The COMMONWEALTH FUND

Tracking Trends in Health System Performance

JULY 2016

Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction

Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016

Munira Z. Gunja, Sara R. Collins, Michelle M. Doty, and Sophie Beutel

Abstract For people with low and moderate incomes, the Affordable Care Act's tax credits have made premium costs roughly comparable to those paid by people with job-based health insurance. For those with higher incomes, the tax credits phase out, meaning that adults in marketplace plans on average have higher premium costs than those in employer plans. The law's cost-sharing reductions are reducing deductibles. Lower-income adults in marketplace plans were less likely than higher-income adults to report having deductibles of $1,000 or more. Majorities of new marketplace enrollees and those who have changed plans since they initially obtained marketplace coverage are satisfied with the doctors participating in their plans. Overall, the majority of marketplace enrollees expressed confidence in their ability to afford care if they were to become seriously ill. This issue brief explores these and other findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

BACKGROUND

About 26 million Americans have health insurance through the Affordable Care Act's coverage expansions, either through the state or federal marketplaces or through expanded eligibility for Medicaid.[1] Estimates from a recent survey (The Commonwealth Fund's Affordable Care Act Tracking Survey, conducted between February and April 2016) indicate this coverage is improving people's ability to get health care. Sixty-one percent of respondents who were enrolled in marketplace plans or Medicaid said they would not have been able to access or afford their care before they got their new insurance.[2]

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Sara R. Collins, Ph.D.
Vice President, Health Care Coverage and Access
The Commonwealth Fund
src@cmwf.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1883
Vol. 17

Using these survey data, this brief examines the costs of marketplace plans and how consumers view the affordability of their health insurance. We compare premiums and deductibles reported by marketplace enrollees with those reported by adults in employer plans and examine whether these costs have increased over time. We also investigate if enrollees are choosing plans that limit the number of providers offered ("narrow network" plans) and the level of consumers' satisfaction with the doctors participating in their plans.

AFFORDABILITY OF MARKETPLACE PLANS

Premium Costs Are Similar in Marketplace Plans and Employer Plans

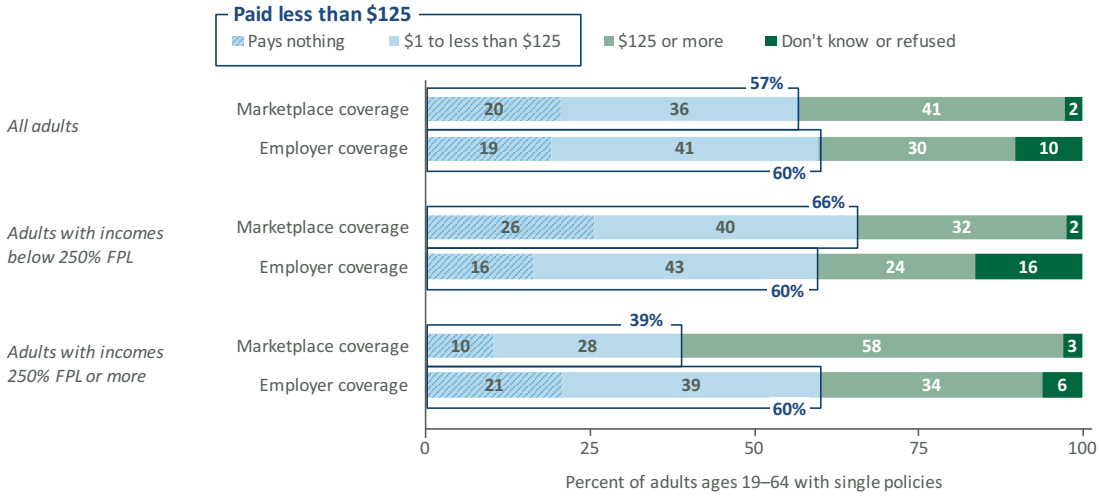
Of the 11.1 million people enrolled in marketplace plans in 2016, more than eight of 10 are paying for their premiums with the help of federal tax credits.[3] The effect of these tax credits on consumers' costs is reflected in this brief's findings.

Among adults with single policies (i.e., those covering only themselves), those enrolled in marketplace plans reported that the amount they pay for their premiums is similar to what people with employer-based coverage pay. Fifty-seven percent of adults in marketplace plans and 60 percent in employer plans spent less than $125 per month on insurance premiums. These figures include the one of five people with either type of insurance who paid nothing (Exhibit 1).[4]

Most people who purchased marketplace plans were eligible for premium tax credits. Fifty-nine percent of people with marketplace coverage had incomes under 250 percent of the federal poverty level ($29,425 for an individual and $60,625 for a family of four), making them eligible for the most generous premium subsidies (Table 1). As a result, 66 percent of these adults paid less than $125 a month toward their premium, including 26 percent who paid nothing. Among people with

Exhibit 1

Low-Income Adults with Marketplace Coverage Paid Monthly Premiums Comparable to Low-Income Adults with Employer Coverage



Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four. Segments may not sum to subtotals because of rounding. Bars may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

employer coverage in this income range, 60 percent paid less than $125 per month, including 16 percent who paid nothing.

Under the ACA, adults with incomes between 250 percent and 400 percent of poverty ($29,425 to $47,080 for a single person) receive smaller tax credits for marketplace coverage, while those with incomes above 400 percent of poverty receive no tax credit and pay the full premium. In contrast, most people in employer plans, regardless of income level, receive premium contributions from their employers. Thus, among adults at 250 percent of poverty or higher, 58 percent of those with marketplace coverage spent $125 a month or more on premiums compared with only 34 percent of those in employer plans.

