

ACA and Consumers: How and Why This Matters for Researchers

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I've been asked to talk about the Affordable Care Act (ACA), to reflect on the myriad of ways in which it will affect consumers, and what our role may be as researchers in trying to determine the law's impact. You may all be at different levels of knowledge about the Act, so I'm going to try to weave this all together, laying out specifics of the Act itself, while I highlight where there are opportunities for research to add value, specifically, where there are opportunities for us as professionals concerned with the consumer perspective, to add value.

I appreciate the chance to sort through all of the information swirling about in my head about what this all means. I've spent much of the past four years trying to educate my colleagues in Wisconsin, now also in Kansas, as well as nationally about how the ACA is intended to work. Of course, it has been a moving target. Anyone who is working with local community groups trying to educate them on this well knows how the shifting sands have caused confusion and in some cases resistance to learning about the law.

Confusing as all of this may be, I do know some things. Most importantly, that this is the first major piece of legislation since the New Deal set to transform even more lives than Medicare did when it first passed into law in 1965. And it is set to do this in some stunning ways, and some fairly pedantic ways, and sometimes in fairly sloppy ways, maybe even slippery ways with consumers sliding all over the place, depending on specific states where they live, employers they work for, and other criteria that will determine how they are insured and by what kinds of entities. I also know that there is most definitely a role for those of us who care about consumers and do research to better consumer information and products.

Before talking about the Act specifically, let me give a sneak peak at what we now know about insurance enrollment. As of the end of April 2014, data on enrollment show over 8 million signed up for health insurance through the state-based Exchanges, 1 million over the administration's initial goal (Park, Watkins, Andrews, & Parlapiano, 2014). The great majority of those, 80%, have been deemed eligible for premium tax credits (Levitt, Claxton, & Damico, 2014). An important caveat here is that the numbers of people successfully enrolled may be less since enrollment requires payment of premiums. A House Energy and Commerce Committee (HECC) report has enrollment numbers based on premiums paid coming in far shorter, at 67%, while the insurance companies, the true repositories of these data, are reporting higher numbers, of at least 85% paying premiums and therefore being successfully enrolled (Huffington Post, 2014). Democrats are pointing to misleading aspects of that HECC report, including that given the late surge in enrollment, over 3 million were not yet even required to have paid their premiums. While indicative of the ongoing politicized nature of how data are being interpreted, getting a more accurate number of how many are enrolled will be critical for evaluating success moving forward.

Enrollment numbers outside of the Marketplans are also impressive. There are 7 million people determined eligible for Medicaid or CHIP (the Children's Health Insurance Program) through the Exchange enrollment process (Park et al., 2014). What is not yet known is how many of these were in their regular renewal cycles and how many are totally new to these publically supported programs. Enrollment into state Medicaid programs is not automatic through the Exchanges. This process links folks back to their state Medicaid offices. So it will take time to sort out the new enrollment numbers. Even where states have not expanded nor changed their eligibility criteria, some previously hidden eligible people, especially children, are being discovered through this enrollment process. That is, ACA outreach has proven to be a successful outreach strategy for encouraging previously eligible Medicaid individuals to enroll. Perhaps some of the stigma has been removed as so many were now enrolling with

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government support. This potential impact, even in states without Medicaid expansions, will be interesting to observe more closely.

Reports about the numbers of young adults taking advantage of staying on their parents' family-based plans vary. A Commonwealth Report (Collins, Rasmussen, Garber, & Doty, 2013) puts that number at about 7.8 million while the press is still reporting earlier data (Sommers, Buchmueller, Decker, Carey, & Kronick, 2012) that show closer to 3 million taking advantage of this expansion of family coverage. Regardless, this aspect of ACA is both popular with the public and is making an impact on decreasing the number of uninsured young adults, and likely easing the worry for their parents.

Finally, and perhaps surprisingly, there has also been a surge in employer-based coverage, adding approximately 8.2 million more insured through that vehicle, even before the penalties for firms with over 50 full-time employees kicks in in January 2015 (100-199 employees) and 2016 (50-99 employees) (Carman & Eibner, 2014). (Those firms with over 199 employees were required to self-insure.)

