Health Reform Monitoring Survey -- Texas

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Issue Brief #8:

Affordability of Marketplace Plans in the Largest Metropolitan Areas of Texas

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AT A GLANCE

Federal tax credits made some plans premium-free for individuals earning about $17,000 per year.

Even with tax credits, premiums for plans with the lowest coverage cost about $150 per month for individuals earning $35,000 per year.

Without tax credits, the cheapest Bronze plans are similarly priced across Texas cities, although plans with other levels of coverage varied more widely across the state.

Lower income Texans are much more likely to be uninsured than higher income residents of the state. Data collected by the Urban Institute and the Kaiser Commission on Medicaid indicate that in 2011-2012, 26% of individuals in Texas households with incomes between 139% and 250% of the federal poverty level were uninsured. The percent uninsured declined to 13% for households earning between 251% and 399% of the FPL, and to 10% for households earning 400%+ of the FPL. One of the strategies for making health care more attainable under the Affordable Care Act is the provision of tax credits to purchase insurance in state-based marketplaces for persons earning between 139% and 399% of the federal poverty level. We refer to this group as the "Target Population."

In June 2014, 15% or 1.5 million individuals in the Target Population in Texas remained uninsured. In Issue Brief 6 , we reported that almost half of the people in this income category did not buy a policy in 2014, because the costs were too high, or they did not have enough money. In this issue brief, we present and compare the premiums that were offered in the Texas marketplace for those who did and did not qualify for tax credits in the four largest cities in Texas.

ABOUT THE SURVEY

The Health Reform Monitoring Survey (HRMS) is a quarterly survey of adults ages 18-64 that began in 2013. It is designed to provide timely information on implementation issues under the ACA and to document changes in health insurance coverage and related health outcomes. HRMS provides quarterly data on health insurance coverage, access, use of health care, health care affordability, and self-reported health status. The HRMS was developed by the Urban Institute, conducted by GfK,

and jointly funded by the Robert Wood Johnson Foundation, the Ford Foundation, and the Urban Institute. Rice University's Baker Institute and The Episcopal Health Foundation are partnering to fund and report on key factors about Texans obtained from an expanded, representative sample of Texas residents (HRMS-Texas). The analyses and conclusions based on HRMS-Texas are those of the authors and do not represent the view of the Urban Institute, the Robert Wood Johnson Foundation or the Ford Foundation. Information about the sample demographics of the cohort is available in Issue Brief #1. This Issue Brief is a summary of data extracted from the HRMS Survey in Texas that was administered in June 2014. We will continue to report on survey data through additional Issue Briefs and future surveys.

COMPARING THE TARGET POPULATION ACROSS MAJOR CITIES IN TEXAS

We compared survey respondents in the Target Population living in the four largest core based statistical areas (CBSAs) in Texas: Dallas-Fort Worth, Houston, San Antonio, and Austin. CBSAs include each of these cities, plus counties closely related through commuting patterns. Table 1 providers rates of uninsurance for the adult nonelderly population for each CBSA as reported in the 2012 American Community Survey, which is the most recent U.S. Census data prior to when Healthcare.gov began selling insurance plans in the Marketplace in 2014.

Table 1: Uninsured Rates by City, Ages 18-64, 2012

	% who were uninsured
DFW	29.3
Houston	30.9
San Antonio	23.2
Austin	26.4

Source: American Community Survey, U.S. Census Bureau

The estimated size of the Target Population for these 4 metropolitan areas is 6,133,555 persons.

Table 2 lists the estimated number of persons in the Target Population by CBSA who enrolled in a Marketplace plan as of June 2014.

Table 2: Number of Marketplace Enrollments for the Target Population by City, June 2014

	Marketplace Enrollment
DFW	219,905
Houston	162,577
San Antonio	83,859
Austin	96,427

The estimated number of persons who enrolled in the 4 largest cities of Texas in these income categories totals 562,768, which is the majority of the total number of persons (734,000) who purchased insurance plans through the Marketplace through April 2014 as reported by the US Department of Health and Human Services.

COMPARING THE PREMIUMS OF MARKETPLACE PLANS ACROSS MAJOR CITIES IN TEXAS

Health insurance plans in the Marketplace were categorized by the Affordable Care Act according to the expected share of health care costs that customers would be expected to pay under each plan. Consumers who selected bronze plans could expect to pay 40% of health care costs out of pocket; silver plans on average would lead consumers to pay for 30% of costs out of pocket. And consumers who purchased the more expensive gold and platinum plans could expect to pay 20% and 10%, respectively, of health care costs out of pocket. Because plans at higher "metal levels" pay for a larger share of a patient's health care expenses, one would also expect insurers to charge larger premiums for these plans.