Half of Adults in Marketplace Plans Say Their Premiums Are Affordable

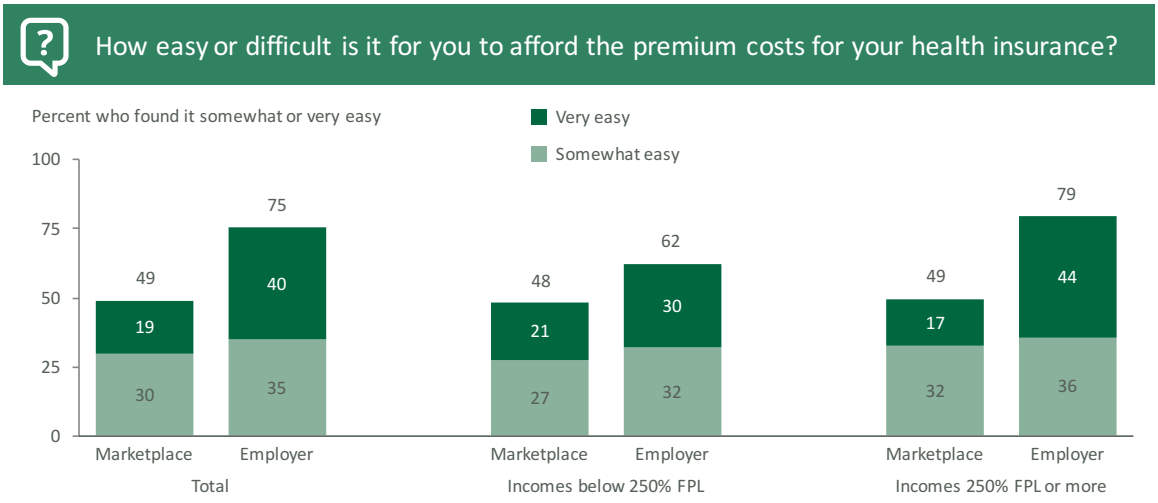
When we asked people their views on affordability, we limited the survey sample to respondents who paid all or part of their premium and knew the amount they paid.

Half (49%) of adults with marketplace coverage found it somewhat or very easy to afford their premium (Exhibit 2). This rate is statistically unchanged from April–June 2014, after the ACA's first open enrollment season (data not shown).[5] People with marketplace coverage—those with low as well as higher incomes—found it more difficult to afford their premiums than did people with employer coverage. Compared to other survey respondents, employer plan enrollees with higher incomes reported the easiest time affording their premiums.

Views of affordability diverge at higher income levels. This reflects the phase out of premium tax credits in marketplace plans at higher incomes and the fact that people in employer plans are much more likely to have higher incomes than are marketplace enrollees. Half (51%) of 19-to-64-year-old adults in employer plans had incomes of 400 percent of poverty or higher, compared with only 19 percent of those in marketplace plans (Table 1).

Exhibit 2

Half of Adults in Marketplace Plans View Their Premiums as Affordable



Adults ages 19–64 who pay all or some of premium and are aware of their premium amount

Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four. Segments may not sum to subtotals because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Lower-Income Adults with Marketplace Coverage Less Likely to Have High Deductibles

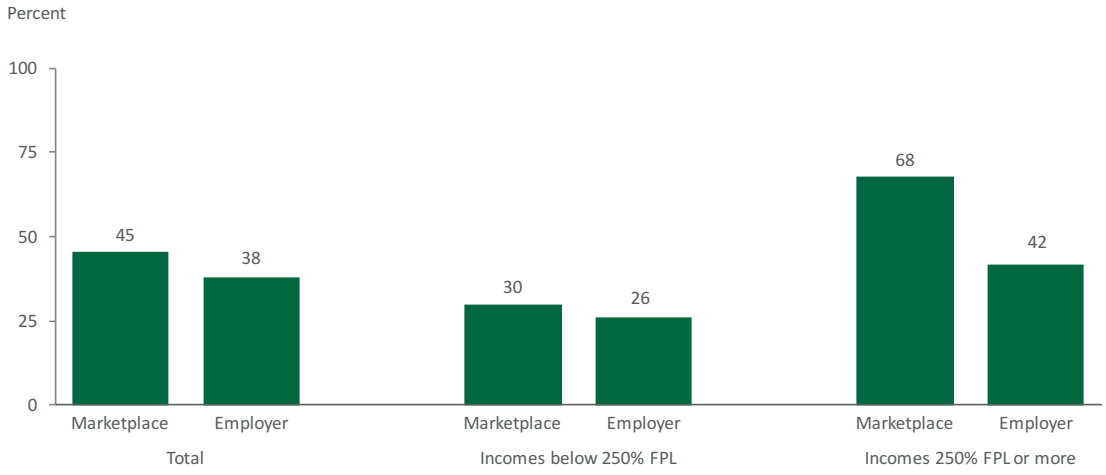
The ACA requires insurers that sell plans in the marketplaces to offer silver-level plans that come with cost-sharing reductions for adults earning between 100 percent and 250 percent of the federal poverty level. These reductions lower an individual's deductible amount, copayments, and coinsurance, substantially so for enrollees with the lowest incomes.[6] In 2016, 57 percent of marketplace enrollees are estimated to be covered by plans with these reductions.[7]

The effect is clear: among marketplace enrollees living under 250 percent of poverty, 30 percent said they had deductibles of $1,000 or more (Exhibit 3). But more than two-thirds (68%) of marketplace enrollees at 250 percent of poverty or more reported deductibles of $1,000 or greater. Cost-sharing reductions become less generous as income rises and are phased out completely at 250 percent of poverty. The share of adults with incomes between 138 percent and 250 percent of poverty with deductibles of $1,000 or greater was also significantly smaller than the share of adults with incomes of 250 percent of poverty or higher (45% vs. 68%) (data not shown).