Costs, Quality and Access: The Drivers of Reform

Let's now take a step back and remember why we had health reform in the first place. The U.S. health care system has been plagued with problems of costs, quality, and access. Few would disagree that costs are excessive, that quality is uneven. We have the best medicine anywhere in the world at the same time our population health statistics place us poorly compared to other industrialized nations. We have well-documented health disparities with patients often not receiving the recommended treatments. Access to care is inadequate for many. We have had millions who are uninsured, and millions more who are underinsured, usually finding that fact out when they were most in need of health care services (Schoen, Hayes, Collins, Lippa, & Radley, 2014). Access also means having the appropriate providers available, who are culturally sensitive, and also willing to take one's form of insurance. International comparisons often rank us in last place for overall ranking of health care among the most economically advanced countries (Thomson, Osborn, Squires, & Jun, 2013).

Who is uninsured in the US varies by geography, age, income, and race, among other characteristics. There are heavier pockets of uninsurance in the south and west, and in inner city neighborhoods. While most understand that it is likely better to be insured than not, that health care services are easier to obtain with insurance, and that medical bankruptcy is less likely, few who are insured understand that being insured does not guarantee equal quality or access. Communities with larger numbers of uninsured people have more difficulty recruiting and retaining physicians. Their hospitals have less trauma and burn units and more emergency room crowding and diversion. In general, insured patients living in those communities have lower quality of, access to, and satisfaction with, health care. So the goal of getting more people insured impacts the currently insured as well as those not.

The Affordable Care Act

The Basics

There are many ways that we as a nation could have approached solving the problems of costs, quality, and access. Suffice it to say that through a very messy political process we ended up with The Affordable Care Act. The Act itself was built from a solution proposed in 1989 by Butler in a Heritage Foundation Report (Butler, 1989). That is, this was initially a conservative solution, building on the private insurance market. It was a counter to the calls for Medicare expansion to all. It was also the basis for the Massachusetts health reform plan enacted under a Republican governor, a plan that through its success with its individual mandate and increasing rates of insurance, many looked to as the model for how the ACA would work (Kaiser Family Foundation, 2012). In light of all of this, it remains curious that the response by Congressional conservatives has been so vehemently anti ACA, beginning with the troubled passage of the bill into law with no Republican votes.

The Act is very comprehensive, covering many aspects of improving costs, quality, and access. It has ten major sections referred to as titles. Title I is the one most covered in the press, "Quality, Affordable Health Care for All Americans." The others are:

Title II: The Role of Public Programs

Title III: Improving the Quality and Efficiency of Health Care

Title IV: Prevention of Chronic Disease and Improving Public Health

Title V: Health Care Workforce

Title VI: Transparency and Program Integrity

Title VII: Improving Access to Innovative Medical Therapies

Title VIII: Community Living Assistance Services and Supports Act (CLASS Act which is currently unfunded.)

Title IX: Revenue Provisions

Title X: Reauthorization of the Indian Health Care Improvement Act.

The Act has two intertwined goals. The first is addressed by Title I, to make better health insurance coverage more available and more affordable for legal residents. Many whom I speak to in rural communities are concerned either with those in their communities who remain undocumented being (a) a part of this program for citizens or, conversely, (b) excluded. Some have speculated that this aspect of the ACA might prove a catalyst for immigration reform. For now, the ACA does not address the needs of people without papers beyond some attempts to fund more fully the group of safety net providers known as federally qualified health centers (FQHCs) where many currently receive care.

The second goal of the ACA is to reform health care delivery and financing to provide better quality and outcomes and more cost effective care. All of the titles have elements designed to work toward this goal.

I think that the ACA has the potential to be transformative. Driven by concerns with costs and quality of and access to care, it is set to change how health is created, including a balance of personal and social responsibilities, a balance between what the medical care system provides and what other actors provide, and definitely a focus on prevention and primary care. It is set to change how health care is delivered and by whom. It is set to change how health care is paid for and how much is paid. It is set to change how private insurance is purchased (for many) while including new minimum standards for all. And it is set to change how the public insurance systems work, with changes in financing for Medicare, and opportunities for the expansion of the Medicaid population. This is so much more than health insurance reform. And the ACA is doing some of this by encouraging pilot projects, such as the Accountable Care Organizations model being used to encourage more efficient and cost effective use of evidence-based practice in Medicare, and by giving Community Transformation Grants so that communities can initiate grassroots efforts aimed at improving health from the ground up.

