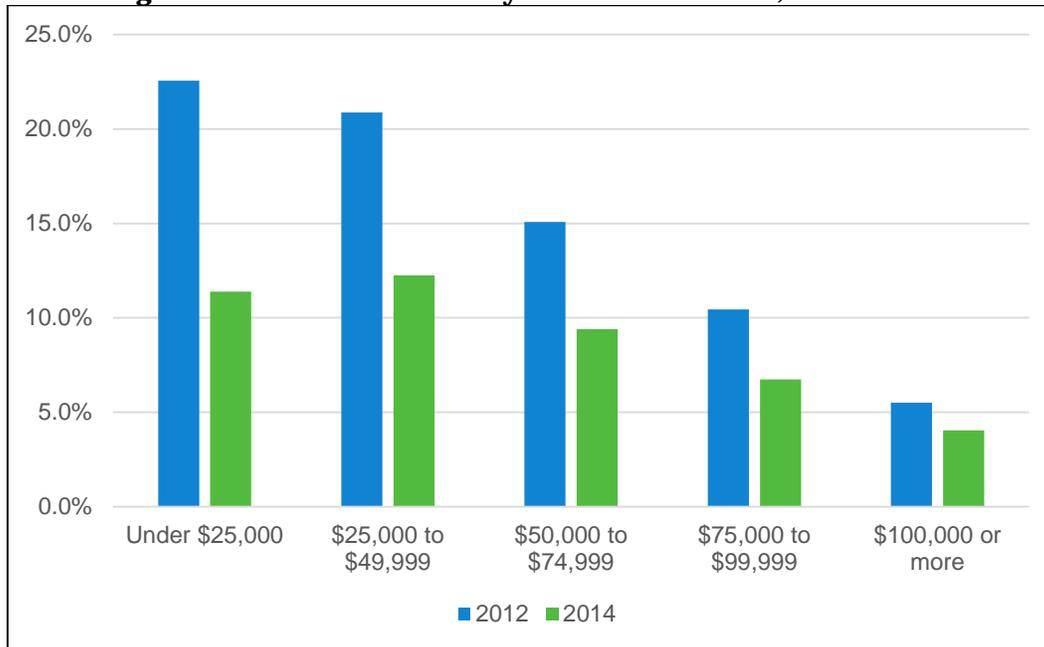
Figure 2-8. Uninsured population by federal poverty level, ages 18-64, 2014



Source: OIC estimate based on OFM: 2014 American Community Survey, adjusted for Medicaid undercount, January 2016.

Figure 2-9 displays the uninsured rate by household income for 2012 and 2014. All groups experienced improvement in the uninsured rate. The under \$25,000 group had the largest drop in the uninsured rate (11.2 percentage points) followed by the \$25,000 to \$49,999 group (8.6 percentage points).

Figure 2-9. Uninsured rate by household income, 2012 & 2014



Source: U.S. Census Bureau, 1-Year ACS 2012, 2014 American Community Survey, adjusted for Medicaid undercount, January 2016.

3.0 ACA COVERAGE EXPANSIONS

This section details the various provisions of the ACA that helped improve access to coverage. The Affordable Care Act built on an existing structure of how people get health coverage and with the exception of Medicare, expanded access within each category of coverage. Support for employer-sponsored coverage increased and Medicaid eligibility expanded. Also, subsidies, improved coverage, and the individual mandate all encouraged people to buy individual health plans inside or outside of the state's exchange, Washington Healthplanfinder.

3.1 COVERAGE EXPANSIONS

Health Care Exchanges

The ACA created exchanges (or marketplaces) where individuals, families, and small businesses can purchase health coverage. For those who qualify, subsidies are available to reduce monthly premiums or out-of-pocket costs. States were allowed to either establish their own exchange or join the federal marketplace.² Washington operates its own state-based exchange called Washington Healthplanfinder, an online portal that allows consumers purchasing individual coverage to compare health plans and determine whether they qualify for subsidies or Medicaid, all in one place. Washington's exchange has had a powerful impact on the uninsured rate, especially through its unprecedented outreach and enrollment efforts. As of September, 2015, it had 152,517 enrollees.³

Federal Subsidies

The ACA targeted the high cost of buying health insurance by creating subsidies which help people in two ways:

- 1) Individuals with incomes between 139 – 400 percent of the Federal Poverty Level may qualify for a subsidy if they buy a Qualified Health Plan (QHP) through the Exchange. Subsidies are paid directly to a consumer's insurance company to reduce their monthly premium. According to Washington's Exchange, 119,969 people, representing 79 percent of those enrolled in a QHP through the Exchange qualified for a premium subsidy as of September, 2015.³
- 2) Individuals with incomes of less than 250 percent FPL who enroll in a silver-level plan may be eligible for cost-sharing subsidies to lower out-of-pocket costs. As of September, 2015, a total of 66,055 exchange enrollees received cost-sharing subsidies totaling \$5,121,635.³

² As of the drafting of this report, there are various types of federally-based marketplaces: a marketplace wholly run by the federally facilitated marketplace, state-partnership marketplace, and federally-supported state-based marketplaces.

³ Washington Health Benefit Exchange, Health Coverage Enrollment Report, September 2015.

