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THE HEALTH OF AMERICA REPORT

NEWLY ENROLLED MEMBERS IN
THE INDIVIDUAL HEALTH INSURANCE
MARKET AFTER HEALTH CARE REFORM:

THE EXPERIENCE FROM 2014 AND 2015



BLUE CROSS BLUE SHIELD, THE HEALTH OF AMERICA REPORT

EXECUTIVE SUMMARY



The Affordable Care Act (ACA) expanded access to health insurance for millions of Americans and broadened medical benefits. Under the health reform law, anyone can obtain coverage regardless of age and health status. The law also applied the ACA's insurance reforms and expanded benefits to individual policies sold outside of government marketplaces.

Major reforms took effect in 2014, prompting many individuals who lacked coverage, and needed immediate health care services, to enroll for coverage. In addition, many individuals with significant medical conditions had previously been covered through state-based "high-risk" pools, and these people also transitioned into individual coverage. Overall, individual policies before reform offered less generous benefits. The ACA broadened benefits made available to everyone, including, for example, preventive services and screenings, maternity care, disease management, mental health and substance abuse services.

For more than 80 years, Blue Cross and Blue Shield (BCBS) companies have provided secure and stable health coverage to people in communities across the country. As part of this continuing commitment, BCBS companies have participated in the new ACA marketplaces more broadly than any other insurance carrier. As a result, millions of newly enrolled BCBS members are the largest single group of individuals whose health status and use of medical services can be examined for key insights into the medical needs and costs associated with providing care for the new individual market enrollees.

This report is a comprehensive, in-depth study of medical claims among those enrolled in BCBS individual coverage before and after the ACA took effect. In addition, the report also compares the newly enrolled ACA members to those who receive insurance through their employers.

Because the ACA guarantees coverage for pre-existing conditions and broadens benefits available to everyone, individual policies that comply with the law now resemble those offered by employer groups. Thus, comparing the health status, use of medical services and costs of caring for members receiving coverage through the employer market with those covered through ACA-compliant¹ individual policies is important to understanding the dynamics now at work in the health care system.

1. "ACA-compliant" coverage describes health insurance purchased on or off the ACA marketplaces that meets all of the requirements of the ACA for individual coverage. Compared with individual insurance purchased prior to 2014, ACA-compliant coverage has richer benefits on average and may be subsidized for individuals depending on their incomes.



Comparing the health status and use of medical services among those who enrolled in individual coverage before and after the ACA took effect, as well as those with employer-based health insurance, the study finds that:

- Members who newly enrolled in BCBS individual health plans in 2014 and 2015 have higher rates of certain diseases such as hypertension, diabetes, depression, coronary artery disease, human immunodeficiency virus (HIV) and Hepatitis C than individuals who already had BCBS individual coverage.
- Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical services in their first year of coverage, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015, as well as those with BCBS employer-based group health coverage.
- The new enrollees used more medical services across all sites of care—including inpatient hospital admissions, outpatient visits, medical professional services, prescriptions filled and emergency room visits.
- Medical costs associated with caring for the new individual market enrollees were, on average, 19 percent higher than employer-based group members in 2014 and 22 percent higher in 2015. For example, the average monthly medical spending was \$559 for individual enrollees versus \$457 for employer-based group members in 2015.

STUDY FINDS...

Newly enrolled in BCBS individual health plans in 2014 and 2015 appear to:

- have higher rates of certain diseases**
- used more medical services across all sites of care**
- have higher medical costs associated with care**

