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Before and After the Affordable Care Act: Consumers' Coverage Experience Through the Eyes of State Consumer Assistance Programs

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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

The Affordable Care Act (ACA) has had a dramatic impact on health insurance coverage. The number of uninsured has declined by an estimated 4.2 percent, and 11.7 million people have signed up for insurance through the health insurance marketplaces.¹ The ACA also set new standards for the adequacy of health insurance, including limits on out-of-pocket cost-sharing and requirements that insurers cover a minimum set of health benefits. Yet while we know that access to health insurance has improved, important questions remain about whether that insurance is adequately meeting people's needs. Most of the ACA's reforms went into effect just one year ago and there have been limited efforts to collect and analyze enrollment and coverage data.² As a result, our understanding of consumers' experiences with plans' cost-sharing, provider networks, and benefit design is lacking.

One source of information about consumers' coverage experiences are the state-run Consumer Assistance Programs (CAPs). CAPs were created and designed to assist consumers with health coverage questions and problems. CAP call centers receive calls from consumers on a wide range of issues, from those seeking coverage to those with coverage that is not meeting their needs. Many CAPs pre-date the ACA; others were created and funded in 2010 under a grant program authorized in the ACA. As a result, these programs provide a unique lens on consumer experiences with coverage both before and after the ACA went into full effect in 2014. They can help us understand how consumers have benefited from the insurance reforms embodied in the ACA—and where there may still be gaps or problems with their insurance coverage.

Background and Methodology

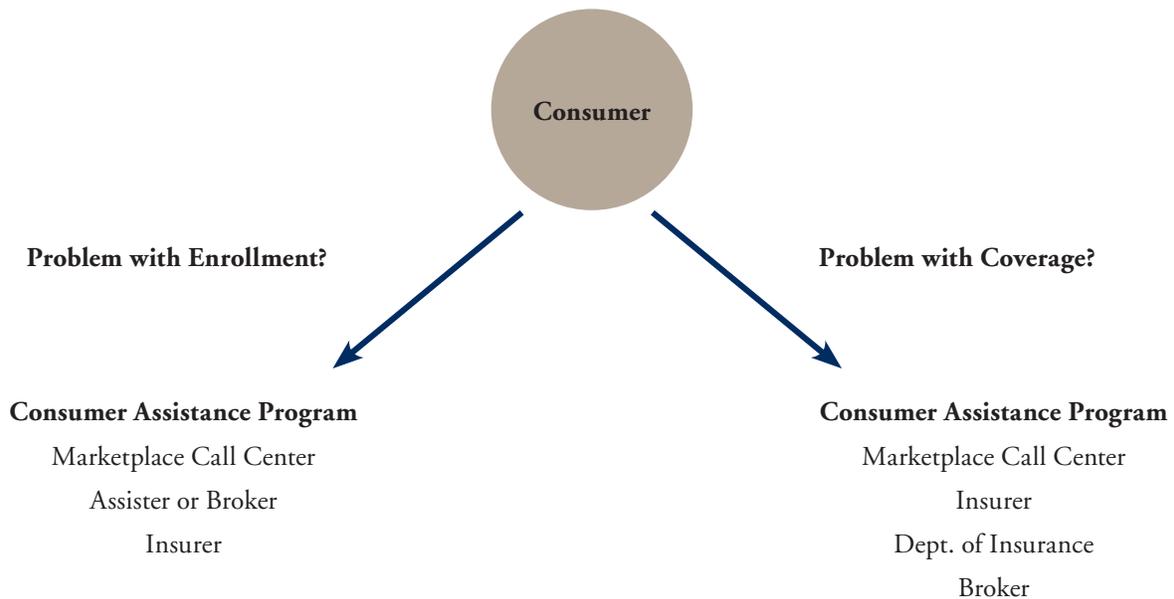
Prior to the ACA, several states established programs, either within state agencies or as independent entities, to assist consumers with private health insurance issues. Referred to as ombudsman or consumer assistance programs, these entities respond to consumer questions or complaints about coverage and also assist consumers with resolving or appealing adverse insurer decisions.