Medicaid Expansion

The ACA expanded Medicaid eligibility to include non-disabled, non-pregnant adults under age 65 with a household income of up to 138 percent of the FPL. This expansion filled a major gap in our health care system by extending Medicaid eligibility to nearly all low-income adults.

A 2012 Supreme Court decision, *NFIB v. Sebelius*, found that Medicaid expansion was optional for states. In 2013, the Washington State Legislature passed a law expanding Washington's Medicaid program. At the time, the state Health Care Authority (HCA) estimated there were 1.04 million potential new Medicaid enrollees.⁴ This projection included both newly-eligible individuals and those already eligible but not enrolled. Of the 1.04 million potential new enrollees, the HCA estimated that only 328,000 people would enroll by 2018. Contrary to this projection, as of December 2015 more than 1.7 million individuals enrolled in Medicaid⁵ representing an increase of more than 680,000 since 2012.

Individual Mandate

Under the ACA, everyone is required to buy health insurance if they can afford to do so. This ensures that both good and bad risk – healthy and sick people – are included in insurance pools. The individual mandate is a pillar of the ACA and encourages a shared responsibility that helps to keep coverage affordable.

Most U.S. citizens and legal residents must have qualifying health insurance that meets a minimum standard of coverage or pay a fine on their federal income taxes. The fine is called the "shared responsibility payment," also commonly known as the individual mandate. The amount of the fine is either a percentage of income or a flat dollar amount, whichever is greater. The penalty for 2015 is 2 percent of a person's income or \$325.

Exemptions from having coverage exist and apply to people who are unable to afford insurance, people who go without health insurance coverage for less than three consecutive months, or other circumstances detailed in the law.⁶ Although controversial, the individual mandate has been instrumental in encouraging people to get health coverage.

Employer Mandate

The ACA requires large employers – those with 50 or more full-time or full-time equivalent employees in the preceding year – to offer health coverage to their employees, or pay a fine. This fine is called the "employer shared responsibility payment," also commonly known as the employer mandate. The coverage must be "affordable" and meet "minimum value," as defined by the law. If a large employer

⁴ Health Care Authority, Report to Senate Health Care Committee "2014 Medicaid Expansion Overview" January 22, 2013 available at http://www.hca.wa.gov/documents/legislative/012213_senate_health_hca_overview_medicaid_expansion.pdf.

⁵ Excludes coverage that is not comprehensive coverage and individuals eligible for Medicare.

⁶ More information about the shared responsibility payment exemptions and the employer coverage mandate can be found at the Internal Revenue Service's website, <https://www.irs.gov/Affordable-Care-Act>.

does not offer any coverage or offers unaffordable coverage, penalties may apply when at least one employee enrolls in a QHP through the exchange and receives a subsidy.

Under the ACA, small businesses with 25 or fewer employees may be eligible for a tax credit to help cover the cost of providing health insurance to their employees. To qualify, an employer must purchase coverage through the Small Business Health Options Program (SHOP) marketplace. In Washington, the state operates its own small business exchange, called Washington Healthplanfinder Business.

Keeping Children on Parents' Plan until Age 26

Under the ACA, if a parent's health plan covers dependents, children may remain on the plan until age 26. Before the ACA, health insurers could remove a child at age 19 or older if the child was a full-time student. This contributed to young adults having the highest number of uninsured of any age group. The ACA makes it easier and more affordable for people under age 26 to keep health insurance and contributed to the large drop in uninsured in the 18-24 age group in Washington.

3.2 BETTER COVERAGE

In addition to market reforms, the ACA requires health insurers to deliver better value to consumers. No one can be denied health insurance because of a pre-existing condition, caps on lifetime benefits are prohibited, and insurers must spend more on delivering care than on administrative costs. Previously, most individual health plans did not include critical coverage for prescription drugs or maternity. Now, all individual and small employer health plans must cover 10 essential health benefits.⁷