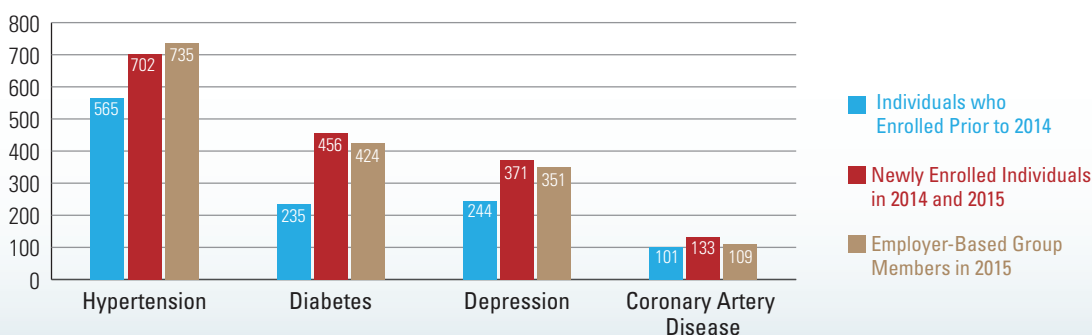
The data underscores the need for health insurers, medical professionals and newly insured consumers to work together to ensure that individuals understand their benefits, and use them to improve their health and well-being. BCBS companies are changing their individual health plan products to enhance care management programs to address the unique needs of this population. In addition, patient-focused care programs that emphasize prevention, wellness and coordinated care—programs that are offered across the country by Blue Cross and Blue Shield companies—can support individuals in getting healthy faster and staying healthy longer.

DISEASE PREVALENCE AND USE OF MEDICAL SERVICES

Consumers who newly enrolled in BCBS individual health plans in 2014 and 2015 received significantly more medical services in 2015, on average, than those with BCBS individual plans prior to 2014 who maintained BCBS individual health coverage into 2015.

During the first nine months of 2015, data show that those who enrolled for coverage after the ACA had higher rates of hypertension, diabetes, coronary artery disease and depression than individuals who enrolled prior to 2014. Due to the shorter period of time for which claims data on this group is available, it is possible that the rate of disease among individuals newly enrolled in 2014 and 2015 is underestimated in this report.

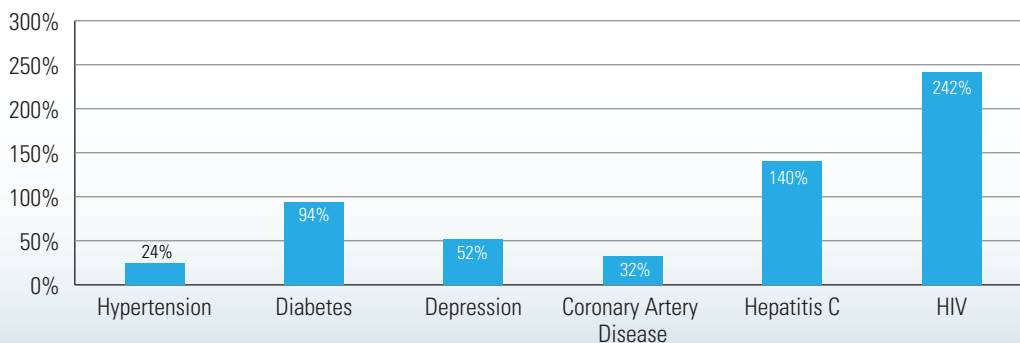
2015 PREVALENCE OF SELECT CONDITIONS (PER 10,000)



Based on the first nine months of 2015 medical claims data.
The blue bar represents individuals who enrolled prior to 2014 and continued BCBS individual coverage into 2015.