Building upon this model, the ACA provided \$30 million in grant funding to states to establish or to expand existing consumer assistance programs. This program was one of the law's earliest initiatives to assist consumers. The purpose of the CAP funding was to provide a comprehensive one-stop shop for consumers with private health insurance issues. States must use CAP funding to support the following activities: 1) assist with filing complaints and appeals, including providing information about the external appeals process; 2) collect data on consumer problems and questions; 3) educate consumers about their rights and responsibilities with health insurance; 4) assist with enrolling into health coverage; and 5) resolve problems related to obtaining tax credits.³ With the initial ACA funding in 2011, 35 states were able to establish a CAP or to support an existing CAP. However, because Congress has not appropriated any

additional funding since the ACA was enacted, there are currently only 13 ACA-funded CAPs remaining.

Of the 13 CAPs supported with ACA funding, Mississippi, Missouri, and New Mexico used their funding to establish new CAPs. The remaining ten CAPs used the federal funding to support or to expand existing programs. The CAPs were designed to complement—and not duplicate—the functions of the health insurance exchanges (also called marketplaces) in providing consumers with help and support. While the marketplaces provide consumer assistance with eligibility determinations and enrollment, they generally do not have the infrastructure to help people resolve problems with their coverage after they have enrolled in a plan. In general, if a consumer contacts a marketplace because of a problem with their plan benefits, the marketplace will refer them to their insurer, their state Department of Insurance, or a CAP program if one exists in the state. See Exhibit 1. Insurers in states with CAPs must provide their contact information on the ACA-mandated summary of benefits and coverage, and many states also require insurers to include the CAP's phone number on Explanation of Benefits (EOB) forms so that consumers with questions or concerns about their coverage can get assistance.

Exhibit 1. Where Consumers Go for Help



A majority of the CAPs operate as independent state agencies or entities, while CAPs in California, the District of Columbia, Michigan, Missouri, New Mexico, and North Carolina operate within the state's department of insurance or health insurance related agency. All the 13 CAPs have dedicated websites or toll-free numbers for consumers to contact them, but the range of services that the CAPs provide vary. All provide information about health insurance options, coverage, and rights, respond to questions and complaints, and assist with appeals. A number of CAPs perform a mediation function between insurers and enrollees, helping consumers better understand the scope of their coverage and working with insurers to resolve disputes or correct mistakes, often before issues rise to a formal grievance or appeals process. Less than half of the CAPs directly assist consumers with identifying coverage options or help enroll them into coverage. This is due to the different ways in which states structured their CAPs. For example, the Missouri CAP was only established to assist consumers with complaints and cannot assist consumers with enrollment. In New York, the organization functioning as the CAP also functions in other roles; any enrollment questions received through the CAP are referred to the assister or Navigator arm of the organization.⁴

While CAPs' primary function is to help consumers resolve coverage problems, a secondary, but no less important function is to help policymakers and regulators

learn about and assess potential systemic issues relating to consumers' access to affordable, adequate health insurance and health plan compliance with consumer protection standards. All CAP grantees must collect and report data on consumer problems to the U.S. Department of Health & Human Services, and officials noted that these reports, combined with regular phone calls, help keep them apprised of emerging problems. CAPs also play a role at the state level. More than half of the CAPs—California, Connecticut, the District of Columbia, Maryland, Massachusetts, New York and Vermont—help policymakers and regulators monitor consumer issues related to their health coverage. CAPs in Connecticut, the District of Columbia, Maryland and Vermont are statutorily required to annually report on issues related to consumers' health insurance and provide recommendations accordingly. These reports are for legislatures, governors, or state officials.⁵ Massachusetts and New York also use their CAPs' call center data to monitor trends and make policy recommendations.⁶ For example, New York's CAP played an important role assisting the state pass recent legislation protecting consumers when they unknowingly use an out-of-network provider. California's Legal Affairs & Policy Development Department within the Department of Managed Health Care uses its CAP complaint data to review for systemic issues and refers them to the Office of Enforcement or other appropriate departments for corrective action.⁷

CAP	Existed prior to ACA	Part of State Department of Insurance
California	Yes	Yes*
Connecticut	Yes	No
District of Columbia	Yes	Yes*
Maryland	Yes	No
Maine	Yes	No
Massachusetts	Yes	No
Michigan	Yes**	Yes
Mississippi	No	No
Missouri	No	Yes
New Mexico	No	Yes
New York	Yes	No
North Carolina	Yes**	Yes
Vermont	Yes	No

*California's CAP is housed in its Department of Managed Health Care and works in partnership with community-based organizations as required under Ca. Health and Safety Code § 1368.05. D.C.'s CAP is housed in the Department of Healthcare Finance.