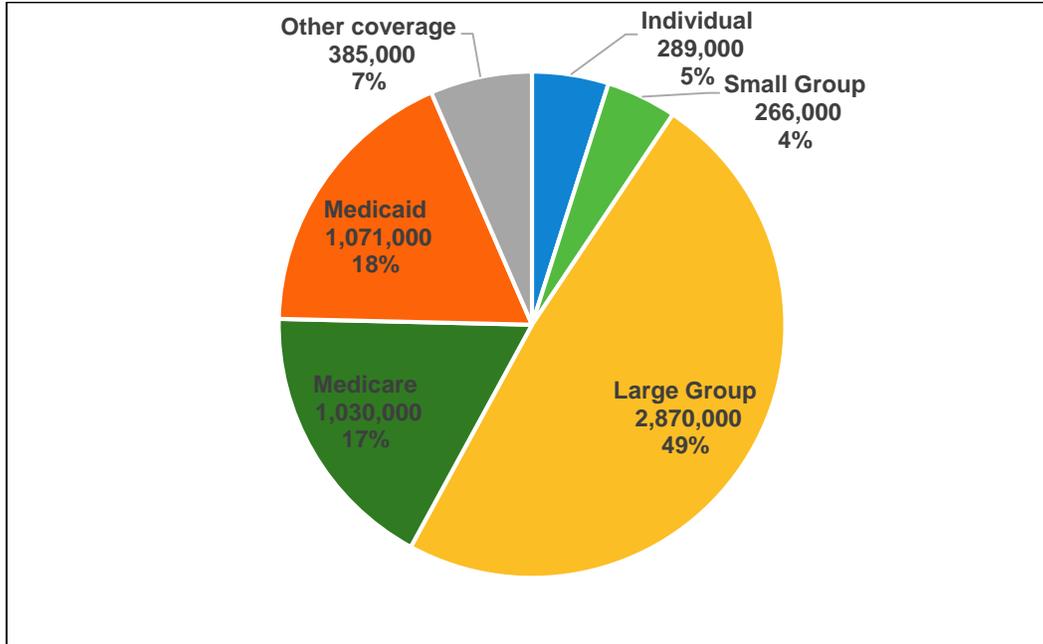
3.3 SOURCE OF HEALTH COVERAGE

Employer-sponsored coverage remains the dominate source of health insurance for most people. More than half of insured residents get their coverage through their employer, including dependents. Medicaid is the second most common source of coverage and has increased due to its expansion. Medicare is a growing source of coverage in Washington state due in large part to an aging population. The remaining sources of coverage include the individual market and military coverage.

Figures 4-1 and 4-2 show how the distribution of coverage types has changed from 2012 to 2014.

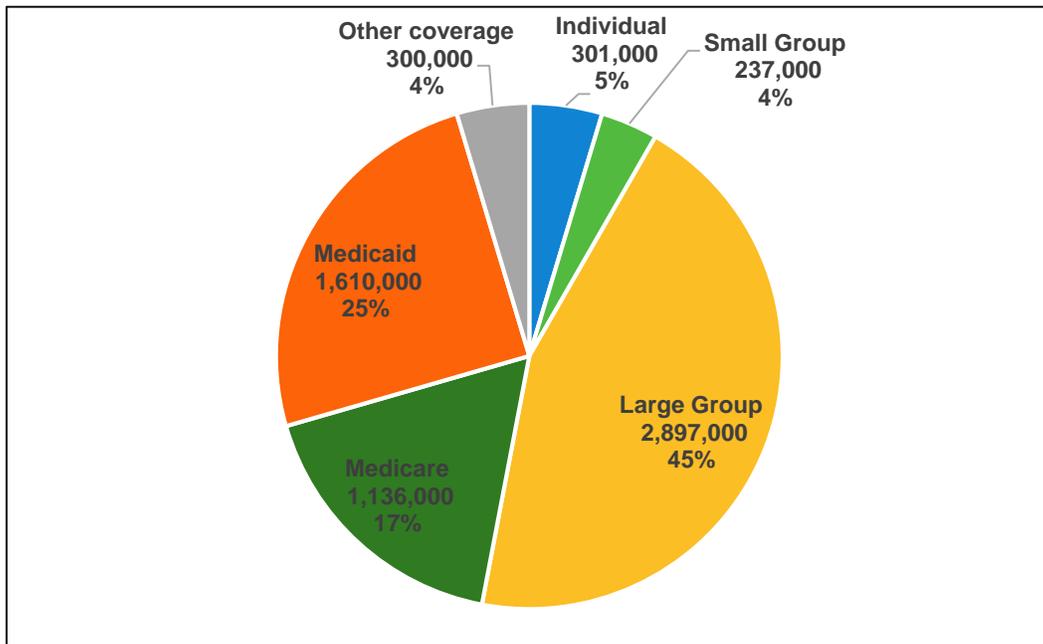
⁷ Essential Health Benefits include outpatient care, hospitalization, emergency care, maternity and newborn care, mental health and substance disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision).

Figure 4-1. Source of health insurance coverage, 2012



Source: OIC estimate based on company filings, HCA Medicaid data, and U.S. Census Bureau, 1-Year ACS 2012

Figure 4-2. Source of health insurance coverage, 2014



Source: OIC estimate based on company filings, HCA Medicaid data, and 2014 American Community Survey, adjusted for Medicaid undercount, January 2016.