But yes, insurance reform is what we are most focused on for now. Title I is built around the notion of shared responsibilities between individuals, employers, and the government. Therefore, many conceptualize how the ACA works to insure more people by using a three-legged stool approach, a stool that is only sturdy with all three legs under it. The three legs represent the vehicles through which Americans are expected to be insured: the employment sector, the Marketplaces, and the public sector (Medicare, Medicaid, Veteran Administration, TRICARE and CHAMPUS, and the Indian Health Service). Key features of the ACA include:

- regulation of the health insurance industry (some might say it is their mandate, replete with its own penalties for noncompliance);
- creation of large purchasing pools where those previously unable to buy insurance through their places of employment can now purchase group-rated plans in the Exchanges/Marketplaces;
- mandating large employers (those over 50 full-time equivalents) to offer insurance to their employees;
- mandating individuals to be insured; and
- expansion of Medicaid to cover those most vulnerable. This feature has lost its teeth through the Supreme Court ruling of June 2012, which made state participation voluntary.

The ACA is highly dependent on the major consumer protections built into the regulation of the health insurance industry. These regulations include:

- no more exclusions for consumers who have pre-existing conditions;
- no more cancellation of policies for someone being too sick (though non-payment of premiums remains a valid reason for policy cancellation);
- no more lifetime maximums on the amount paid for care for Essential Benefits; and
- coverage of, AND no more annual maximums on the amount paid for, care for Essential Benefits.

Many refer to these regulations as “the consumer protections” and they are standard across all health plans except for those grandfathered in. These strong consumer protections mean that families are more secure in not being one major illness away from being uninsured or uninsurable. It also paves the way for workers to work where they want, and for whom they want, including being their own bosses and starting their own businesses. Disengaging health insurance from the need to work for an employer that offers that benefit, without the fear of losing it if one changes jobs, may foster new entrepreneurial opportunities. Much is coming out of late to highlight how this may change the expectation of health insurance being a fringe benefit (Kaiser Health News, 2014). In farming communities this may foretell a change with family members no longer having to work “off-farm” in order to secure health insurance through more affordable employer-based plans. Farm family premiums have been exceptionally high due to the individually-rated premiums for a high risk occupation. From a community economic perspective this change in the relationship between work and insurance benefits, and choices for workers, will be particularly interesting to track and analyze for impacts on consumers and communities, including and perhaps most importantly, our rural communities where economic vitality is less flexible.

The required benefits that must be covered in all plans is another regulation imposed on insurers by the ACA. These 10 “Essential Benefits,” as they are called, include: ambulatory patient services, emergency services, mental health and substance use disorder services, rehabilitative and habilitative services and devices, preventive and wellness services (which must be provided with no copayments), maternity and newborn care, prescription drugs, pediatric services (including oral and vision care), lab services, and chronic disease management. These are the types of benefits already found in most plans offered by large employers. They cover a range of usual medical services needed by men and women of all ages. The comprehensive nature of these benefits works well for community risk pooling as intended but is an aspect of the law that is problematic for individuals who were accustomed to purchasing policies more specific to their own needs. It may be one of the features that is called into question and may need more research to understand consumer concerns, as well as education on true risk management among diverse groups.

Insurance companies are also required to cap annual out-of-pocket payments. While the limits seem high (\$6,350/yr for an individual; \$12,700 for a family), in the past there were often no limits on these, so high is better than no limit. This limit applies to the aggregate of copayments and deductibles; it does not include the cost of premiums.

When faced with negative reactions to this type of community rating, I have found it useful to remind folks of two issues. One concerns medical needs and risks, the other concerns our definition of family. To the first, it is most true that while we are all at varying risks for adverse health events, we are far less able to predict medical needs than we would like to think. We know that risks are higher as one ages, yet we all understand that preventable injuries occur (most are not “accidents”) at any age. Further, population health data are showing (for example) increasing numbers of young people diagnosed with asthma and diabetes, two diseases which require expensive chronic care management. Even children get sick in ways and at times that we would not expect.

The second concept, that of family, is a bit more difficult to explain because it contains large notions of community. At its base though is an understanding that even if one is insured, and immediate family members are insured, others in an extended family network may not be. From a purely financial and social-emotional standpoint, it seems reasonable to expect that extended family members are called upon when a family member is ill (Doherty, 1981). Some of that support though may be financial. That is, there are reasons for people to want family members to be insured that are self-serving (though some may also be merely compassionate).