Cost-sharing reductions have made deductibles similar to those incurred in employer plans for adults with lower incomes. The share of lower-income adults with high deductibles is similar in marketplace plans and in employer plans. At higher incomes, however, marketplace enrollees were significantly more likely than employer plan enrollees to have a high-deductible plan.

Exhibit 3

Low-Income Adults with Marketplace Coverage Less Likely to Have High Deductibles Than Adults with Higher Incomes



Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

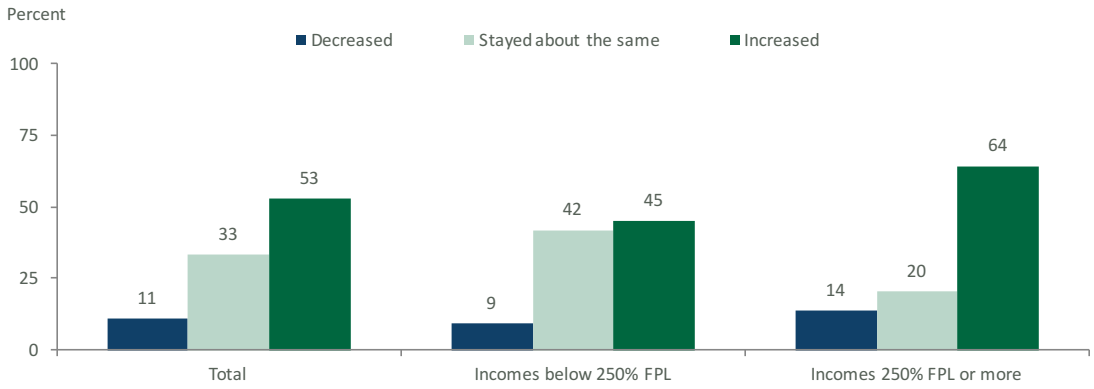
Lower-Income Adults with Marketplace Coverage Less Likely to Report Premium Increase

The survey finds evidence that the tax credits are protecting many enrollees from premium increases. Higher-income adults were much more likely to report premium increases than lower-income adults were (Exhibit 4). About two-thirds (64%) of people in marketplace plans with incomes of 250 percent of poverty or more reported their premiums had increased over the time they had their plan, compared to 45 percent of adults with lower incomes who receive the largest tax credits.

Exhibit 4

Low-Income Adults with Marketplace Coverage Less Likely to Have Premium Increases Than Adults with Higher Incomes

Over the time you have had a health plan through the marketplace, has the amount you have had to pay in premiums increased, decreased, or stayed about the same?



Adults ages 19–64 who have had marketplace coverage since before January 2016

Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

In contrast to premiums, deductibles and copayments on average were more likely to have stayed the same over the course of people's enrollment in the marketplaces. Half (51%) of adults who had marketplace coverage since before January 2016 and whose plans had a deductible reported that their deductible amounts stayed the same, while 36 percent reported an increase and 10 percent reported a decrease (data not shown).[8] These results were similar across income categories. Similarly, nearly half of adults with marketplace coverage since before January 2016 reported the amount they pay in either copayments or coinsurance for doctor visits (48%) and prescription drugs (45%) has stayed the same (data not shown). One-third (34%) of enrollees reported their copayments or coinsurance increased for doctor visits, while 29 percent reported an increase for prescription drugs.

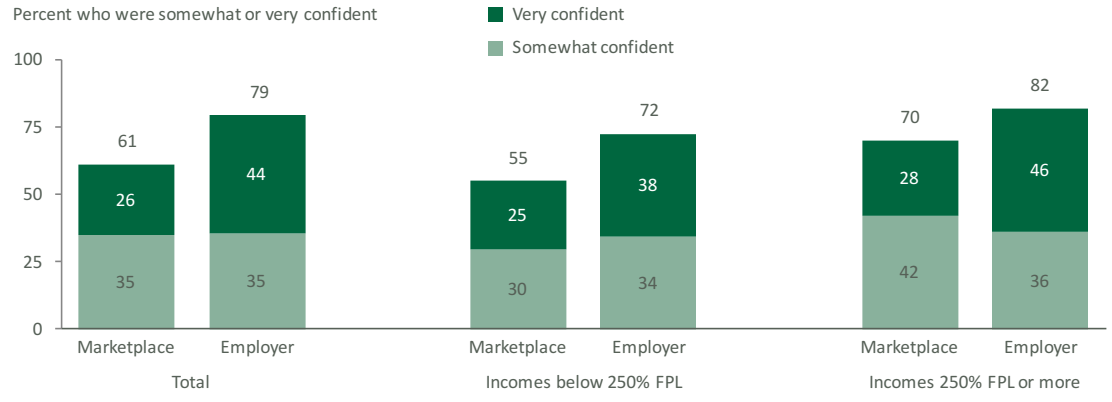
Most Marketplace Enrollees Were Confident They Could Afford Health Care If Sick

We asked people about their confidence in their ability to afford care if they were to become seriously ill. Majorities of people with marketplace plans (61%) and employer plans (79%) were very or somewhat confident they could afford needed care if they became sick, but larger shares of those with employer plans expressed confidence (Exhibit 5).