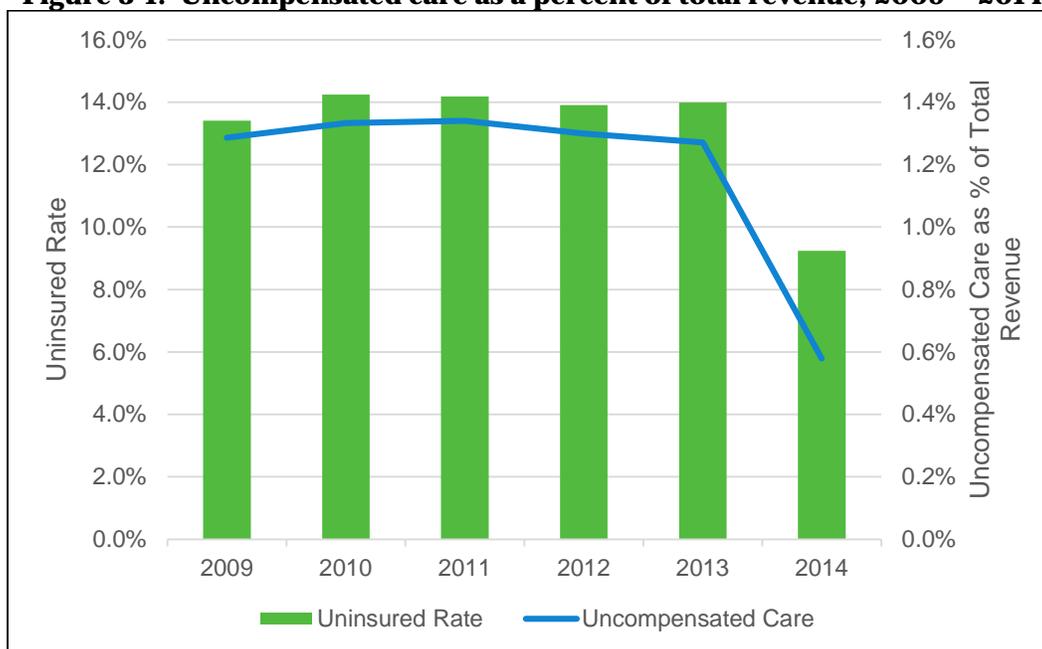
4.0 UNCOMPENSATED CARE

The ACA significantly lowered the amounts of uncompensated care in Washington state. Prior to 2014, many uninsured individuals would wait until they were very sick or suffered an emergency to enter the health care system and often did so through emergency rooms. Federal and state laws prohibit emergency departments from denying care and provide support for defraying the costs associated with treating the uninsured. Many of these patients could not afford the ensuing medical bills, which amounted to large, unpaid medical debt. As a result of providing this care to uninsured patients, hospitals provided significant amounts of uncompensated care.⁸

The financial consequences of uncompensated care impact all health care consumers. Medical providers shift these costs to insured patients, which results in higher premiums from insurance companies. Uncompensated care costs also have a significant impact on government budgets. In 2013, state and local governments provided approximately 37 percent of uncompensated care funding, totaling \$19.8 billion.⁹

The ACA and its focus on improving access to coverage was predicted to positively impact the amounts of uncompensated care, and the data confirm that prediction. In 2014, the ratio of uncompensated care to total hospital revenue dropped to 0.6 percent, the lowest level in all years for which data are available (Figure 3-1). The large decline from \$2.35 billion (1.3 percent of total revenue) in 2013 to \$1.20 billion (0.6 percent) in 2014 is likely attributed to the reduction in the uninsured population in the state.

Figure 3-1. Uncompensated care as a percent of total revenue, 2009 – 2014



Source: DOH, Community Hospital Quarterly Files, 2009 – 2014; Hospital Income Statements, 2009 – 2014.

⁸ Uncompensated care is defined as the sum of both “bad debt” and charity care provided by the hospital or health care provider.

⁹ Coughlin, T.A., Holahan, J., Caswell, K, McGrath, M., “Uncompensated Care for Uninsured in 2013: A Detailed Examination.” Kaiser Family Foundation.

5.0 EMERGING ISSUES

While the ACA made health coverage available to nearly all Washington residents, challenges remain regarding affordability, access, and the underlying cost of care. The following narrative is a high-level overview of notable trends.

RISING COSTS OF HEALTH CARE

A recent report from the Centers for Medicare and Medicaid Services (CMS) highlights the increasing cost of health care. CMS reported that national health care spending increased by 4.5 percent per capita in 2014, representing faster growth than in the previous five years.¹⁰ The underlying cost of health care is of significant concern to health insurers because they must accurately predict health care utilization in order to keep premiums low and gain market share while remaining profitable.

Historically, health insurers used medical underwriting to exclude unhealthy individuals from coverage. The ACA ended this practice by prohibiting insurers from denying people coverage because of pre-existing conditions. Now, health insurers are employing other methods of managing risk, including using narrower provider networks, increasing utilization management, managing prescription drug benefits, and increasing consumers' out-of-pocket costs. We are continuing to monitor actions insurers take to curb increased costs, especially when there is a potential impact on consumers' access to care.

Health insurers have limited methods to control the cost of health care coverage. They can raise premiums, increase out-of-pocket costs, or generally manage the health care that their members receive. Although premiums in Washington have increased more slowly than before the ACA, an OIC analysis of health plans approved in 2015 and 2016 reveals that out-of-pocket costs are increasing significantly.¹¹