Wrapped around all of this is the difference in this commodity we call health care. If someone chooses to remain uninsured against theft well, they lose their belongings if they are robbed. Society does not necessarily expect to replace lost goods. However, society does choose to intervene, albeit late and not necessarily in the most effective ways, when someone is sick. Those who remain uninsured cost all of us. So risks are not as known as we'd like to think, and we all benefit when we think of insurance for others as well as self; therefore, having some minimum standards in insurance policies such as those identified as Essential Benefits seems reasonable. While we may be comfortable with a neighbor foregoing property insurance, we should be more circumspect if they remain uninsured for their health.

There are several reasons why insurers were generally supportive of the bill before it became a law. For one, there are millions of new "covered lives" to be had, and that was going to be good for business. Also, there was a leveling of the playing field when all insurers were going to be required to play by the same rules. All were going to have to ignore pre-existing conditions, take all comers, and pay out for them with no annual nor lifetime maximum payments. But perhaps the most important reason was the mandate that individuals must be insured or face a penalty or fine. Insurers can be in the game when there were going to be so many more buyers. With the mandate, the uninsured were going to be strongly encouraged to buy their products. Some have even gone so far as to argue that the ACA can survive without the employer mandate but not without the individual mandate (Blumberg, Holahan, & Buettgens, 2013; Long et al., 2014). It may be the reason why the employer mandate has seen deadline changes to accommodate requests from businesses but there was no parallel adjustment in the open enrollment Marketplace deadline for consumers. (While March 31 seemed like an extension, it really was not. The mandate requires one be insured for only 9 months of the year. The extension to March 31 allowed the open enrollment period to coincide more directly with what the law really allowed.)

The ACA builds on our currently strong employer-based insurance system in the US. Though this number is in constant flux, a 2011 CPS report indicates that over 55% of Americans receive their insurance through their places of work (Janicki, 2013). The employer mandate requires large employers (i.e., those with 50 or more full-time employees or full-time equivalents) to offer their employees health insurance that is adequate (at least a 60/40 sharing of costs), affordable (less than 9.5% of household income for a single plan), and covers a list of essential health benefits. It does NOT require employers to offer coverage to an employee's spouse in order to comply with the employer mandate. Again, these provisions have been delayed until January 2015 for firms with 100-199 full-time employees, and until January 2016 for those with 50-99. Those with over 200 had already been required to self-insure.

Smaller businesses are not mandated to offer health insurance to their workers (a much misunderstood feature), but in an attempt to strengthen the employer-based focused intent of the ACA, tax credits are given to the smallest employers (those with less than 25 employees), to assist employers to pay for that insurance. The SHOPS (Small Business Health Options Program) were opened this year to allow small businesses to increase their purchasing power through buying insurance for their employees through this system of pooling small businesses. Because the website for these also faltered, many were unaware that the SHOPS were open for business. That is, insurers were offering policies in these SHOP pools, though signup this year was only via phone. Enrollment in these will also need to be monitored.

Then there is the individual mandate, the consumer responsibility part of the stool. The fact that the risk rating system is fairly minimal allows premiums to be more affordable for all, including those sick and those older, potentially making the mandate more tolerable. The individual mandate requires that almost all are insured or face penalties. Any type of insurance will count: public or private, employer based or individual. And policies that were to have been cancelled but were given a year's reprieve also count. Acknowledging the existence of insurance will be part of the annual tax filing, though the specifics of how this will work are not yet clear.

There are exemptions to the penalty. The financial exemptions include anyone who does not have access to health insurance that is less than 8% of their annual household income, including those who would otherwise have been eligible for Medicaid if their states chose to expand. There are also some religious and tribal exemptions, and the incarcerated or those here without papers, and therefore not eligible, will not be penalized. There are also several hardship exemptions. For all see healthcare.gov (2014).

One of the concerns consumer advocates have is with a misunderstanding of the penalties and timing of when folks will understand those penalties accurately. The media has repeatedly stated that the penalties are \$95/year for being uninsured, but in actuality it is \$95 OR 1% of income, whichever is greater. And the penalty rises every year to 2.5% of income by 2016. Many people who are opting to pay the penalty and remain uninsured are likely going to be very surprised April 2015 when they find this out and yet will have missed their second chance at an open enrollment period, which is November 15, 2014-February 15, 2015. They will face penalties for two years' worth of being uninsured, the second at a greater cost of 2% of annual income.

