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April 23, 2020

The Honorable Delores Kelley
Chair, Senate Finance Committee
3 East Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Re: Maryland Health Insurance Market Study of Low-Income, Rural, and Medically Underserved Areas

Dear Chair Kelley:

On behalf of the Maryland Insurance Administration (MIA), I am pleased to submit the Report on Maryland Health Insurance Market Study of Low-Income, Rural, and Medically Underserved Areas. During the 2018 legislative session the MIA received a grant from the Centers for Medicare & Medicaid Services to study barriers to purchasing and utilizing health insurance for people living in low-income, rural, or medically underserved areas of the state. Additionally, on May 29, 2018 the MIA received a letter from Senator Middleton requesting that the Senate Finance Committee receive periodic updates on the report as well as the final report upon its completion.

In order to complete the report, the MIA contracted with the Schaefer Center for Public Policy at the University of Baltimore to conduct a market research study to identify barriers to answer the following research questions: 1.Why do Maryland residents living in areas considered low-income, rural or medically underserved decline to purchase health insurance? 2. Do Marylanders living in areas considered low-income, rural or medically underserved use their existing health insurance coverage? If not, why? Attached please find the report.

Sincerely,

A

Al Redmer, Jr.
Insurance Commissioner

For further information concerning this document contact:

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This document is available in alternative format upon request
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The Administration's website address is: www.insurance.maryland.gov

SCHAEFER CENTER FOR PUBLIC POLICY

KNOWLEDGE THAT WORKS FOR GOVERNMENT AND NONPROFIT ORGANIZATIONS

Maryland Health Insurance Market Study of Low-Income, Rural, and Medically Underserved Areas

Maryland Insurance Administration

UNIVERSITY OF BALTIMORE

Schaefer Center for Public Policy

Maryland Insurance Administration

Maryland Health Insurance Market Study of Low-Income, Rural, and Medically Underserved Areas

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March 20, 2020

ACKNOWLEDGEMENTS

The following Schaefer Center staff members and University of Baltimore faculty members played key roles in the collection and analysis of the data used for the analysis included in this document.

- Dr. Ann Cotten, Director (Primary Report Author)
- Michelle Cantave, Survey Manager
- Jasmine Greene, Research Analyst
- Dr. Sarah V. Ficenec, Research Associate (Primary Report Author)
- Dr. Al Lyles, Professor and Faculty Fellow (Primary Report Author)
- Andrea Garry, Graduate Fellow
- Courtney Prestwich, Graduate Fellow
- Gaines Brown, Graduate Fellow
- Justin Wright, Graduate Fellow

The research team is appreciative of the assistance from the staff of Maryland Insurance Administration. The team would like to specifically acknowledge:

- Al Redmer, Jr., Insurance Commissioner
- David Cooney, Associate Commissioner, Life and Health
- Jason Stein, Network Adequacy Analyst
- Joy Hachette, Associate Commissioner, Consumer Education and Outreach
- Theresa Morfe, Chief Market Conduct Examiner, Life and Health – Compliance and Enforcement
- Zachary A. Peters, Chief of Staff

The research team is also appreciative of support from the Maryland Health Benefit Exchange, the League of Life & Health Insurers of Maryland, and the local clinics and local health departments that helped to promote the focus groups and web survey.

ABOUT THE SCHAEFER CENTER FOR PUBLIC POLICY

Established in 1985 with a mission to bring the University of Baltimore's academic expertise to bear in solving problems faced by government and nonprofit organizations, the Schaefer Center has grown into one of Maryland's preeminent policy centers offering invaluable assistance in support of Maryland's public sector.

Housed in the University of Baltimore's College of Public Affairs, the Schaefer Center complements its professional staff by drawing upon the expertise of faculty and students in its three schools Criminal Justice, Health and Human Services, Public and International Affairs in its research, consulting, and professional development work.