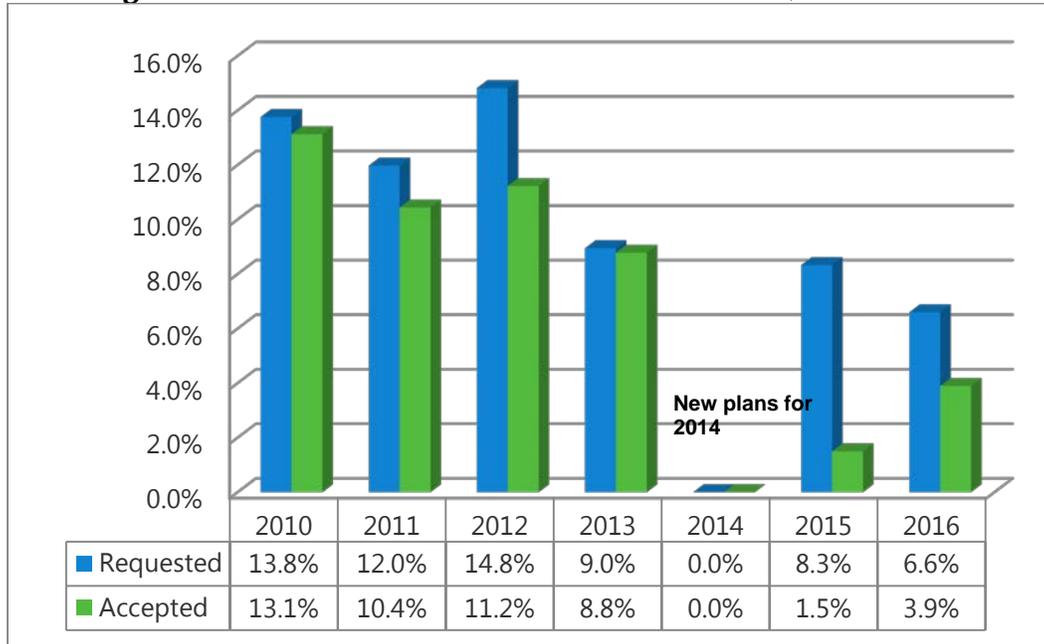
Despite rising healthcare costs, a positive outcome of the ACA has been the lower increases in health insurance premiums. Figure 5-1 shows that insurers' emphasis on keeping premium costs down resulted in rates moderating over the past few years. For individual plans approved for 2016, rates increased slightly from 2015, at 3.9 percent, far below the increases earlier in the decade. The small change in rate increases reflects a competitive marketplace for health insurance with insurers competing heavily on premiums to gain market share.

The rates displayed in Figure 5-1 reflect both what was requested by insurers and what was approved by the OIC.

¹⁰ Martin, A.B., "National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending," Health Affairs (December 2015).

¹¹ Out-of-pocket costs (or cost-sharing charges) are generally defined as the charges a person pays when using benefits covered by his or her health plan and include deductibles, co-insurance, and co-payments.

Figure 5-1. Rate increases in the individual market, 2010 – 2016



Source: OIC analysis of company filings

NARROW NETWORKS

Since ACA implementation, narrow networks have emerged as a tool insurers use to contain costs. A narrow network generally includes a smaller number of medical providers and in-network facilities than traditional provider networks.

We are closely monitoring this trend to ensure that insurers provide adequate access to covered services. In 2014 and 2015, Washington was the first state in the country to adopt strong network access regulations to protect consumers. These regulations require insurers to provide access to covered services at in-network cost-sharing levels, while also allowing insurers flexibility to design high-value networks.

HIGHER DEDUCTIBLES

A recent report revealed that high deductibles lead individuals to cut back on necessary health care, suggesting that high-deductible health plans may be detrimental to a consumer's ability to access health care.¹² Consumers with significant expected health costs may spend less overall on health care if they choose plans with higher premiums, but they are often attracted to lower-premium plans.

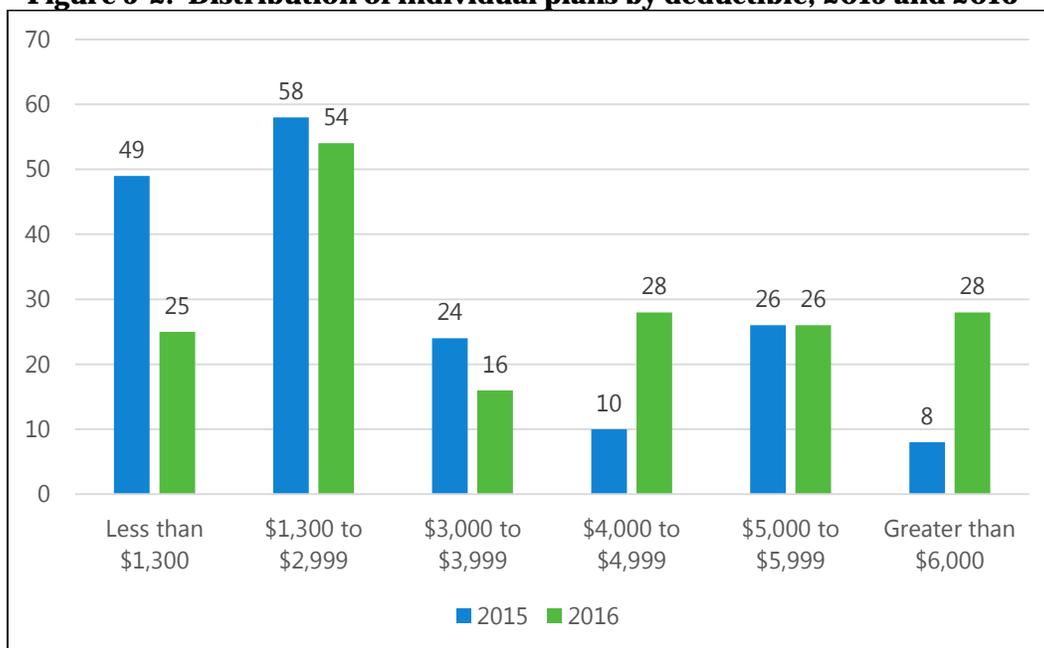
In order to stay within actuarial limits defined by the ACA, insurers must differentiate the coverage of their plans within tiers: bronze, silver, gold, and platinum plans, referred to collectively as metal levels.