Exhibit 5

Majority of Adults with Marketplace Coverage Confident They Could Afford Needed Care

How confident are you that if you became seriously ill you will be able to afford the health care that you need?



Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

PROVIDER NETWORKS

Four of 10 Adults Chose a Narrow Network Plan

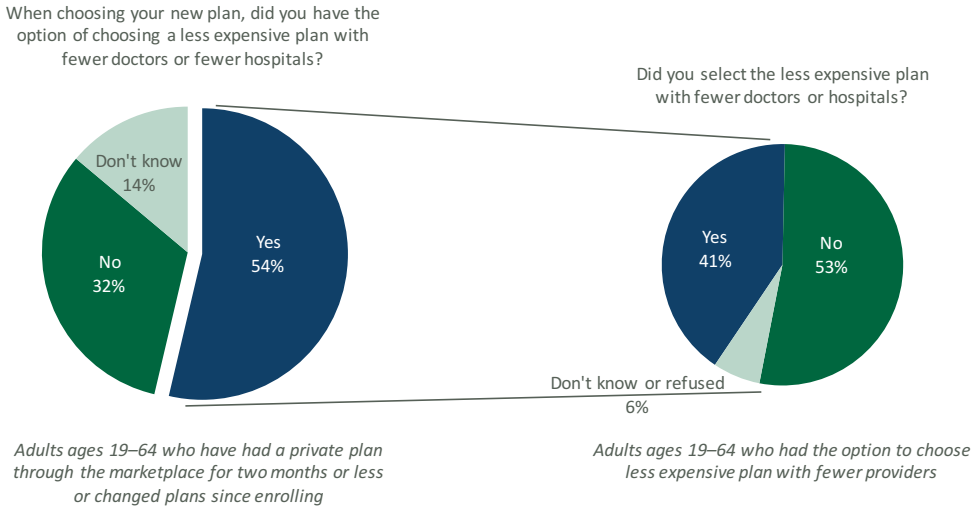
Insurer competition in the marketplaces has led to the proliferation of health plans that offer a narrow, or limited, network of health care providers at a lower price than plans with broader networks. This has led to concerns over access to care.

In the survey, more than half (54%) of people who were enrolled in a marketplace plan for the first time or who had changed plans said they had the option of choosing a less expensive plan featuring fewer doctors or hospitals (Exhibit 6). Of those, 41 percent selected the limited network plan.

Across all marketplace plans, more than three-quarters (78%) of enrollees who either recently enrolled or had changed plans reported being very or somewhat satisfied with the doctors covered by their insurance (Exhibit 7). Among these adults, 64 percent reported their plans have some or all of the doctors they want. Sample size limitations prevented us from examining differences between people enrolled in narrow vs. broader network plans.

Exhibit 6

Four of Ten Adults Chose a Less Expensive Plan with Fewer Providers When Given the Option

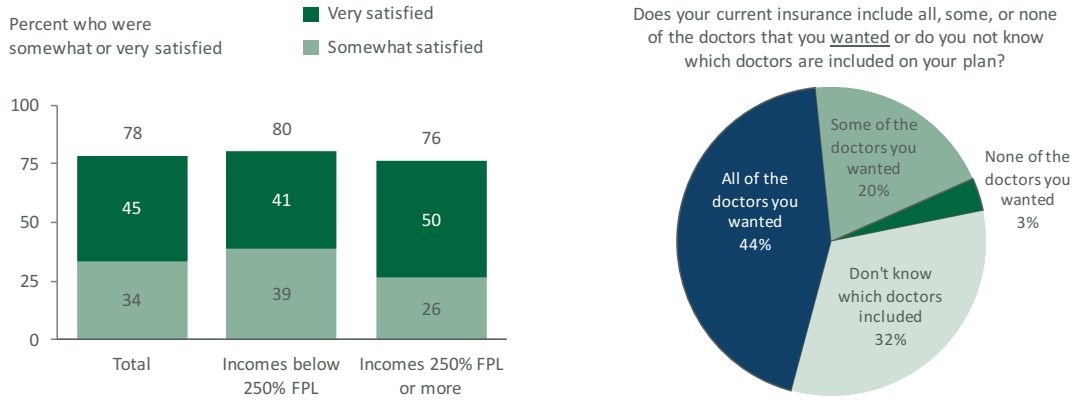


Note: Segments may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Exhibit 7

Four of Five Adults with New Marketplace Coverage Are Satisfied with the Doctors in Their Plans

Since you switched/gained your insurance, how satisfied are you with the doctors covered by your new insurance?



Adults ages 19–64 who have had a private plan through the marketplace for two months or less or changed plans since enrolling or switched from Medicaid to marketplace