The Schaefer Center offers program evaluation, policy analysis, survey research, strategic planning, workload studies, opinion research, management consulting, and professional development services. It is through the Schaefer Center that the University of Baltimore and the College of Public Affairs meet a central component of the University's mission of applied research and public service to the Baltimore metropolitan area and to the state of Maryland.

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For information about contracting with the Schaefer Center, please contact the director, Ann Cotten, at 410-837-6185 or acotten@ubalt.edu.

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EXECUTIVE SUMMARY

The Maryland Insurance Administration (MIA) received a grant from the Centers for Medicare & Medicaid Services to study barriers to purchasing and utilizing health insurance for people living in low-income, rural, or medically underserved areas of the state. In turn, MIA contracted with the Schaefer Center for Public Policy at the University of Baltimore to conduct a market research study to identify barriers to answer the following research questions.

1. Why do Maryland residents living in areas considered low-income, rural or medically underserved decline to purchase health insurance?
2. Do Marylanders living in areas considered low-income, rural or medically underserved use their existing health insurance coverage? If not, why?

The target population for the study included residents of the 160 zip codes in Maryland that meet at least two of the following conditions: 1) rural; 2) low-income; or medically underserved. The zip codes were located in the following jurisdictions: Anne Arundel, Baltimore City, Baltimore, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester. Approximately 1.1 million (19%) of Maryland's residents live in the study zip codes. Of that population, 71,000 (6.4%), are estimated to be uninsured. Just under half (47%) of this uninsured population has an annual income that is between 138 and 399% of the Federal Poverty Level (FPL).

To understand why residents in the study zip codes do not purchase health insurance or do not use the health insurance they have, the research team contacted 42,482 cell phone and landline numbers to complete 1,176 telephone surveys. These surveys were supplemented with 51 open access web surveys and seven focus groups with a collective total of 42 participants. The key findings from the study are presented in this executive summary and discussed in detail in the body of the report.

For the purpose of this report, there are three populations of interest. *Insured* are individuals who currently have health insurance and have used it as least once in the past year. *Uninsured* are individuals who do not have health insurance. *Under-utilizers* are individuals who have health insurance, but have not used it within the last 12 months.

KEY FINDINGS

TRENDS IN HEALTH INSURANCE COVERAGE

1. **Maryland is above the national average for the percent of residents who have health insurance – 93.5% in Maryland compared to 90.6% nationwide**.[1] Lower income Marylanders (138-399% of FPL) are slightly more likely to be insured (97%) than their counterparts across the United States (95.5%).[2] The same is true of the lowest income households (135% FPL or less), 98.2% of which are insured compared to 96.5% nationally.[3]

2. **The uninsured rate in low-income, rural, and medically underserved areas in Maryland (6.4%) is comparable to the statewide rate (6.5%).**[4] Uninsured people in the study areas generally match the uninsured population statewide in terms of gender and age but are slightly more likely to have a lower income than the uninsured population statewide (2.3% below 138% of FPL vs 1.8% statewide). Uninsured people in the study zip codes are also more likely to be White (49% compared to 42% statewide), Black or African American (42% compared to 29% statewide), and less likely to be Hispanic or Latino (12.1% compared to 35.3% statewide) than the uninsured population in the state overall.[5]

3. **Paying for health care worries some Marylanders in low-income, rural and medically underserved areas.** A slight majority (57%) of uninsured survey respondents were "very worried" about being able to afford health insurance deductibles, monthly insurance premiums (52%), and unexpected medical bills (50%).[6] They were more worried about health insurance and health care costs than utilities (40%), rent (36%), food (27%) or gasoline and transportation costs (26%). These findings mirror those nationally where the percent of people for whom cost is the most important factor in selecting health insurance increased from 33% in 2003 to 59% in 2018.[7] During the same period, the percentage of people who identified coverage benefits (benefits included and provider choice) as most important have decreased from 60% to 26%, coinciding with the introduction, expansion and increased out-of-pocket cost of High Deductible Health Plans (HDHPs).[8]