**Michigan and North Carolina's CAPs were built into existing programs that assisted consumers.

Because of their unique perspective on the consumer experience with insurance coverage and how it might be changing in the wake of the ACA, we conducted interviews with officials from ten CAPs currently supported with federal funding: the District of Columbia, Maine, Maryland, Massachusetts, Michigan, Missouri, New Mexico, New York, North Carolina, and Vermont. We also reviewed, when available, quarterly and annual

reports from 2013 and 2014 that these CAPs submitted to federal regulators as part of their federal funding and if available, public reports to state legislatures. Because of differences in how the CAPs collect, categorize and report data, as well as differences in the populations they serve, we do not attempt in this paper to compare or quantify consumer issues or complaints across the CAPs.

Consumer Experiences in 2013: Life Before the Affordable Care Act

In their written reports and during interviews, CAP personnel reported that access to coverage and affordability were top consumer concerns in 2013. "We had a lot of uninsured," reported one CAP official. Another estimated that approximately 70 percent of consumers contacting them were uninsured. However, for other CAPs the uninsured were not a significant proportion of calls, largely because the primary mechanism for consumers to learn about their state CAP was through insurers' EOB forms.

For people seeking coverage, CAPs reported providing them with a list of insurers selling individual policies, but acknowledged that many consumers applying for coverage with these companies were turned down or quoted

premiums that were unaffordable due to their health status. As fall back options, CAPs reported referring people to the state or federal high risk pools. However, the federal high risk pool (called the Pre-existing Condition Insurance Plan or PCIP) stopped accepting new enrollees in early 2013, and most state programs had waiting periods in which pre-existing conditions would not be covered or premiums that few could afford.⁸ More often, CAPs reported that they worked to find people free or reduced-priced care, either through local community health centers, discount pharmacy programs, or other safety net providers.

For people with insurance, affordability was a primary concern. Commonly cited calls were from those that

could not afford their premium and those that could not afford prescription drugs. CAPs also reported receiving calls from consumers that had health insurance, but it came with a pre-existing condition exclusion on their policy, meaning that their insurer refused to pay for any treatment or care associated with a health care condition they had prior to enrolling in the plan. Consumers also called to complain about plans with high deductibles. In other states, the primary reason for calls from people with insurance was because their insurer denied payment on a claim.

CAPs also helped consumers navigate some of the ACA's insurance reforms that went into effect in 2010, such as the requirement that insurers cover preventive care

without cost-sharing. This benefit has helped millions of people obtain affordable preventive services, but also generated a lot of confusion. Many consumers believed they were receiving a preventive service, such as a colonoscopy, but were later billed because of the way that providers and plans were categorizing the service.⁹ CAPs, after receiving numerous calls from consumers, were able to provide insurers and federal and state regulators with early warnings about the problem. Eventually officials, working with insurers, were able to improve the way preventive services were categorized and claimed, reducing consumers' exposure to unwarranted cost-sharing.¹⁰ The CAPs in our study report that the number of calls relating to coverage of preventive services has significantly declined.

Transitioning to a Reformed Insurance Market in 2014: Consumer Challenges

January 1, 2014 ushered in sweeping reforms of the individual and small group health insurance markets. Insurers were prohibited from denying coverage or charging people higher premiums because of health status, and pre-existing condition exclusions on policies were banned. New standards were established for the generosity of coverage through a minimum essential health benefit package and annual limits on out-of-pocket costs. In addition, new health insurance marketplaces were established in which consumers could compare and enroll in health plans, most with income-related subsidies to reduce premiums and cost-sharing. Consumers also had new obligations to buy insurance – failure to maintain coverage could result in a tax penalty at the end of the year.

All of the CAPs we spoke with took calls from consumers with questions about the new marketplaces; in some cases the CAP had a formal referral arrangement with the marketplace call centers or navigators. These CAPs reported a significant increase in calls in late 2013 and early 2014 relating to eligibility for subsidies and enrollment in marketplace plans. For example, one CAP reported a 40 percent increase in their call volume over the same period the year before. While many callers only required general information about the new marketplaces and their new rights and obligations, CAP call centers also heard about a wide range of consumer problems as

the market transitioned in 2014. As one CAP staffer put it, “2014 was the year for people to have problems with their marketplace plans.” CAPs reported calls about:

- *Plan cancellations.* In the fall of 2013, many consumers on individual insurance policies called after receiving letters from their insurer that their plan would be cancelled and that they needed to transition to a new individual market or marketplace policy.¹¹
- *Long marketplace wait times and technical glitches.* Many consumers called the CAPs to complain about long wait times and technical problems enrolling through the marketplaces. While the volume of these calls declined during the course of the open enrollment period, CAPs in some states report that significant technical problems with the marketplace eligibility and enrollment systems remain.
- *Health plan ID cards.* One of the most common problems cited in early 2014 was that many consumers had to wait a long time to receive a health plan ID card. They often called the CAP because of anxiety that they could not obtain medical services until they had one. CAPs were often able to use their contacts with insurers to help identify the problem and expedite the delivery of the ID card. CAPs were also able to educate consumers that they could call

their plan to get an ID number and use that to receive services until their card arrived.