¹² What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. NBER Working Paper No. 21632. Brot-Goldberg, Z.C, Chandra, A., Handel B.R., Kolstad, J.T

Consumers who purchase more comprehensive plans generally have lower cost-sharing, though they pay higher premiums. Given the significant variety of cost-sharing arrangements, it can be difficult for consumers to choose a plan that best fits their needs. For example, a consumer with high health care costs may select a bronze plan because of its low premium, not fully understanding that a gold plan would provide more comprehensive coverage.

As Figure 5-2 indicates, 2016 health plans had significantly higher deductibles than seen in 2015 plans. (Figure 5-2). In particular, there were 50 percent fewer low deductible plans (plans with deductibles lower than \$1,300) and 20 more plans with deductibles greater than \$6,000.

Figure 5-2. Distribution of individual plans by deductible, 2015 and 2016¹³

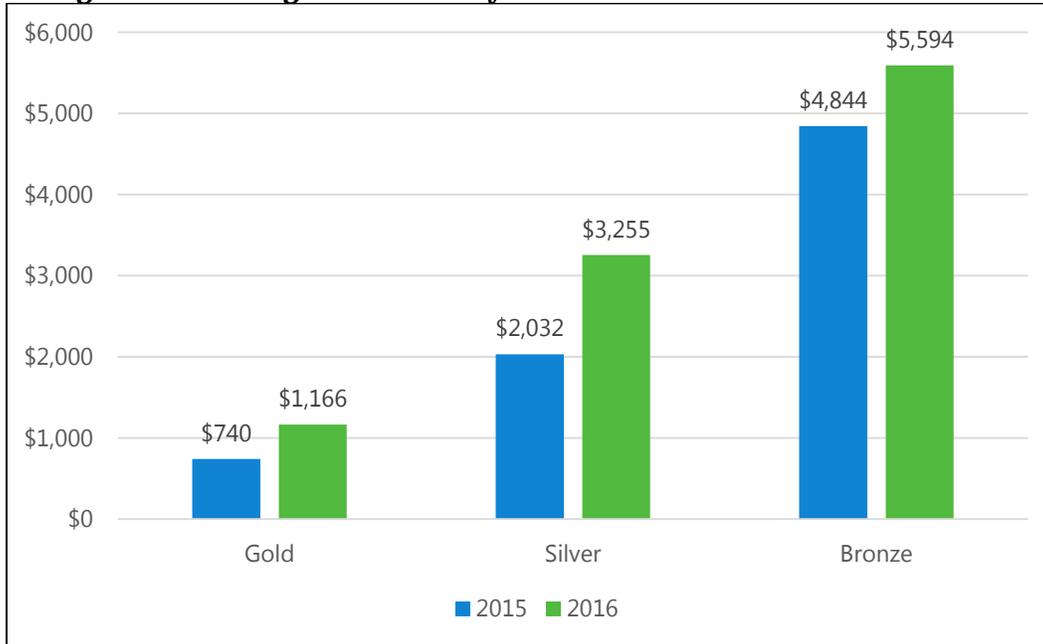


Source: OIC analysis of company filings

The increase in deductibles is also apparent when plans are examined by metal level (Figure 5-3). The most significant increase in deductibles is at the silver level, where the average deductible increased by over \$1,000 in 2016.

¹³ Market-wide data without platinum and catastrophic plans. Individual market only.

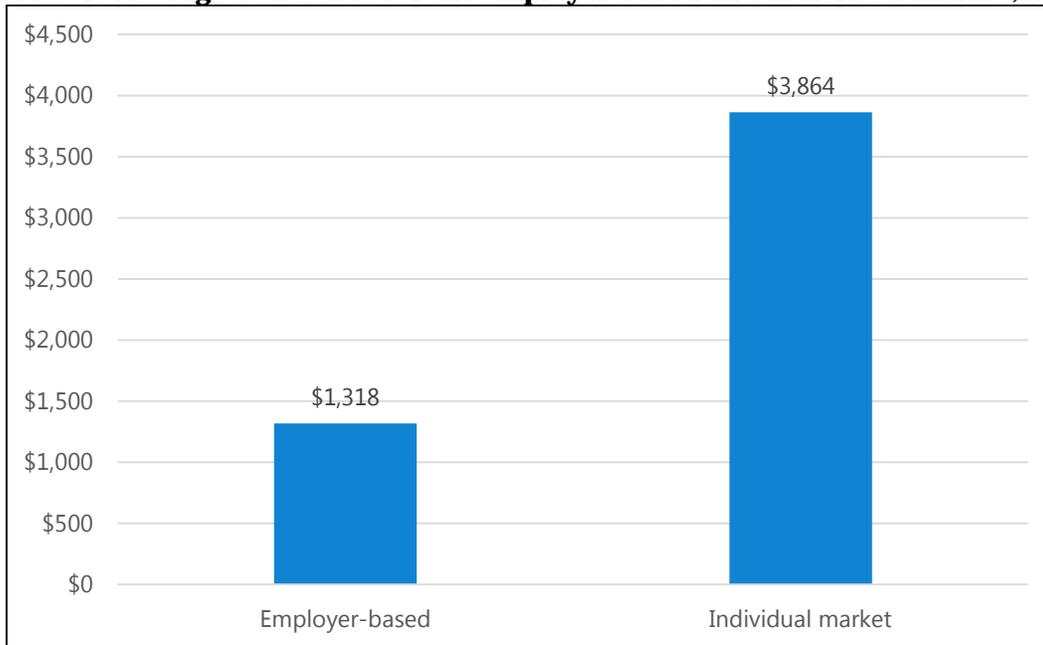
Figure 5-3. Average deductible by metal level in the individual market¹⁴



Source: OIC analysis of company filings

Consumers in the individual market typically have a much larger deductible than those who get insurance through their employers. A comparison of the market-weighted average deductible against the nationally-weighted average for employer-sponsored plans shows that, on average, consumers in the individual market have deductibles that are \$2,546 higher than consumers in employer-sponsored plans (Figure 5-4).