4. **Cost can keep some uninsured people from getting healthcare**. Of the uninsured survey respondents in the study zip codes who have not visited a health provider in the last 12 months, 26% said it was because the cost was too high.[9] Additionally, 9.4% of the insured respondents did not visit a health provider in the past year.[10] Some participants in the focus group conducted for this study also reported foregoing care because they did not have health insurance. Some Marylanders in the study zip codes without

insurance reported having difficulty paying (1) their deductible (34%), (2) monthly premiums (28%), and (3) co-payments (24%).[11]

Nationwide, 67% of insured adults worry about being able to afford an unexpected medical bill "for them and their family", 53% worry about the deductible for their health insurance, 44% worry about prescription drug costs, and 42% worry about their insurance premiums.[12]

5. **Almost half of uninsured respondents in the study zip codes went without needed health care due to the cost**. Just under half (45%) of the uninsured respondents did not get needed medical care in the past 12 months due to the cost compared to 13.4% of insured respondents.[13] Approximately one third of uninsured respondents did not get needed dental care (38.3%), specialist care (36.2%), recommended medical tests or treatment (32.6%), or did not fill a prescription (29.8%).[14] The percent of insured respondents who did not get care was almost one third of uninsured respondents with the exception of dental care which 21.6% of insured respondents did not seek.[15] Nationally, 26% of people postponed needed healthcare and 21% did not get recommended tests and treatments.[16]

6. **Being uninsured is a strategy used by many to lower health care costs**. Uninsured respondents in the study zip codes (85%) reported going without health insurance to lower health care spending compared to 32% of the under-utilizers.[17] The same percentage (85%) tried harder to stay healthy to save on health care expenses as did 81% of health insurance under-utilizers.[18]

7. **A significant proportion of uninsured survey respondents in the study zip codes are unable to pay medical bills.** Just under 40% of uninsured respondents have been unable to pay medical bills over the past 12 months, and one quarter are currently paying medical bills over time.[19] For under-utilizers, the proportions are much lower with 13% unable to pay medical bills and 17% reporting paying medical bills over time.[20]

8. **Health care costs for many uninsured respondents were relatively low.** Just over one third (38.3%) of uninsured respondents in the study zip codes spent less than $500 on out-of-pocket health care costs in the prior 12 months.[21] Just under one quarter (23.4%) did not know how much they paid in the prior year.[22] Just under one in ten respondents (8.5%) spent more than $5,000 in health expenses in the past year.[23]

WHY PEOPLE IN STUDY AREAS DO NOT HAVE HEALTH INSURANCE

9. **Health insurance is perceived by some to be too expensive and for some affordable options do not meet needs.** Cost is a major reason why Marylanders in low income, rural, and medically underserved areas do not have health insurance. Of the 47 people surveyed who did not have health insurance: 60% said the cost was too high; 51% sought coverage and could not afford it; and 49% thought they could not afford coverage.[24] Just under one quarter (23.4%) of those without health insurance said that the coverage they can afford does not meet their needs.[25] In six of the seven focus groups, the cost of insurance (premium, deductible, and co-pay) was identified a reason for not purchasing health insurance. In three of the seven focus groups, confusion about or challenges with affording sufficient coverage was identified as a reason for not having coverage.

10. **Confusion and lack of knowledge during the application process discourage some people from getting insurance.** One quarter of insured survey respondents found the enrollment process to be difficult or confusing and the same percentage did not know how to get insurance.[26]

    A lack of information about insurance options, what is covered, and the application process was identified as a reason for not purchasing health insurance in five of the focus groups. Some participants felt that the process of applying was hard to understand and that help was not available. Others did not know what was covered in the various plans. Still others thought it was difficult to decide what to purchase because the coverage was different with each plan. Some participants said there was a lack of advocates looking out for their best interests