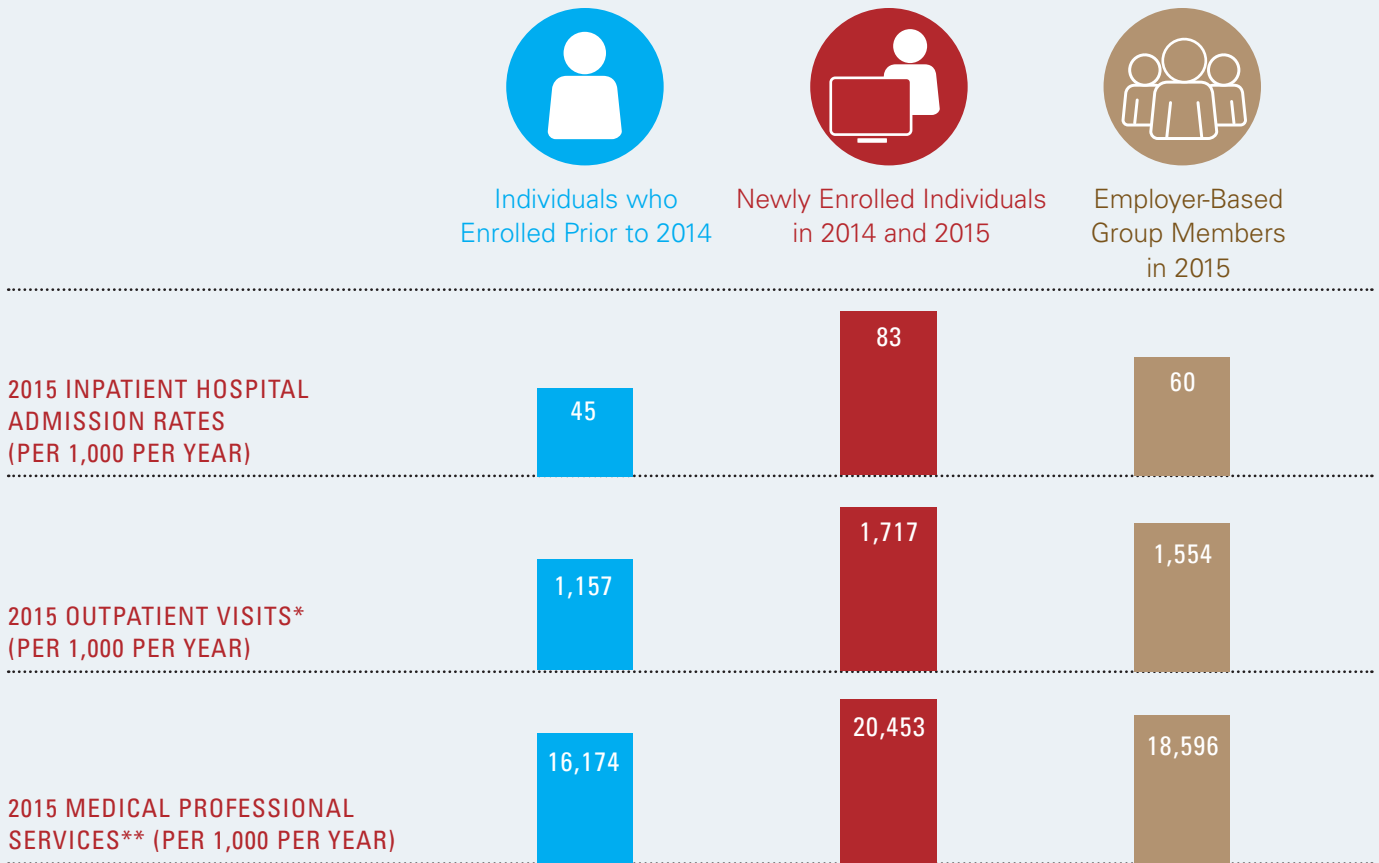
Those enrolling after health-care reform took effect also had higher rates of HIV and Hepatitis C in 2015. New enrollees have rates of HIV and Hepatitis C of 41 and 24 per 10,000 respectively, compared to 12 and 10 respectively among those with individual policies prior to health care reform. Rates of HIV and Hepatitis C for those who receive insurance through their employers were 11 per 10,000 for both conditions.

PERCENTAGE DIFFERENCE IN 2015 PREVALENCE OF SELECT CONDITIONS BETWEEN INDIVIDUALS WHO ENROLLED PRIOR TO 2014 VERSUS NEWLY ENROLLED IN 2014 AND 2015



Based on the first nine months of 2015 medical claims data.