Figure 5-4. Average deductible for the employer-based and individual market, 2015¹⁵



Source: OIC analysis of company filings; KFF Employer Health Benefits, 2015 Annual Survey

¹⁴ Table represents Individual market only excluding platinum and catastrophic plans.

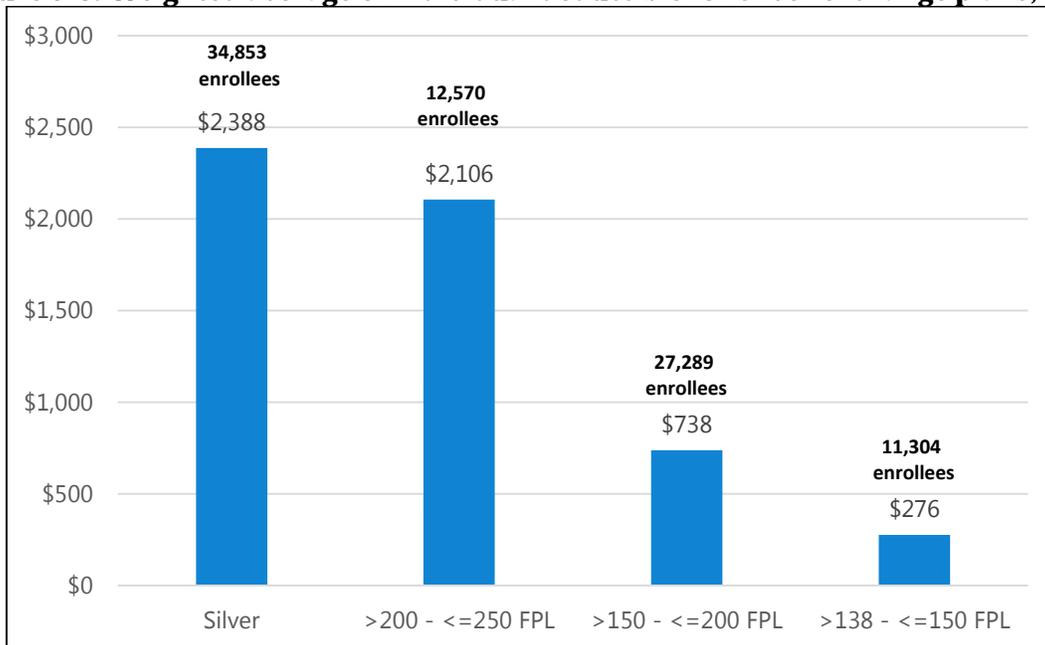
¹⁵ Employer-based average uses national data.

Many consumers are choosing to enroll in bronze-level plans because the premium is typically lower, but are then confronted with steep out-of-pocket costs when they seek care. Some may be eligible for cost-sharing subsidies, but are not aware of this option when selecting their plan.

Bronze plans provide an acceptable tradeoff between lower premiums and increased financial risk for some people, especially if they are generally healthy. A report from Washington’s exchange indicates that more than 21,000 individuals between 138 percent to 251 percent of the FPL enrolled in bronze plans. But people with an income up to 250 percent of FPL could enroll in a silver plan and take advantage of cost-sharing subsidies. What this data does not show is why consumers select certain plans or whether consumers understand how premiums and cost-sharing affect them on an individual basis. Further efforts are needed to make sure consumers understand their choice and the tradeoffs they are making when purchasing health insurance.

Figure 5-6 shows average deductibles for silver plans weighted by plan enrollment. There is considerable variation in the deductibles with enrollees in the highest cost-sharing plans experiencing an average deductible of \$276 compared to a deductible of \$2,388 for enrollees in silver plans without cost-sharing subsidies.

Figure 5-6. Weighted average of individual deductible for silver exchange plans, 2015