11. **Losing or not being able to afford employer-based coverage results in people becoming uninsured**. Nationally, almost all large firms (96% with 100 or more employees) and just over half (54%) of medium firms (3-49 employees) offered health insurance in 2018.[27] However, the take up rate by employees dropped from a high of 83% (2001) to 76% (2018), and actual coverage declined from a high of 70% (2001) to 60% (2018).[28] At the same time, annual family premiums exceeded $20,000 in 2019 with employees paying approximately $6,000 plus deductibles and copays.[29]

    Just over 40% of uninsured survey respondents in the study zip codes said they did not have insurance because the person in their family who had employer-based coverage lost or changed jobs.[30] Another 10.6% said their employer did not offer coverage or they did not enroll in their employer's plan.[31] Slightly less, 8.5%, said the person who held the

health insurance was no longer part of the family and 6.4% said their employer no longer offered health insurance.[32] The same percentage said they traded health insurance for higher pay or another benefit. Of the uninsured respondents who are employed, self-employed, or an unpaid worker at a family business, 11 respondents (44.0%) work more than one job, with most working two jobs, one individual working three jobs and one individual working four or more jobs.[33]

12. **Some believe health insurance is not necessary.** Just under 15% of survey respondents in the study zip codes without health insurance said they did not need coverage.[34] Just over one quarter of these respondents did not need coverage because they were healthy, another quarter said they could get care at the emergency room, and another quarter said they can get care at another provider without insurance.[35] This belief was shared by many focus group participants. Some thought good health made insurance unnecessary while many thought there were other ways to get healthcare including local health departments or emergency room care. Still others thought it was cheaper for healthy people to pay for care out-of-pocket.

13. **Application process can be a barrier to getting insurance.** Focus group participants in at least two groups thought the application process was a barrier to getting health insurance. For some, the process was too time-consuming, while for others the requirements such as an employer coverage waiting period and being required to have an address (especially for homeless people) were barriers to getting health insurance. The required documentation and eligibility requirements were also problems, and participants indicated that starting applications for health insurance can lead to an onslaught of calls from insurance agents (described as and perceived by participants as "harassment").

14. **Coverage limitations (services and providers) discourage people from getting insurance**. Health insurance coverage limitations in terms of services covered and eligible providers was identified by some focus group participants as a reason for not purchasing health insurance. Some were concerned that coverage they could afford would not meet their needs while others were concerned that not everything would be covered and they would end up with unexpected bills.

15. **Having health insurance is perceived by some to negatively impact health care.** A few focus group participants believed that having health insurance negatively impacts care. Some said the type of insurance (i.e. Medicaid) affects the amount of time people must wait for care. Others were concerned about being required to make multiple visits for treatment or being over-treated so doctors can collect additional fees.

16. **Technology can be a barrier to getting health insurance.** Some of the focus group participants said that insurance plans and providers rely heavily on online portals which are inaccessible to people who lack access to technology or the internet, or to those who lack technical skills.

WHY UNDER-UTILIZERS IN THE STUDY AREA DO NOT USE THEIR HEALTH INSURANCE

17. **Good health is a primary reason cited for not using insurance.** Twenty-nine percent of survey respondents who did not use their health insurance in the past year report they were not sick enough to go to a doctor.[36] Another 17.6% said they do not have any health problems, and 5.5% say they take care of themselves so they do not have to go to the doctor.[37] Good health is the primary reason why focus group participants did not use their health insurance.

18. **The cost for seeing a health care provider is too high for some.** Just under 8% of insured survey respondents said that the cost of seeing a health care provider was too high.[38] For some focus group participants, it was cheaper to pay for care out-of-pocket than to use insurance. Others said using insurance was too expensive because people do not always meet their deductibles.

19. **Insurance and billing are too confusing for some.** Some focus group participants said insurance is confusing and they do not understand what will be covered. They also felt that medical billing in general is too confusing.