What the Marketplace Looks Like

Insurers are now offering policies through employers, through a still existent private market, and now through the Marketplaces or Exchanges. Any consumer can purchase in the Marketplace, but it is assumed that those with employer-based coverage would not need nor choose to shop for a plan there. These are all state-based entities even as many are administered by the federal government. They are state based in that the insurance companies offer state specific policies that have been negotiated with and approved by the state insurance departments. Note that while the main avenue for accessing the Marketplaces is the web, they can also be accessed via phone, mail, or in person.

Policies offered in the state Marketplaces now fall into four *metal* tier categories and one other category for catastrophic plans. The latter are only available for those under age 30 or those in financial hardship, including those in states who would be eligible for Medicaid if their states chose to expand. The four metal tiers are bronze, silver, gold and platinum. The least expensive metals have lower premiums but higher out-of-pocket costs. Each tier is actuarially rated for adequacy. The bronze plans are 60/40, silver 70/30, gold 80/20 and platinum 90/10.

Insurance adequacy is an actuarial term. It refers to the cost of all of the health care an insured person may receive in a given year (outside of the premiums). That is, in a 60/40 plan the average individual in that plan would expect to pay 40% of their total out-of-pocket expenses such as copays and deductibles while the insurer pays 60%. What is important to understand is that this is yet another way in which the insurance plans are being required to be more substantial so that Americans are no longer at risk for being severely underinsured. This new standard is the reason why some policies were cancelled and premiums may be going up for many, especially in the private market. Until now, many people have been purchasing "bare bones" policies, some of these actuarially rated at 50/50 or even less.

Premium ratings are now basely solely on age, group/geographic region, single/family status, and smoking status. The oldest enrollees in the plan can be charged at most three times the premium of the youngest enrollee. This is an improvement from the reality of rates five times higher or more. The smoking status is a hold-over from a fairly consistent differential in existing policies, based on this well-known risk factor. In order to discourage smoking and encourage prevention, smokers are assessed a surcharge on their premiums, a surcharge that is not eligible for premium tax credits. I've heard of some turning down insurance due to high cost when this surcharge was added, so this may need to be reconsidered in terms of sound community policy. If the intent is to ensure that people's medical needs are met through insurance, this surcharge may indeed discourage those most in need of it from purchasing, once again leaving the community to shoulder the financial implications.

One of the major "risk" factors that the ACA eliminates is gender rating, which resulted in women paying significantly more for premiums. Particularly beneficial for women is the elimination of pre-existing conditions, which differentially impacted them as they tried to obtain insurance (e.g., prior c-sections, breast or cervical cancer, prior treatment for domestic or sexual violence). Also mandatorily included in the plans, and highly relevant for women's health, are coverage of maternity and newborn care, with no copayments for a plethora of preventive services (e.g., birth control products or counseling, well woman visits, gestational diabetes screening during pregnancy, breastfeeding support and supplies, domestic violence screening and counseling, mammograms, and pap smears).

While anyone can purchase a plan in the Marketplace, only those without an employer-based plan that is adequate (60/40) and affordable (premium for single plan is <9.5% of household income) are eligible for tax subsidies if they otherwise qualify. Some purchasing family plans are being caught

ineligible for Marketplace subsidies because they do have access to employer plans for singles that meet those criteria but have family plans that are significantly more expensive. Analyzing the real impact of this for families might lead to reconsideration of these specific eligibility criteria.

Tax subsidies are the way to make insurance more affordable for many, targeting consumers with assistance (Angeles, 2013). As noted above, 80% of those in Marketplace plans qualified (Levitt, Claxton, & Damico, 2014). There are two kinds of subsidies. Premium tax credits help consumers pay for the premiums, and cost-sharing subsidies help consumers pay for out-of-pocket payments. The subsidies work on a sliding scale of support. Under the ACA no one whose income is less than 400% of the Federal Poverty Line (FPL) (\$45,960 for an individual, \$94,200 for a family of four) is supposed to pay more than 9.5% of their annual income for premiums. (It remains unclear how this number was arrived at. Many Americans think that is too high but perhaps because they have been unaccustomed to budgeting for this expense.) The sliding scale gives premium subsidies to pay the balance of the premium if it is more than the assigned limit. The limit ranges from 2% for someone at 100% of FPL (\$11,490) to 9.5% for someone at 400% FPL (\$45,960), with FPL based on family size. The maximum amount of the subsidy applies to the second lowest cost tier plan. Any premium amounts above that limit are the responsibility of the insured alone.