- *Communication breakdowns between Medicaid and the marketplaces.* CAPs received calls from frustrated consumers, particularly those with incomes close to the threshold for Medicaid eligibility, who were bounced between the marketplace and the state Medicaid agency and back again before they could successfully enroll in coverage.
- *Trouble proving income.* Under federal rules, if the marketplace cannot verify an applicant's projected income with federal income data sources, the applicant is asked to submit verifying documentation.¹² CAPs reported that a number of clients made several attempts to submit the necessary proof of income, both online and via the mail, but the information was never processed, causing them to lose subsidies as a result.
- *Transitioning off marketplace plans.* Many consumers called CAPs because they had transitioned from a marketplace plan to new coverage, such as an employer

plan, Medicare or Medicaid, yet were still receiving premium invoices from their marketplace carrier. In many cases, CAPs reported that information about a consumer's change of circumstance (and request to cancel their plan) was not adequately communicated between the marketplace and their insurer.

- *Lack of information about plan provider networks.* CAPs reported that many callers complained about a lack of transparency relating to health plan provider networks. Consumers called CAPs to complain that they had lost access to physicians and other providers that they had had under their previous coverage, or that providers listed in an insurer's provider directory were not actually in-network.

CAP staff working in states with a federally facilitated marketplace also noted that the marketplaces did not establish a functional complaint and appeals process for consumers with complaints about their coverage. This left CAPs and the consumers they served without clear guidelines for where and how to report problems and see them through to resolution.

Consumer Experiences in 2014 and Beyond: Life After the ACA

CAPs reported that the primary benefit brought about by the ACA is the ability to connect people to affordable coverage who would have previously gone uninsured, or who would have struggled to afford coverage. The problem of pre-existing condition discrimination has "gone by the wayside," said one CAP staff person. In all of these states, the uninsured rate has declined significantly.¹³ For example, in North Carolina, the uninsured rate fell to approximately 16 percent after implementation of the marketplaces, down from 20 percent in 2013. Similarly, Maryland also saw a drop in its uninsured rate to 7.8 percent from 12.9 percent.¹⁴

CAPs also reported a greater number of options for people transitioning between sources of coverage. For example, one CAP reported that "conversations about COBRA are completely different now." While previously COBRA was the only coverage option for most people transitioning off employer-based coverage, marketplace plans generally offer them a much more affordable alternative. Conversations with people in the two-year waiting period

for Medicare coverage due to disability have also been transformed. In most states, before the ACA, many of these individuals went uninsured because no affordable health insurance option was available to them. CAPs are now able to point them to marketplace coverage, often with significant subsidies.

Several CAPs also reported a significant reduction in the number of calls reflecting problems with health coverage affordability. While lack of affordability had once been their number one consumer complaint, one CAP reported that, post-ACA, the issue "got knocked out of the top ten." However, once technical and other problems with marketplace systems are resolved, affordability could once again emerge as a top consumer problem.

Continued Coverage Gaps and Problems

In spite of major coverage gains for many of the people that CAPs serve, call center workers identified a number

of significant continuing problems that consumers face in obtaining and maintaining coverage. These include:

- *Access to affordable coverage.* Two significant problems CAPs hear about from consumers are:
 - Low-income consumers (below 100 percent of the federal poverty level) who would be eligible for Medicaid in states if they expanded eligibility continue to have difficulty obtaining coverage and care. This is often called the Medicaid “coverage gap.” These individuals continue to need referrals to sliding scale community clinics and discounted or free care programs.
 - Some families are unable to afford dependent coverage through an employer-sponsored plan, but they are deemed ineligible for financial assistance through the marketplace. The problem, often called the “family glitch,” arises because people with an offer of affordable coverage from their employer are ineligible for marketplace tax credits. However, the test for “affordability” is based not on the cost of covering the family on the employer’s plan, but only on the cost of the employee’s self-only coverage.
- *Access to affordable covered benefits.* While CAPs reported that the ACA’s requirement of a minimum standard benefit package has helped reduce the number of calls from people with trouble accessing care, access to affordable prescription drugs remains a significant problem. A number of insurers require enrollees to pay a percentage of the charge for drugs, which can be hundreds or even thousands of dollars for the most costly drugs. One CAP has documented a noticeable increase in complaints and appeals over payment for mental health services and potential violations of mental health parity rules. Other CAPs report calls about high deductibles for marketplace health plans, one noting that significant cost-sharing is a “super barrier” for low- and moderate-income people needing health care services.
- *Access to providers.* CAPs reported numerous calls from plan enrollees about inadequate provider networks. While many calls relate to the lack of information about networks while consumers shopped for a plan, other consumers are calling to complain about