Note: Segments may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

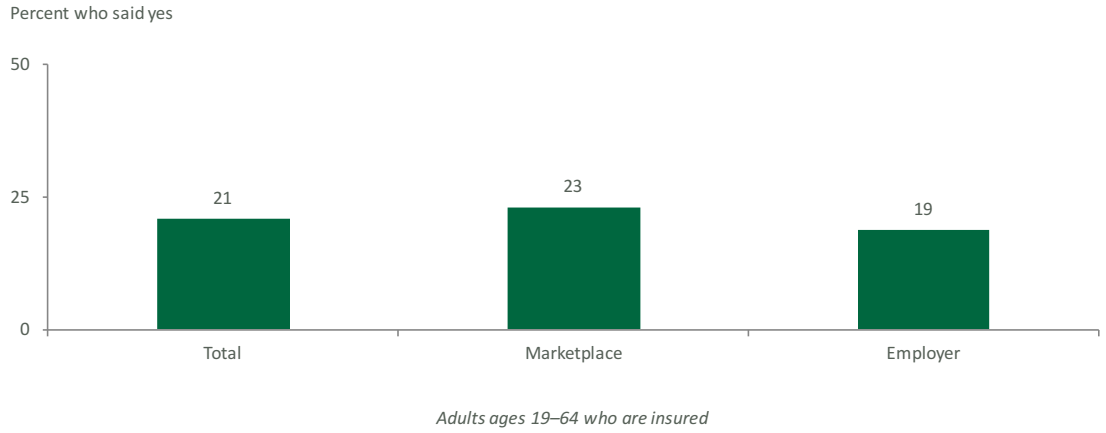
Rate of "Surprise Medical Bills" Similar in Employer and Marketplace Plans

The proliferation of narrow network plans does not appear to be creating more problems with so-called surprise medical bills. Such bills arrive unexpectedly from an out-of-network provider, as when, for example, a patient is operated on by an in-network surgeon at an in-network hospital but is billed by an out-of-network anesthesiologist.[9] We found no difference in the rate of reports of surprise bills between adults with employer coverage and adults with marketplace coverage: about one of five in both groups reported they had experienced a surprise medical bill (Exhibit 8).

Exhibit 8

Rate of "Surprise Medical Bills" Similar for Adults Insured with Employer and Marketplace Coverage

Have you or a family member ever received care at a hospital that you thought was covered by your insurance, but you received a bill from a doctor who was not covered by your plan?



Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

SHOPPING FOR MARKETPLACE PLANS

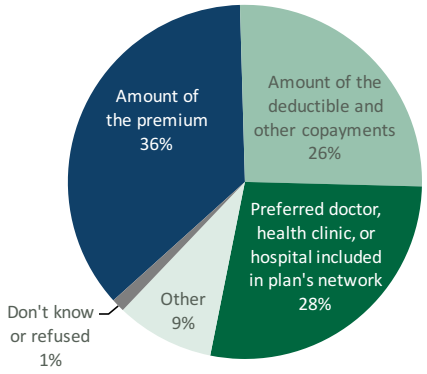
Cost Was Most Important Factor in Selecting a Plan

Premiums and cost-sharing figured most prominently in people's decisions regarding choice of marketplace plan (Exhibit 9). Six of 10 (62%) adults who either had enrolled in private plans through the marketplace for the first time or switched health plans said the premium amount (36%) or the amount of the deductible and copayments (26%) was the most important factor in their decision. Choice of doctors and hospitals was also important. More than one-quarter (28%) said the inclusion of their preferred provider (doctor, health clinic, or hospital) in their plan's network was the most important factor in choosing a plan.

Exhibit 9

Cost Is the Most Important Factor in Plan Selection Among Marketplace Enrollees

What was the most important factor in your decision about which plan to select?



Adults ages 19–64 who have had a private plan through the marketplace for two months or less or changed plans since

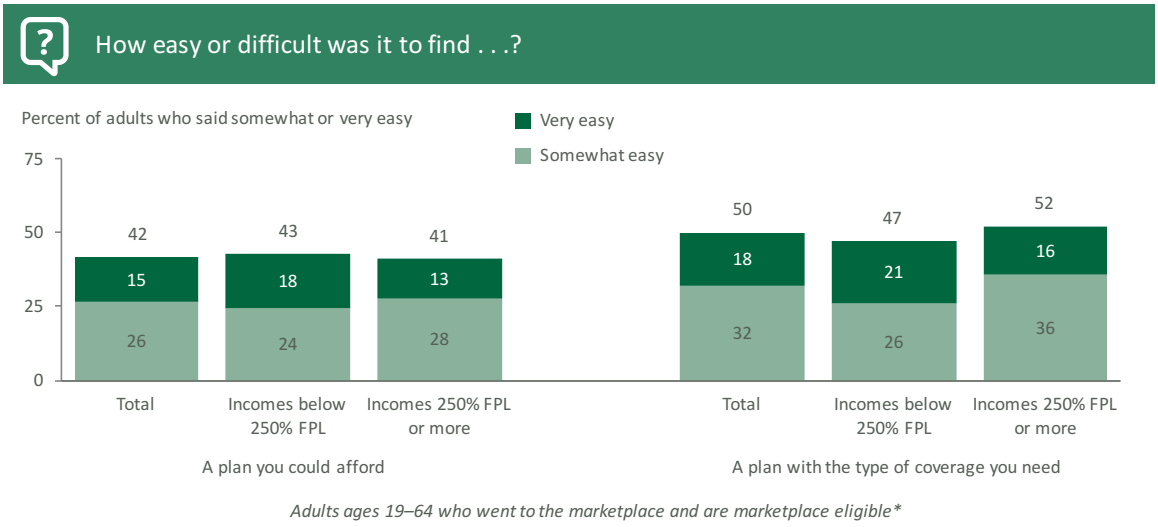
Note: Segments may not sum to 100 percent because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Fewer Than Half of Adults Found It Easy to Find an Affordable Plan

When asked about their experiences finding affordable plans and adequate coverage, adults' views were the same as they were in April-to-June 2014 and March-to-May 2015 (see the Affordable Care Act Tracking Survey interactive). Low- and higher-income adults alike found it difficult to find affordable plans. This year, 42 percent of adults who visited the marketplace and whose incomes make them eligible for coverage said it was somewhat or very easy to find an affordable plan (Exhibit 10).[10]

Exhibit 10

Fewer Than Half of Adults Said It Was Easy to Find an Affordable Plan



* Marketplace eligible includes adults in expansion states with incomes >138% FPL and adults in nonexpansion states with incomes >100% FPL.
Notes: FPL refers to federal poverty level. 250% of FPL is $29,425 for an individual or $60,625 for a family of four. Segments may not sum to subtotals because of rounding.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Why Do Marketplace Enrollees Switch Plans or Keep Them?