New enrollees also utilized more medical services across all sites of care in 2015 compared to enrollees who first purchased their coverage prior to 2014. Inpatient admissions were higher by 84 percent; outpatient visits by 48 percent and medical professional services by 26 percent. New enrollees also utilized more medical services compared to members who received their coverage through an employer, with inpatient admissions higher by 38 percent; outpatient visits by 10 percent and medical professional services by 10 percent.

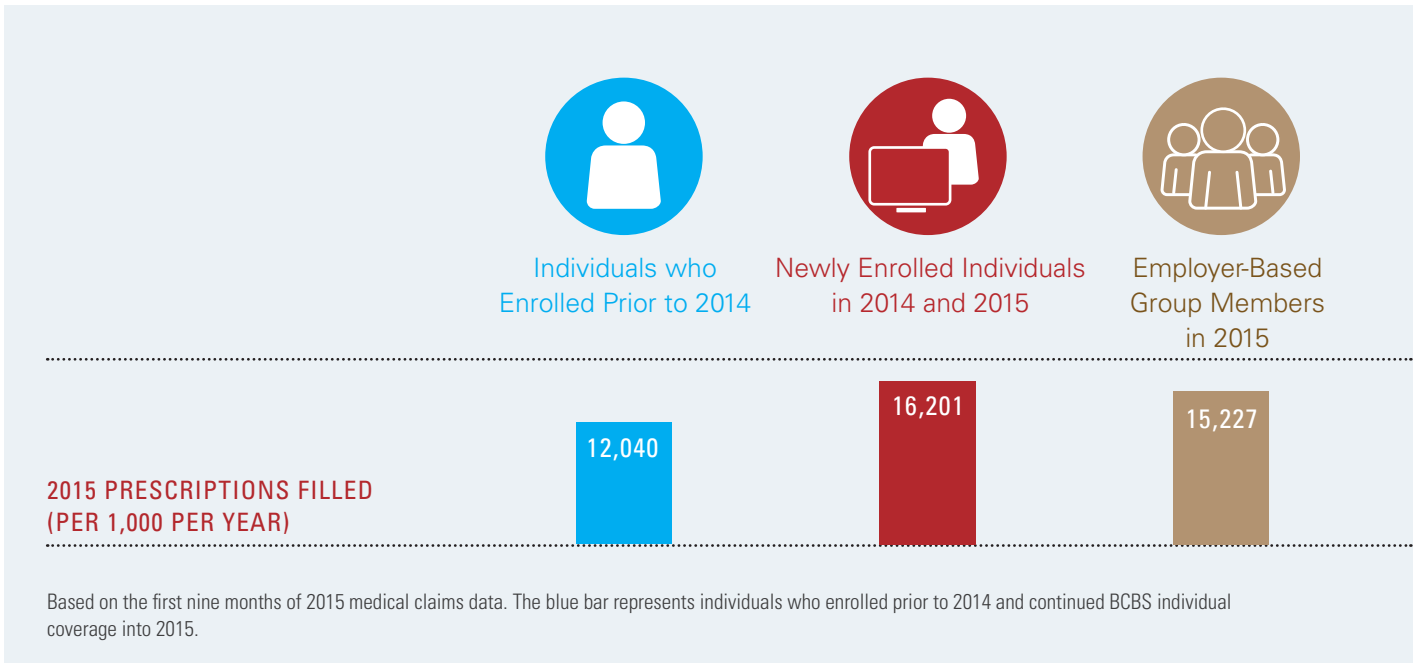


Charts based on the first nine months of 2015 medical claims data. The blue bar represents individuals who enrolled prior to 2014 and continued BCBS individual coverage into 2015.