MARYLAND HEALTH CONNECTION

20. **Most uninsured survey respondents know about Maryland Health Connection (MHC).** Of the uninsured survey respondents in the study zip codes, 70% had heard of Maryland Health Connection before being interviewed.[39] Most (71.4%) had visited the MHC website, 42.9% called the customer support center, 28.6% visited a local department of social services to learn more about MHC, and 21.4% visited a local health department to learn about MHC.[40]

21. **Sources of information on MHC varied in their levels of helpfulness.** Uninsured survey respondents offered mixed views on the sources of information they accessed about obtaining insurance through the Maryland Health Connection. The customer support center was the most helpful with 33% of respondents finding it "very helpful" and another 33% finding it "helpful".[41] Those who visited the Maryland Health Connection website were evenly divided between those for whom it was "very helpful" or "helpful"

and those for whom it was "not at all helpful".[42] All of the respondents who attended Local sign-up events found them to be "not at all helpful."[43]

22. **For some cost is a barrier to getting insurance through Maryland Health Connection**. For 40% of uninsured survey respondents from study zip codes who contacted Maryland Health Connection, cost was a major issue.[44] Approximately 28% tried to purchase coverage on MHC but could not afford it even with a subsidy. Another 7.5% were not qualified for a subsidy and could not afford the insurance, and 5% thought they could not afford coverage even with the subsidy (and therefore did not attempt to purchase coverage on MHC).[45]

ACCESSING HEALTH CARE

23. **Access to care was problematic for some respondents.** Uninsured respondents were more likely to be told a doctor's office or clinic was not accepting patients with respondents' insurance or not accepting any new patients (29.8% compared to 24.1% of under-utilizers), be unable to get an appointment as soon as needed (17% compared to 12.5% of under-utilizers), and were slightly more likely to be unable to find a specialist in their area (12.8% compared to 9.8% of under-utilizers).[46]

    Under-utilizers were slightly more likely to not be able to find a doctor in their area (14.3% compared to 12.8% of uninsured).[47]

24. **Uninsured respondents use emergency room care more than others.** Uninsured respondents were more likely to use the emergency room (36.2%) compared to insured people (28.9%) and under-utilizers (3.6%).[48]

25. **Those who use their insurance use health care more than others.** The vast majority of respondents who used their insurance in the past year saw a doctor (93.3%), specialist (64.2%), or dentist/dental hygienist (62.6%). By comparison, a smaller proportion of under-utilizers saw a doctor (11.6%), specialist (3.6%), or dentist/dental hygienist (37.5%). Uninsured respondents use health care more frequently than under-utilizers. Just over a third (36.2%) saw a doctor, specialist (27.7%), or dentist/dental hygienist (31.9%). Insured respondents were also the most likely to see a mental health professional (13.8% compared to 2.7% of under-utilizers and 12.8% of the uninsured).[49]

26. **People who do not use their health insurance generally report being in better health**. Respondents who did not use their health insurance (under-utilizers) reported having the best overall health, with 25% reporting their health as "excellent" and 33% reporting it to be "very good".[50] This compares to just 19.1% of uninsured respondents reporting "excellent" health and 27.7% who report their health to be "very good". A smaller

proportion of respondents who use their health insurance (11.8%) report they have "excellent" health when compared to under-utilizers or uninsured. The proportion of those who use their insurance who report their health is "very good" (30.1%) or "good" (34.5%) is comparable to the proportion of uninsured and under-utilizers who report being in "very good" or "good" health.[51]

INTRODUCTION

The Maryland Insurance Administration (MIA) received a grant from the Centers for Medicare & Medicaid Services to study barriers to purchasing and utilizing health insurance for people living in low-income, rural, or medically underserved areas of Maryland. In turn, MIA contracted with the Schaefer Center for Public Policy at the University of Baltimore to conduct a market research study to answer the following research questions.

1. Why do Maryland residents living in areas considered low-income, rural or medically underserved decline to purchase health insurance?