Nearly half (46%) of adults with marketplace coverage since before the most recent open enrollment period said they have changed plans over the time they have had coverage.[11] We asked why people had either changed or kept their plans.

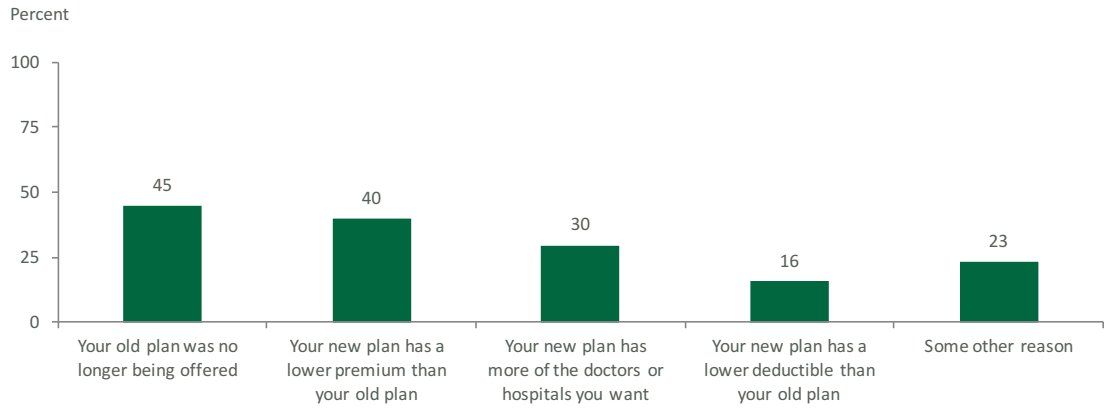
Switching plans. Among adults who had changed their marketplace plans, 45 percent did so because their old plan was no longer being offered (Exhibit 11). Similar to their priorities in selecting a plan, 40 percent reported they switched plans for a lower premium, 30 percent did so for more of the doctors or hospitals they want, and 16 percent did so to obtain a lower deductible.

Keeping the same plan. Most adults (87%) reported they kept the same plan simply because it was easier to do so (Exhibit 12). About three-quarters (77%) of adults said they kept the same plan because they were satisfied with their coverage, and 64 percent did so because they liked the doctors in their network.

Exhibit 11

Consumers Cite Costs, Choice of Providers as Factors When Switching Plans

What are the reasons you changed plans?



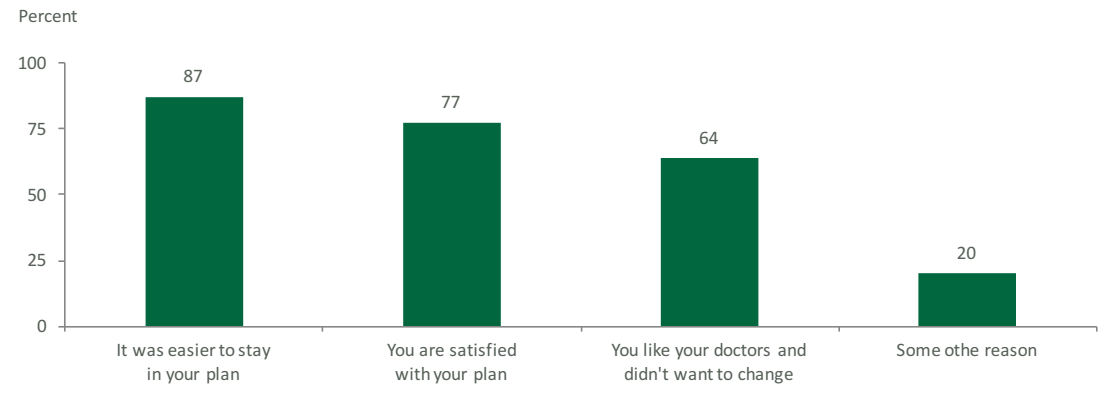
*Adults ages 19–64 who changed marketplace plans**

* 46 percent of adults ages 19–64 who have had marketplace coverage since before January 2016 switched plans since enrolling.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

Exhibit 12

Adults Said Staying in Same Marketplace Plan Was Easier

What are the reasons you kept the same plan?



*Adults ages 19–64 who stayed in the same plan marketplace plan**

* 50 percent of adults ages 19–64 who have had marketplace coverage since before January 2016 stayed in the same plan since enrolling.
Data: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

CONCLUSION

The affordability of marketplace plans continues to be the subject of considerable debate. A recent analysis of insurers' 2017 rate requests in 14 large cities by the Kaiser Family Foundation finds a weighted average increase of 10 percent.[12] While these preliminary requests are subject to state rate review, it is likely that premium increases will be higher in 2017 than in 2016.[13]

However, most consumers will be shielded from the full premium increase. More than eight of 10 marketplace enrollees have tax credits to help pay their premiums. The tax credit is calculated as the difference between what enrollees are required to pay as a share of their income and the premium of the benchmark silver plan in their market. This means that most of the premium increases next year will be absorbed by enrollees' tax credits, particularly if they select the benchmark plan. An analysis by the U.S. Department of Health and Human Services (HHS) of 2016 premiums found that among people eligible for tax credits in marketplace plans, premiums rose by just 4 percent on average, or $4 per month, despite earlier predictions of much larger increases across plans offered in 2015.[14] The large amount of plan switching found in this survey, as well as in HHS marketplace data, indicates that many people will likely shop for the best deal.