We examined the health insurance plans that were offered by insurers for 2014 in each of the four largest Texas metropolitan areas as reported by Healthcare.gov. Tables 3 and 4 list the price of the cheapest plan for bronze, silver and gold plans in each of the 4 CBSAs for a 30-year old and a 50-year old. We specifically report the premium charged for the Blue Cross Blue Shield Silver HMO plan as well because BCBS was the only health insurance company that offered a plan in each of the 26 distinct markets (rating areas) in Texas, and they tended to have much larger networks of hospitals included in their plans than most other insurance companies.

Table 3: Lowest Priced Premiums for a 30-year old in 2014 by Plan Type and City

	Bronze	Silver	BCBS HMO Silver	Gold
DFW	$165	$235	$235	$288
Houston	$149	$211	$211	$252
San Antonio	$150	$182	$213	$208
Austin	$156	$183	$222	$209

Table 4: Lowest Priced Premiums for a 50-year old in 2014 by Plan Type and City

	Bronze	Silver	BCBS HMO Silver	Gold
DFW	$260	$369	$369	$453
Houston	$234	$332	$332	$397
San Antonio	$236	$287	$334	$327
Austin	$246	$288	$349	$328

Health insurance premiums increase as the metal level increases. For example, the cheapest bronze plan for a 50-year-old in the Dallas Fort Worth area is $260 per month, while the cheapest gold plan costs $453. Premiums for plans for 50 year olds are approximately 57 percent more expensive than for 30 year olds, reflecting the greater health care utilization of older individuals.

The premiums for bronze plans are relatively similar across cities. For bronze plans, a 30 year old can expect to pay $149 per month for insurance in Houston and $165 for insurance in Dallas Forth Worth, a $26 differential. In contrast a 30 year old purchasing a gold plan could pay as little as $208 per month in San Antonio, but $288 per month in Dallas Fort Worth—an $80 per month differential. In Dallas Fort Worth and Houston, the Blue Cross Blue Shield plan was the cheapest silver plan in the rating area. In contrast, the BCBS plan was not the cheapest silver plan in San Antonio and Austin, reflecting the higher price the insurer was charging for access to a larger network. BCBS may have charged a lower price in the larger cities in an effort to gain a larger number of customers, or perhaps because it was able to negotiate lower prices with health care providers.

COMPARING THE PRICE OF SUBSIDIZED MARKETPLACE PLANS ACROSS TEXAS CITIES

Uninsured individuals earning between 139% and 399% of the FPL were eligible to receive subsidies to purchase health insurance. The amount of the subsidy was most generous for those earning 139% of the FPL and declined to 0 as household income rose to 399% of the FPL. Table 5 lists the premiums of the cheapest plan by metal level, once subsidies are taken into account for those who qualify for federal assistance.

Table 5: Lowest Priced Premiums (including subsidies) for a 30-year old in 2014 by Plan Type and City

	Bronze	Silver	BCBS HMO Silver	Gold
DFW				
150% of FPL	$0	$50	$50	$103
200%	$45	$114	$114	$167
300%	$165	$235	$235	$288
Houston				
150% of FPL	$0	$50	$50	$91
200%	$52	$114	$114	$155
300%	$149	$211	$211	$252
San Antonio				
150% of FPL	$0	$27	$57	$53
200%	$58	$91	$121	$117
300%	$150	$182	$213	$208
Austin				
150% of FPL	$0	$18	$57	$44
200%	$56	$82	$121	$108
300%	$156	$183	$222	$209

Table 6: Lowest Priced Premiums (including subsidies) for a 50-year old in 2014 by Plan Type and City

	Bronze	Silver	BCBS HMO Silver	Gold
DFW				
150% of FPL	$0	$46	$46	$129
200%	$1	$110	$110	$193
300%	$153	$262	$262	$345
Houston				
150% of FPL	$0	$47	$47	$111
200%	$13	$111	$111	$175
300%	$165	$263	$263	$327
San Antonio				
150% of FPL	$0	$10	$57	$50
200%	$22	$74	$121	$114
300%	$174	$226	$273	$266
Austin				
150% of FPL	$0	$0	$57	$36
200%	$18	$60	$121	$100
300%	$170	$212	$273	$252

Premiums are substantially cheaper at all metal levels for those earning 150% (or about $17,000 per year) or 200% of the FPL. Premiums for those living in households at 300% of the FPL are the same as the unsubsidized prices listed in Tables 3 and 4. There is no reduction in premiums for those at 300% of the FPL (which was $34,470 in 2013) in these Texas cities, because the amount of the subsidy is determined by the premium for the second-lowest priced silver plan in each city, relative to household income. In this case, the premium amount does not exceed the maximum percentage of income set by the ACA as a reasonable contribution toward health care costs.