networks that are more limited than what they had before. “It was really hard for consumers to find a good plan with a good network,” one CAP staffer told us. Another told us of calls from consumers who were “hard pressed to find a doctor in their neighborhood.” However, the intensity of network problems varied from state to state, from “very few” calls in New Mexico and Vermont to “[i]t’s our number one problem” in New York.

- *Provider balance billing.* One CAP reported a high volume of calls related to surprise or balance bills from out-of-network providers, both before and after implementation of the ACA. The nature of the complaints vary, but most commonly arise when a consumer receives (either by choice or inadvertently) a service from an out-of-network provider and is separately billed by that provider for costs above what their insurance company will pay. Another CAP noted that the problem is particularly acute for patients for whom an air ambulance service is called, with insurers asserting that the air ambulance is “out-of-network” or not medically necessary. In some cases, balance bills can be hundreds or thousands of dollars.¹⁵
- *Affordable plan choices.* CAPs reported that consumers called in late 2014 with complaints about premium increases with their marketplace plans. CAP staff used these calls as an opportunity to educate consumers about the importance of shopping and comparing plans from year to year. CAPs in some states also reported that consumers were overwhelmed with the sheer volume of plan choices available through the marketplaces. They called for better online decision-support tools to help consumers narrow down their plan choices.

CAPs also reported spending considerable time helping consumers understand and use their coverage. Many consumers needed explanations of key insurance terms, such as deductible and co-payment, as well as help understanding provider networks, the financial risks of obtaining out-of-network care, and the use of appropriate care settings. For example, consumers that had previously been uninsured often did not realize that they should no longer use a hospital emergency room as their primary care location.

Conclusion

State-based consumer assistance programs play an important role helping consumers resolve problems with their health insurance coverage. For policymakers and regulators, however, perhaps their most important function is a sentinel one - helping to identify coverage problems that are not isolated or unique, but point to more systemic challenges or gaps in health insurance regulation. Not only does this help shape policy based on data, it also helps ensure that policymakers incorporate the consumer experience into their decision-making. As insurers and markets respond to a rapidly evolving regulatory landscape, there can often be a lag before data on the consumer experience with coverage is available. CAPs, in coordination with other consumer support entities such as state Departments of Insurance, marketplace call centers and navigators can help provide federal and state officials with real-time information on how consumers are accessing and using their health insurance benefits, and where there may be emerging problems. However, unless more federal grant funding becomes available, some state CAPs will need to reduce their services or close their doors, limiting their ability to perform this important sentinel function.

CAPs provide a unique perspective on the consumer experience because of their primary function to help resolve complaints and problems with coverage. One year after full implementation of the Affordable Care Act's insurance reforms and marketplaces, CAPs report

that, not surprisingly, consumers are better able to find affordable coverage options. And the coverage they are getting is generally meeting most people's needs. For others, CAPs report that consumers are not always using their coverage because of high deductibles and other cost-sharing. They also point to remaining gaps in our regulatory and policy framework that make obtaining health care and financial security more difficult for some consumers. These include policy challenges such as accessing coverage in states that did not expand Medicaid and spouses and children in the "family glitch" where employer-sponsored insurance is offered and considered affordable under current federal policy, but still too expensive for the whole family. Policy challenges also include the lack of transparency about what specific benefits health plans cover and which providers are in-network.

Our CAP respondents also consistently report a lack of health insurance literacy among callers, particularly for marketplace consumers without experience with private insurance. This lack of understanding limits consumers' ability to select the health plan that meets their financial and coverage needs. It can also mean they don't use their coverage effectively once enrolled. Going forward, CAPs are likely to continue to be a rich source of information about consumers' experiences with health insurance coverage and whether it is delivering its promised value.

Endnotes

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