The findings present cautionary notes for policymakers. People with higher incomes with marketplace coverage who receive little to no subsidy are more likely to pay more for their premiums and have a high deductible than those in employer plans. Overall, people in marketplace plans are less likely than those in employer plans to view their plans as affordable; fewer than half of those who had shopped for a plan said it was easy to find a plan they could afford. Adjustments to the marketplaces will likely be needed to ensure that consumers can afford both the insurance and the health care they need. These could include changes to the marketplace subsidies and to the law's premium stabilization programs—in particular, the reinsurance program—that have helped moderate premium growth in the marketplace's first three years. However, the fundamental driver of premiums across all health insurance markets is the underlying rate of growth in medical costs. Therefore, ongoing systemwide efforts to slow the rate of increase in medical expenditures will be critical.

Table 1. Demographics of Overall Sample, Adults Enrolled in the Marketplace, and Adults Enrolled in Employer-Sponsored Insurance

	Total adults (% ages 19–64)	Enrolled in a private health plan through the marketplace (%)	Enrolled in employer-sponsored insurance (%)
Unweighted n	4,802	432	2,237
Age			
19–34	34	32	29
35–49	32	28	35
50–64	32	37	33
Race/Ethnicity			
Non-Hispanic White	61	60	70
Black	13	14	9
Latino	17	21	11
Asian/Pacific Islander	5	2	5
Other/Mixed	2	1	2
Poverty status			
Below 138% poverty	30	27	9
138%–249% poverty	20	32	17
250%–399% poverty	18	22	23
400% poverty or more	32	19	51
Health status			
Fair/Poor health status, or any chronic condition or disability[a]	52	48	45
No health problem	48	52	55
Political affiliation			
Democrat	29	34	28
Republican	19	20	22
Independent	24	23	25
Something else	17	14	16
Adult work status			
Full-time	53	43	73
Part-time	14	25	10
Not working	33	32	17
Employer size[b]			
1–24 employees	26	49	15
25–99 employees	14	18	12
100–499 employees	14	11	16
500 or more employees	43	18	54

[a] At least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; or high cholesterol.

[b] Base: full- and part-time employed adults ages 19–64.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016.

NOTES

[1] By the end of The Affordable Care Act's third open enrollment period, marketplace plan enrollment had climbed to 11.1 million people and 15 million more people were enrolled in Medicaid compared to three years earlier. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (CMS, June 30, 2016); U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid & CHIP: April 2016 Monthly Applications, Eligibility Determinations and Enrollment Report* (CMS, June 30, 2016).

[2] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction* (The Commonwealth Fund, May 2016).

[3] The tax credits cap what people pay in premiums as a share of their income, and range from 2.03 percent to 9.66 percent for adults earning between 100 percent and 400 percent of poverty. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (CMS, June 30, 2016).

[4] A larger share of adults with employer plans (10%) did not know the amount of their premium costs than did those with marketplace plans (2%). This is likely because most people with employer health benefits receive and make premium contributions through their paychecks while those with marketplace plans shop for insurance and pay their premiums directly. Included in this response are some people who refused to answer the question.

[5] In the Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014, 49 percent of adults ages 19 to 64 who paid all or some of their premiums and were aware of their premium amount found it somewhat or very easy to afford their premium costs for their health insurance.

[6] S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* (The Commonwealth Fund, March 2016).

[7] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (CMS, June 30, 2016).

[8] Seventy-six percent of adults ages 19 to 64 who have had marketplace coverage since before January 2016 reported their health plan has a deductible. We include adults who reported they currently do not have a deductible but have had a marketplace plan with a deductible in the past. These adults are considered to have deductibles that have decreased over the time they had marketplace coverage.

[9] A 2011 survey found that 40 percent of the respondents that had used out-of-network care did so involuntarily, and a 2015 Consumers Union survey found that 30 percent of privately insured Americans received a surprise medical bill in the prior two years. K. A. Kyanko, L. A. Curry, and S. H. Busch, "Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?" *Health Services Research,* June 2013 48(3):1154–72; and *Surprise Medical Bills Survey, 2015 Nationally Representative Online Survey* (Consumer Reports National Research Center, May 5, 2015). Recently some states have put in place measures to prevent consumers from receiving these bills. New York's "Emergency Medical Services and Surprise Bills Law" went into effect in March 2015 and prohibits consumers in state-regulated health plans from being charged more than in-network cost-sharing for out-of-network services in both emergency and non-emergency situations. A number of other states also have limited regulations aimed at addressing surprise medical bills. See K. Pollitz, *Surprise Medical Bills* (Henry J. Kaiser Family Foundation, March 17, 2016); and J. Hoadley, S. Ahn, and K. Lucia, *Balance Billing: How Are States Protecting Consumers from Unexpected Charges?* (Robert Wood Johnson Foundation, June 2015).

[10] Marketplace-eligible adults are those in Medicaid expansion states who have incomes above 138 percent of the federal poverty level and those in nonexpansion states who have incomes above 100 percent of poverty.