Premiums for 50 year olds are much closer to those of 30 year olds when subsidies are included. This narrowing in prices reflects law makers' intent to equalize affordability of health insurance across income classes, regardless of age.

For those individuals earning 150% of the FPL, there was a bronze plan available in each city that required no premium payment. Such plans should have been attractive to individuals who planned to use little or no health care over the coming year. Any health care incurred in these plans would be subject to a relatively large deductible. Low income persons who expect to have significant health care needs would find it more preferable to purchase a silver plan. The Affordable Care Act provides a cost sharing reduction in addition to the premium subsidy to persons purchasing health insurance through the exchange who earn up to 250% of the FPL. This additional financial assistance lowers the amount of the deductible, reduces the maximum out-of-pocket payment, and copayments for persons who qualify.

LOOKING FORWARD

Substantial numbers of individuals in the Target Population for the Affordable Care Act still remain uninsured in the four largest cities of Texas. While the ACA provides generous subsidies for those individuals at the lower end of the Target Population income distribution, insurance premiums are higher for those earning 300% of the FPL. The prices of these policies is still low compared to the total cost of employer provided health insurance. The Kaiser Family Foundation reports that the monthly cost of an employer-provided HMO policy for an individual in 2013 was $519. However, the employer paid for the majority of the premium, and workers on average paid only $99 per month for coverage. Persons living on incomes of $35,000 per year may still find it difficult to set aside an additional $150 per month to pay for health insurance, particularly if they rarely seek health care.

As we move toward the second year of the Marketplace, the penalties for individuals who do not purchase health insurance will rise to the greater of $325 per person or 2% of household income. For an individual person earning $35,000, the penalty for 2015 would be $700. We will be interested to see whether more persons in the Target Population purchase coverage in the Marketplace as the penalties for not having coverage rise next year.

ABOUT THE AUTHORS

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METHODOLOGY

Each quarter's HRMS sample of nonelderly adults is drawn from active KnowledgePanel® members to be representative of the US population. In the first quarter of 2013, the HRMS provided an analysis sample of about 3,000 nonelderly (age 18–64) adults. After that, the HRMS sample was expanded to provide analysis samples of roughly 7,500 nonelderly adults, with oversamples added to better track low-income adults and adults in selected state groups based on (1) the potential for gains in insurance coverage in the state under the ACA (as estimated by the Urban Institute's microsimulation model) and (2) states of specific interest to the HRMS funders.

Although fresh samples are drawn each quarter, the same individuals may be selected for different rounds of the survey. Because each panel member has a unique identifier, it is possible to control for the overlap in samples across quarters.

For surveys based on Internet panels, the overall response rate incorporates the survey completion rate as well as the rates of panel recruitment and panel participation over time. The American Association for Public Opinion Research (AAPOR) cumulative response rate for the HRMS is the product of the panel household recruitment rate, the panel household profile rate, and the HRMS completion rate—roughly 5 percent each quarter.

While low, this response rate does not necessarily imply inaccurate estimates; a survey with a low response rate can still be representative of the sample population, although the risk of nonresponse bias is, of course, higher.

All tabulations from the HRMS are based on weighted estimates. The HRMS weights reflect the probability of sample selection from the KnowledgePanel® and post-stratification to the characteristics of nonelderly adults and children in the United States based on benchmarks from the Current Population Survey and the Pew Hispanic Center Survey. Because the KnowledgePanel® collects in-depth information on panel members, the post-stratification weights can be based on a rich set of measures, including gender, age, race/ethnicity, education, household income, homeownership, Internet access, primary language (English/Spanish), residence in a metropolitan area, and region. Given the many potential sources of bias in survey data in general, and in data from Internet-based surveys in particular, the survey weights for the HRMS likely reduce, but do not eliminate, potential biases.

The design effect for the Texas data in June 2014 is 2.6198 and the MOE is +/- 4.3. The survey fielded from June 3-26.

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