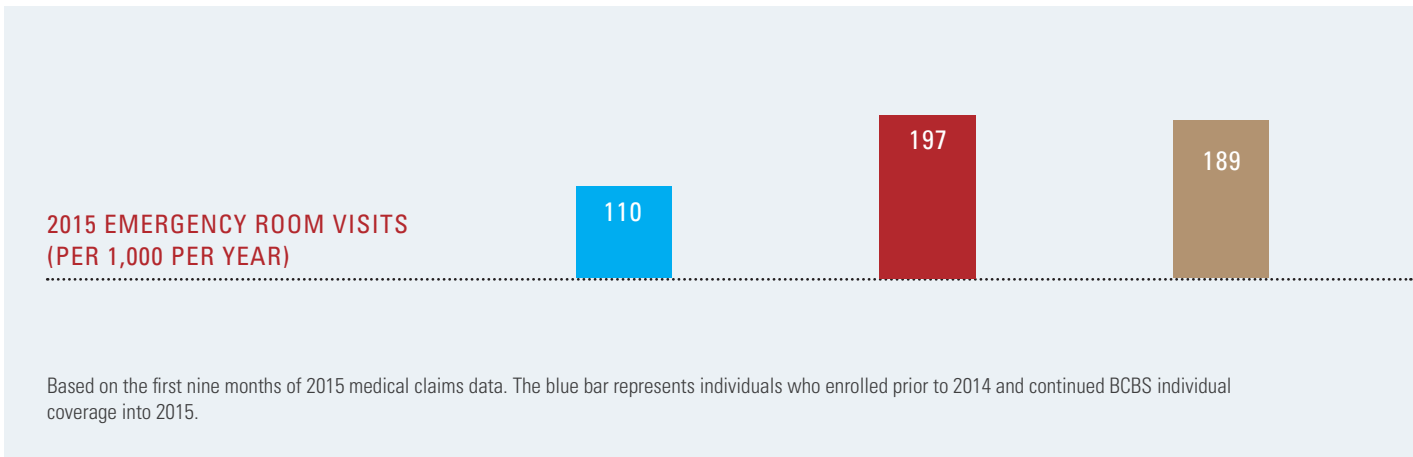
* Outpatient encompasses medical bills submitted by hospitals and health care centers for reimbursement. Patients visit and leave the medical facility on the same day.

** Medical Professional Service encompasses medical bills submitted by physicians and other medical professionals for reimbursement.

New enrollees filled 35 percent more prescriptions in 2015 compared to enrollees who first purchased their coverage prior to 2014 and six percent more prescriptions compared to those who received their coverage through an employer.



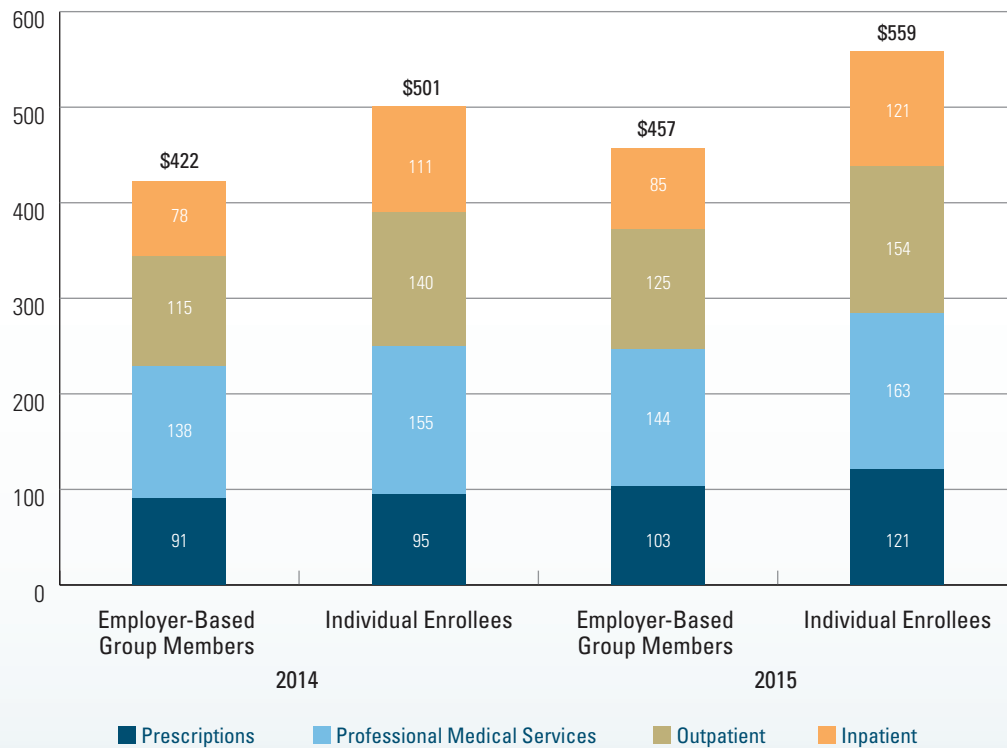
Another clear difference between the previously enrolled individual members and the newly enrolled population is their use of hospital emergency rooms (ER). ER use among the newly enrolled population was 79 percent higher than that of the previously enrolled during the first nine months of 2015 and slightly higher than those who receive their coverage through an employer.