Source: OIC analysis of company filings

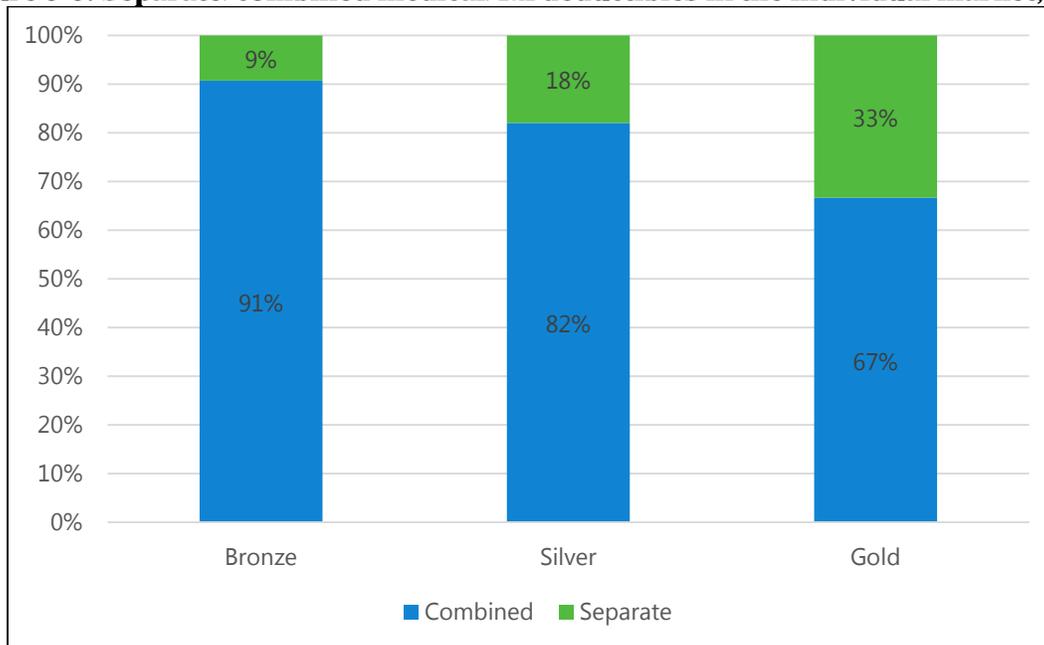
PRESCRIPTION DRUGS

The rising cost of prescription drugs is a significant contributor to the overall increase in health care spending. This issue affects specialty and generic drugs and can be a barrier to consumers receiving critical health care services. We are closely monitoring health plan formularies to ensure compliance with the law, but we have limited authority over the cost of prescription drugs. Solutions at the federal level must be achieved to truly impact and curb this trend.

Another issue is the increasing use of separate deductibles for prescription drugs. Historically, prescription drug costs were pre-deductible. Separate deductibles are used by health insurers to combat the significant increase in prescription drug costs and to more closely manage prescription drug spending. However, this must be monitored as it also may be contributing to consumers' inability to access care.

In 2016, 33 percent of gold plans included a separate prescription drug deductible, an increase of 19 percent from 2015 (Figure 5-5).

Figure 5-5. Separate/combined medical/Rx deductibles in the individual market, 2016



Source: OIC analysis of company filings

6.0 LOOKING FORWARD

The Affordable Care Act dramatically reduced the number of people without health insurance in Washington state. We expect the uninsured rate to continue to decline as the penalty for being uninsured increases and public awareness of Medicaid expansion and premium subsidies available through the exchange increases.

While consumers benefit from increased availability of health insurance coverage, additional work remains to ensure the promise of access to quality, affordable care. Policymakers and stakeholders must work together to build on the success of the ACA and address access and affordability issues.

We will be taking a closer look at a number of the issues raised in this report in the coming months and when possible, will provide data briefs to help provide direction and insight into these emerging trends.

APPENDIX A: DATA AND ASSUMPTIONS

The primary data source for the uninsured estimates is the American Community Survey (ACS), produced by the U.S. Census Bureau. The ACS is a period estimate, which means the data are collected continuously over a period of time and represent the entire period rather than a specific point in time, as the decennial census does. The ACS started asking basic health insurance questions in 2008 and expanded the questions the following year.

The uninsured estimates from 2009 to 2013 are based on proportions derived from the one-year ACS estimates and applied to population estimates generated by the Washington state Office of Financial Management.

The 2014 ACS count of Medicaid enrollees is far below what the program data from the Health Care Authority show. The differential between the actual Medicaid enrollment and the number reported by the ACS was far greater than any historical differences between the two. To compensate for the low Medicaid number, OFM (with input from the OIC and HCA) applied an adjustment to the ACS survey weight to reflect the actual Medicaid enrollment that also took into consideration the historical differences between the ACS and the program data. This adjustment resulted in an increase of over 193,000 enrollees to the Medicaid category and a reduction of an equal amount in other insurance categories, including the uninsured category. The reduction in the other insurance categories was applied based on a RAND study that examined coverage shifts between 2013 and 2014. Consequently, the OFM adjustment to the 2014 ACS produces a statewide uninsured estimate of 8.2 percent, one full percentage point lower than the unadjusted ACS estimate of 9.2 percent for 2014. To minimize the impact of the weight adjustment on the distributions of other key data in the ACS survey, OFM employed a survey data technique called "raking" to maintain the same counts of the key data as found in 2014 ACS for Washington.

The 2015 uninsured estimate is based on the OFM adjustment number as a baseline and then adjusting the number to account for new enrollment in the various insurance categories. Assumptions about movement among categories are also applied utilizing data from a 2014 RAND survey. Medicaid enrollment figures from the HCA, quarterly insurance company filings, and an OIC enrollment survey all serve as primary sources for the 2015 estimate.

The uncompensated care estimates are based on hospital financial and utilization reports from the Washington State Department of Health. Uncompensated care charges are defined as the sum of charity care and bad debts. Uncompensated care charges are adjusted to reflect the cost to the hospital rather than the amount billed.