[11] This switching rate is much higher than that in employer plans, the Federal Employees Health Benefits Program, and Medicare Part D. T. DeLeire and C. Marks, *Consumer Decisions Regarding Health Plan Choices in the 2014 and 2015 Marketplaces,* ASPE Issue Brief (U.S. Department of Health and Human Services, Oct. 28, 2015).

[12] C. Cox, G. Claxton, L. Levitt et al., *Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces* (Henry J. Kaiser Family Foundation, June 15, 2016).

[13] S. R. Collins, *Consumer Experiences in the ACA Marketplaces, Marketplace Stability, and Remaining Challenges to Covering the Uninsured,* Invited testimony, U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Hearing on "Advancing Patient Solutions of Lower Costs and Better Care," June 10, 2016.

[14] Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015–2016,* ASPE Issue Brief (U.S. Department of Health and Human Services, April 12, 2016).

HOW THIS SURVEY WAS CONDUCTED

The Commonwealth Fund Affordable Care Act (ACA) Tracking Survey, February–April 2016, was conducted by SSRS from February 2 to April 5, 2016. The survey consisted of 15-minute telephone interviews in English or Spanish, conducted among a random, nationally representative sample of 4,802 adults ages 19 to 64 living in the United States. Overall, 1,496 interviews were conducted on landline telephones and 3,306 interviews on cell phones.

This survey is the fourth in a series of Commonwealth Fund surveys to track the implementation and impact of the ACA. The first was conducted by SSRS from July 15 to September 8, 2013, by telephone among a random, nationally representative U.S. sample of 6,132 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 1.8 percentage points at the 95 percent confidence level.

The second survey in the series was conducted by SSRS from April 9 to June 2, 2014, by telephone among a random, nationally representative U.S. sample of 4,425 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level. The sample for the April–June 2014 survey was designed to increase the likelihood of surveying respondents who were most likely eligible for new coverage options under the ACA. As such, respondents in the July–September 2013 survey who said they were uninsured or had individual coverage were asked if they could be recontacted for the April–June 2014 survey. SSRS also recontacted households reached through their omnibus survey of adults who were uninsured or had individual coverage prior to the first open enrollment period for 2014 marketplace coverage.

This third survey in the series was conducted by SSRS from March 9 to May 3, 2015, by telephone among a random, nationally representative U.S. sample of 4,881 adults ages 19 to 64. The March–May 2015 sample also was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. SSRS recontacted households reached through their omnibus survey of adults between November 5, 2014, and February 1, 2015, who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. The survey had an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level.

The February–April 2016 sample also was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. Interviews in wave 4 were obtained through two sources: stratified random-digit-dialing sample, using the same methodology as in waves 1, 2 and 3; and households reached through the SSRS omnibus survey, where interviews were previously completed with respondents ages 19 to 64 who were uninsured, had individual coverage, had a marketplace plan, or had public insurance.

As in all waves of the survey, SSRS oversampled adults with incomes under 250 percent of poverty to further increase the likelihood of surveying respondents eligible for the coverage options as well as allow separate analyses of responses of low-income households.

The data are weighted to correct for the stratified sample design, the use of recontacted respondents from the omnibus survey, the overlapping landline and cell phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. 19-to-64 adult population by age, gender, race/ethnicity, education, household size, geographic division, and population density using the U.S. Census Bureau's 2014 American Community Survey, and weighted by household telephone use using the U.S. Centers for Disease Control and Prevention's 2014 National Health Interview Survey.

The resulting weighted sample is representative of the approximately 189 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard regression imputation procedure. The survey has an overall margin of sampling error of +/– 2.0 percentage points at the 95 percent confidence level. The land-line portion of the main-sample survey achieved a 22.6 percent response rate and the cellular phone main-sample component achieved a 13.9 percent response rate. The overall response rate, including the prescreened sample, was 13.9 percent.

About the Authors

Munira Z. Gunja, M.P.H., is senior research associate in the Health Care Coverage and Access program at The Commonwealth Fund. Ms. Gunja joined the Fund from the U.S. Department of Health and Human Services in the office of the Assistant Secretary for Planning and Evaluation (ASPE), Division of Health Care Access and Coverage, where she received the Secretary's Award for Distinguished Service. Before joining ASPE, Ms. Gunja worked for the National Cancer Institute where she conducted data analysis for numerous studies featured in scientific journals. She graduated from Tulane University with a B.S. in public health and international development and an M.P.H. in epidemiology.

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

Michelle McEvoy Doty, Ph.D., is vice president of survey research and evaluation for The Commonwealth Fund. She has authored numerous publications on cross-national comparisons of health system performance, access to quality health care among vulnerable populations, and the extent to which lack of health insurance contributes to inequities in quality of care. Dr. Doty holds an M.P.H. and a Ph.D. in public health from the University of California, Los Angeles.

Sophie Beutel is program associate in the Health Care Coverage and Access program. In this role, she is responsible for providing daily support for the program with responsibilities ranging from daily administrative and grants management tasks to writing and research responsibilities, including tracking developments in the implementation of the Affordable Care Act. Prior to joining the Fund, she was a summer intern with the State of Rhode Island Department of Health. Ms. Beutel graduated from Brown University with a B.A. in Science and Society, on the Health and Medicine track.

Acknowledgments

The authors thank Robyn Rapoport and Arina Goyle of SSRS; and David Blumenthal, Don Moulds, Eric Schneider, Kathy Regan, Deborah Lorber, Chris Hollander, Paul Frame, Jen Wilson, David Squires, and Cornelia Hall of The Commonwealth Fund.

Editorial support was provided by Deborah Lorber.

The
COMMONWEALTH
FUND

www.commonwealthfund.org