MEDICAL SPENDING IN 2014 AND 2015

Average monthly medical spending per member for consumers who newly enrolled in BCBS individual coverage after health-care reform took effect increased 12 percent—from \$501 to \$559—from the first nine months of 2014 to the first nine months of 2015. This increase is due to several factors, including an increased use of medical services and underlying medical-cost inflation. All types of medical services saw increases. By comparison, spending on BCBS members with employer-based group coverage rose eight percent—from \$422 to \$457—during the first nine months of 2014 compared to the same period in 2015. Medical costs of caring for individual members were, on average, 19 percent higher than employer-based group members in 2014 and 22 percent higher in 2015.

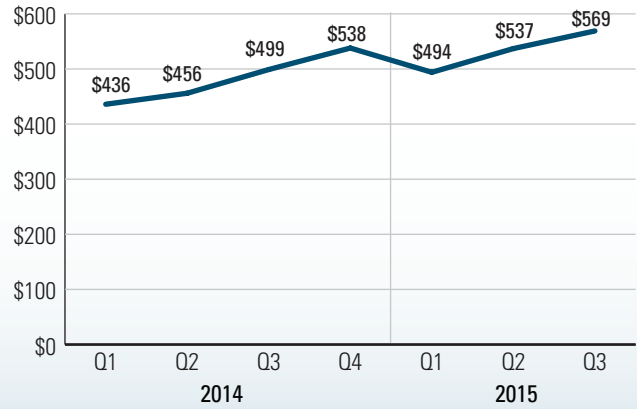
AVERAGE MONTHLY SPENDING FOR INDIVIDUAL ENROLLEES AND GROUP MEMBERS IN 2014 AND 2015 BY TYPE OF SERVICE



Note: Based on medical claims data for the first nine months of 2014 and the first nine months of 2015. 2014 includes all new individual members who enrolled in 2014 through September 2014. 2015 includes all individual members who enrolled in 2014 and remained covered by a BCBS policy in 2015 and those who enrolled through September 2015. Exchange members age 21 through 64 who enrolled in 2015 were younger than those who enrolled in 2014 by a half year, with an average age of 45.1 in 2015 compared to 45.6 in 2014. Employer-based group members age 21 through 64 who enrolled in 2015 were slightly younger than those who enrolled in 2014, with an average age of 42.6 in 2015 compared to 42.7 in 2014.

Throughout the first 21 months of health-care reform, the average medical spending for new BCBS individual members increased steadily, consistent with seasonal patterns and how members typically utilize health benefits throughout the year. More time and data will be needed to understand the long-term health status and costs associated with caring for this new population. In addition, underlying medical-cost inflation and continued demand for medical services will continue to be factors.