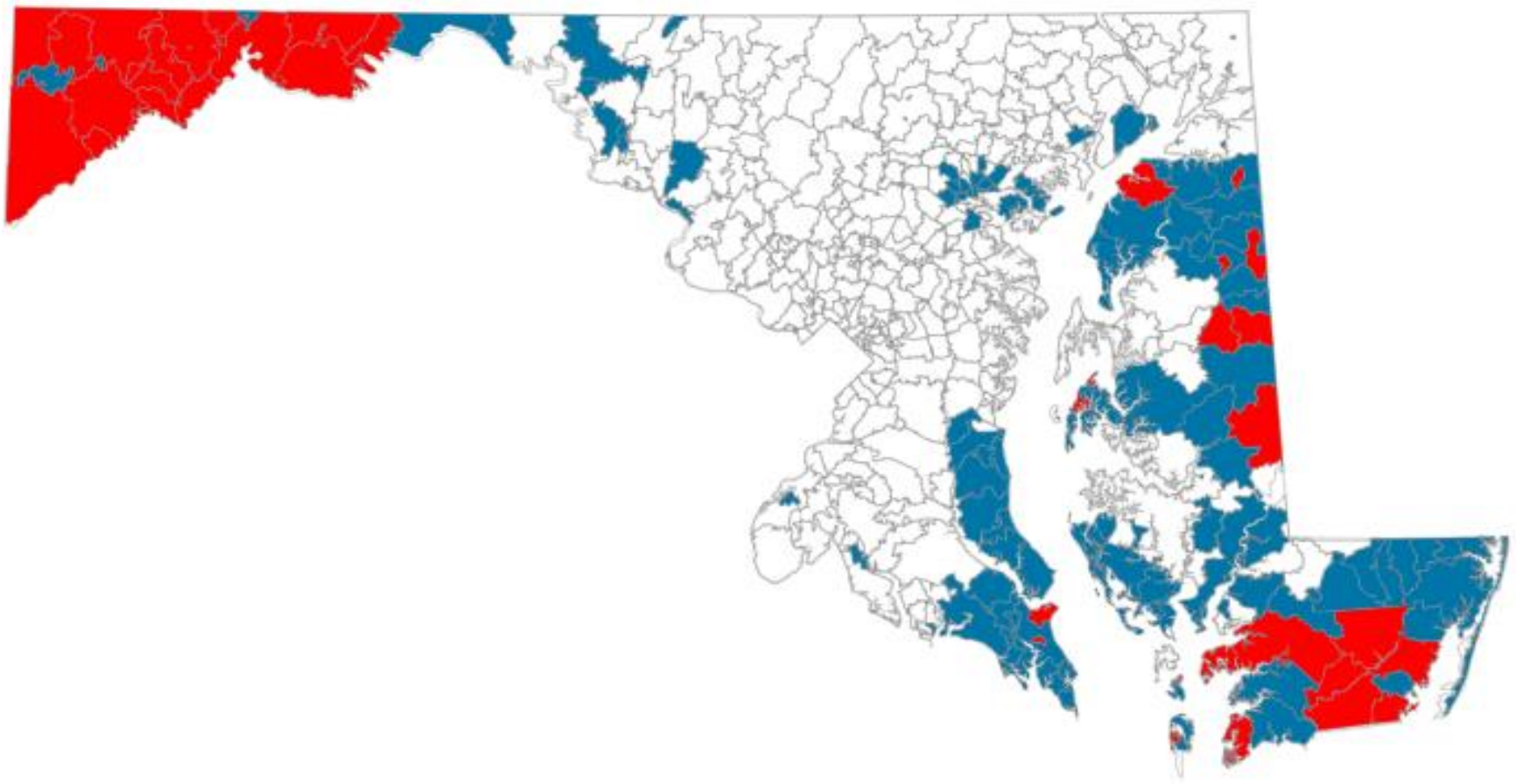
2. Do Marylanders living in areas considered low-income, rural or medically underserved use their existing health insurance coverage? If not, why?