The cost-sharing subsidies are for those under 250% FPL and offer copayment assistance and lower annual out-of-pocket maximums. To qualify for a cost-sharing subsidy one must have purchased a silver plan (70/30 actuarially rated).

These subsidies are determined when household income is provided during the enrollment process, either electronically (where accuracy of data matched to IRS and similarly held information can be verified almost immediately) or by phone or paper. Most consumers will receive this as an advanced tax credit, being responsible for paying only their assigned portion of the premium. If income has changed through the year changing the amount of subsidy for which one is eligible, those differences will be reconciled at tax time. There are specific tables indicating how much must be repaid. Penalties for those who remain uninsured will also be assessed at tax time though the logistics of this remains murky.

How Will We Know if ACA is Doing What it Set Out to Do?

The overarching question we will all be asking for years to come is: Is the ACA doing what it set out to do? We need to remember that its charge was expansive. It is trying to reform the health care delivery system while making insurance more available and affordable. There will be many players evaluating and analyzing different aspects of this. There is the Center for Medicare and Medicaid Innovation, part of the ACA itself, which is testing new payment and delivery methods. There is the Patient-Centered Outcomes Research Institute, another ACA entity, which is charged with doing comparative effectiveness research on treatments. The Agency for Health Care Research and Quality (AHRQ) is the federal agency that will be awarding research grants to conduct the unbiased (politics free) assessment of the health care system's overall performance. As Bindman (2013) has said, "ultimately, the best way to trump the inevitable unsubstantiated rhetoric is through evidence acquired through the performance of rigorous and objective scientific studies" (para. 1).

We in ACCI are most concerned with the questions as they relate to consumers. At first everything will be about tracking insurance status: Who got insured and by what means? We will also be concerned with those left behind either because their states chose not to expand Medicaid eligibility (those who fell into the "gap"), those who lost coverage on a substandard plan that does not meet ACA Essential Benefit standards, those for whom the options available at work or in the Marketplace were too expensive, or those who simply chose not to purchase insurance. We'll want to know if the individual mandate worked to encourage the purchase of insurance, or had folks been waiting regardless to be able to purchase policies, shut out previously because of pre-existing conditions and/or unaffordable prices? The reasoning behind those consumer decisions needs to be understood more fully if we intend to offer a path to health insurance stability. We may also be interested in whether individuals think it was a good idea to increase access to insurance in this way. Right now the numbers seem to belie consumer confidence. While millions are clearly newly insured, public opinion still remains negative (Kaiser Family

Foundation, 2014). It may remain difficult to tease out the personal assessments made apart from political banter.

Many, including Richardson and Yilmazer (2013) are reminding us that there really is no national risk pool, that insurance will happen at state levels, and that there will be variation not only between states but within them on a variety of demographic characteristics, including percentages insured through work and level of poverty. That is, how much uninsurance remains is dependent on a variety of factors that are beyond the ability of the ACA to correct. For example, we expect states to vary in numbers of newly insured based on how many of a state's uninsured would be eligible for Medicaid but are left uninsured because of non-expansion decisions. The premiums themselves will also vary between states because they depend on market competition and other local market factors. We've seen differences in utilization of care with a more even federal program, Medicare, based on how providers are reimbursed, which is partly dependent on region. How much of this will we see with ACA?

We also need to remember that what is affordable today may not be tomorrow. The first few years of premium determinations will be important to track. They will depend on the risk pools of who actually enrolled, how well the actuaries did at predicting risks, and of course, on the underlying price and utilization of medical services.