**AVERAGE MONTHLY SPENDING PER MEMBER
BY CLAIM QUARTER**



Includes medical claims between Jan. 1, 2014 through Sept. 30, 2015.
Includes BCBS individual members age 21 through 64.

CONCLUSION

This is the first comprehensive, in-depth look at the medical needs and costs of caring for individuals enrolled in health insurance coverage with the expanded access and broader benefits called for under the ACA. The findings underscore the need for health insurers, medical professionals and newly insured consumers to work together and assure the most effective use of health care services in every community across the country.

To manage this transition to a new system in which everyone can obtain coverage, BCBS companies are advising consumers on the importance of primary care and medication adherence. It is important that newly insured consumers understand their benefits and are able to access preventive services in the right care setting, at the right time, to improve their health and avoid unnecessary emergency room visits. It is also important for members to be continually enrolled in order to maintain access to primary and preventive care, and fill prescriptions in a timely manner. Importantly, those with chronic conditions need quality, well-coordinated care to ensure the appropriate management of these diseases and improve patients' long-term health.

BCBS companies are expanding patient-focused care programs that emphasize prevention, wellness and coordinated care so that individuals get healthy faster and stay healthy longer. BCBS companies have engaged with more than 327,000 physicians and 2,000 hospitals that now serve 42 million members through these innovative care models. Through these programs, BCBS companies around the country have documented reductions in emergency room visits, fewer hospital admissions and readmissions and reduced hospital infection rates. At the same time, there have been measurable improvements in prevention, including improved cholesterol control, better adherence to best practices for treating diabetes and higher rates of screenings and immunizations.

Currently, BCBS companies serve millions of members through the ACA marketplaces in 46 states and the District of Columbia, with coverage in 89 percent of counties in both urban and rural areas. In addition to offering products on the federal and state-run marketplaces, all BCBS companies sell individual and employer-based group health insurance products throughout the country. BCBS companies insured more than 8.6 million individual members through Dec. 31, 2015.

METHODOLOGY NOTES

This report examines the medical claims of people enrolled in BCBS plans to compare the health status, use of medical services and cost of caring for three distinct populations:

- Individuals across the country who purchased BCBS coverage that became effective on or after January 1, 2014, through both state-based and federally-facilitated marketplaces, as well as individual, ACA-compliant policies sold outside of the government marketplaces;
- People who obtained BCBS coverage in the individual market prior to 2014 and continued to be enrolled in some type of BCBS individual market coverage into 2014 for 2014 statistics and 2015 for 2015 statistics; and
- People with BCBS employer-based group coverage.

The data in this report include approximately 4.7 million individual members and approximately 25 million employer-based group members and focuses on members ages 21 through 64. The impact of the federal risk adjustment program for the individual market is not reflected in this report. The charts report statistics calculated with the first nine months of claims data for each year because the medical claims for the fourth quarter of 2015 were not available at the time of publication. Using only the first nine months of data for both years ensures comparability. Data on medical spending are reported in terms of “allowed” medical costs—an insurance term that describes the total dollar amount paid to the provider and which includes both the insurer payment and member cost-sharing. By using allowed medical spending, claims data can be more easily compared across plans with different member cost-sharing, such as individual market plans with different metal levels.

The analysis relied on data from BCBS companies in many different parts of the country. The statistics discussed in the report represent collective results across many regions, and are not intended to represent the experience of any particular BCBS company. Each company’s circumstances are different; they face different state laws, are exposed to different market dynamics, have adopted varying strategies, and may have experienced divergent results in the individual market since 2014.

This is the sixth study of the Blue Cross Blue Shield, The Health of America Report series, a collaboration between the Blue Cross Blue Shield Association and Blue Health Intelligence, which uses a market-leading claims database to uncover key trends and insights into health care affordability and access to care.