TARGET POPULATION

The target population for this study includes individuals who live in rural, low income, or medically underserved areas in Maryland. To be included in the study, an individual must live in a zip code that meets as least two of the three criteria (rural, low income, medically underserved). Rural zip codes are those defined as such by the Maryland Department of Planning. Low income zip codes are those zip codes where 60% or more of the households have incomes at or below 400% of the federal poverty level (FPL). Medically underserved areas are those that are identified as being medically underserved by the federal Health Resources and Services Administration.

Applying these criteria, 160 zip codes were identified as meeting two or more criteria. Figure 1 shows a map of eligible zip codes from which residents were recruited to participate in the study.

Figure 1: Zip Codes Included in the Study



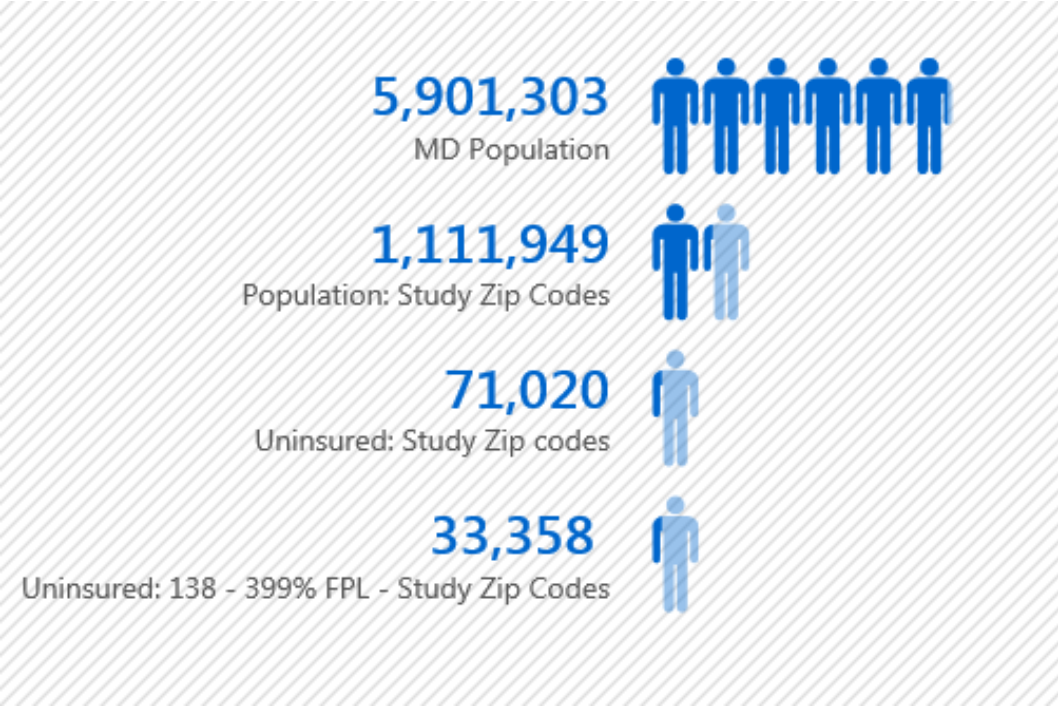
Red zip codes meet all three criteria: low income, rural, and medically underserved.

Blue zip codes meet two of the three criteria - low income, rural, and/or medically underserved.