Another phenomenon to watch carefully is the amount of churning occurring and the impact it has on the financial security and continuity of care for consumers. Churning is a phenomenon of changing eligibility over time, something that low-income families experience on an ongoing basis. "Approximately half of all low-income, non-elderly Americans experience a change of income or family circumstance in a given year, which may result in an involuntary shift in how they are covered from health insurance purchased through an exchange to Medicaid" (Gnadinger, 2014, p. 1). This will be a significant problem in all states, but one can imagine how particularly problematic this will be for low-income families in states without a Medicaid expansion. These families may actually be better off claiming higher income where they can get assistance in paying both for premiums and copays than being left totally uninsured. At the higher end of the eligibility income scale, those at 400% FPL may find themselves in a given month or year suddenly ineligible for tax credits that eased their financial status.

The health services researchers will be tracking the ultimate outcome: better health. The ACA as a whole will be evaluated on that front as there are measures for quality improvement throughout. Prior research and general knowledge suggest that minimizing the barrier of not being insured will impact ability to access services, but we also understand that the minimization will impact areas differentially, with rural as well as inner city communities not faring as well because of lack of providers. We need to understand more fully the impact raising the level of insurance has on communities, on their economic development, and on their vitality.

What do We Already Know about Changing Rates of Insurance?

A key benchmark of the law's success will be whether there is a reduction in the total number of uninsured. Many government programs have enrollment rates that are substantially lower than they would be if everyone who qualified for a benefit actually applied for it. Timing of the measurement of this success matters. As recent data provided show, the "take-up rate" for ACA is comparable to that of two other recent expansions of the social safety net: CHIP (Children's Health Insurance Program), usually a Medicaid expansion program of its own, and Medicare Part D (Kamarck, 2014). Enrollment in CHIP, passed in 1997, started out slow and improved steadily over the first decade of its existence. Enrollment in Part D too increased over time. Evidence is that resistance to these programs minimizes over time as those eligible reap the benefits.

There have been a couple of recent surveys showing that the rates of the uninsured are dropping (Levy, 2014; Long et al., 2014). The recent Gallup poll (Levy, 2014) shows a decline in the numbers of uninsured to 15.6% in the first quarter of 2014 since a high of 18% in the third quarter of 2013. The rates of uninsured have varied since 2008 when they were as low as 14.4%, rising to a previous high of 17.5% in the last quarter of 2011. Rates had been rising even before ACA became law, as employers, especially small businesses, dropped coverage and as unemployment rose. Young adults (18-25 years)

have consistently had the highest rates of uninsurance however the percentages have been lower since September 2010 when ACA allowed this age group to remain on their parents' policies (Levy, 2014).

The decline is especially apparent in states that have expanded Medicaid, as in some states half or more of the uninsured would otherwise be eligible for Medicaid at the 138% FPL (Witters, 2014). Uninsurance rates for those non-expansion states will almost by design continue to lag behind the expansion states.

What Are the Next Steps After Getting Consumers Enrolled?

It has become clear to many doing outreach to consumers that getting folks enrolled has been a complicated process. The website was supposed to help take the mystery out of purchasing insurance and make comparison shopping easy, but it presumes a level of health insurance literacy that many consumers do not have. One must analyze plan offerings to determine which has the best network of providers, which plans offer the best benefit packages and formularies, and at what cost. Well, many consumers don't understand the concept of a network nor formulary, nor understand what copayments are compared to premiums, so they can't yet make informed choices. Even for those of us who understand these terms, the variability in health care needs, particularly for prescription drugs, remains a great unknown from one month to the next, making choosing the best plan even more problematic. Compounding this is the sheer volume of choices. In my home state of Kansas, this year we had four insurance companies offering a total of 65 different plans with, on average, 37 of those plans offered in all counties. No Kansas county had less than a choice of two insurers offering plans.

One common recommendation is to provide consumers with much more in-person assistance to enroll and pick a plan. A change that might help meet that goal is to align sign-up season with tax filing because that could enlist the help of tax preparers. Helping consumers navigate these kinds of choices is within the purview of many ACCI members. We are seeing a multitude of health insurance literacy programs being developed, including those by the national network of Extension educators, to help consumers navigate health insurance more easily and to make choices from an informed perspective.

Our role in the research endeavor is certainly one of our next steps. As Bindman (2013) eloquently states, "Health services researchers face a great challenge. It will prove to be the field's finest hour if investigators can produce timely, accurate, and meaningful results that can help monitor federal health care policy and, if necessary, amend it. However, if they fail to produce rapid results and engage in the public discourse about the law's effects, this failure may raise damaging questions about the value and future of the field" (para. 9).

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