HEALTH INSURANCE COVERAGE NATIONALLY, STATEWIDE, AND IN STUDY ZIP CODES

The U.S. Census Bureau estimated that over one million (1,111,949) individuals resided in the study zip codes in 2018 (Figure 2).[1] Just over six percent (6.4%) of residents in the study zip codes and 3% of those residents with incomes between 138 and 399% of FPL do not have health insurance. As shown in Figure 3, the percent of the population who is uninsured in Maryland (6.5%) is much lower than the national average of 9.4%. Overall, there is little difference in the percent of the population which is uninsured in Maryland (6.5%) and in the study zip codes (6.4%). When examined by income, the uninsured individuals in the study zip codes (2.3%) are slightly more likely to have incomes below 138% of FPL than their counterparts across Maryland (1.8%). Individuals in the study zip codes with incomes between 138% and 399% of FPL are slightly less likely to be uninsured (3%) than their counterparts statewide (3.3%).

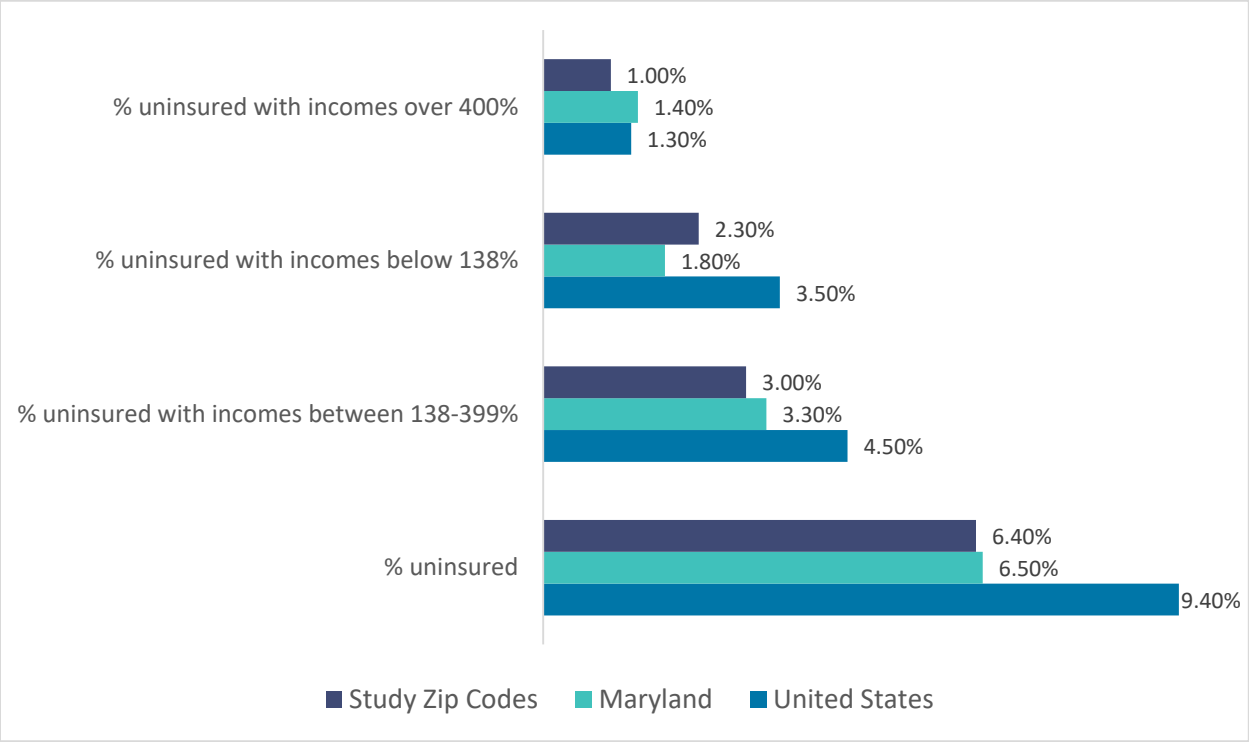
Figure 2: Number of Uninsured People in Study Zip Codes



Data Source: U.S. Census Bureau, American Community Survey Five Year Estimates, 2014-2018.

[1] Source: U.S. Census Bureau, American Community Survey, Five Year Estimates, 2014-2018.

Figure 3: Percent Uninsured by Jurisdiction and Income

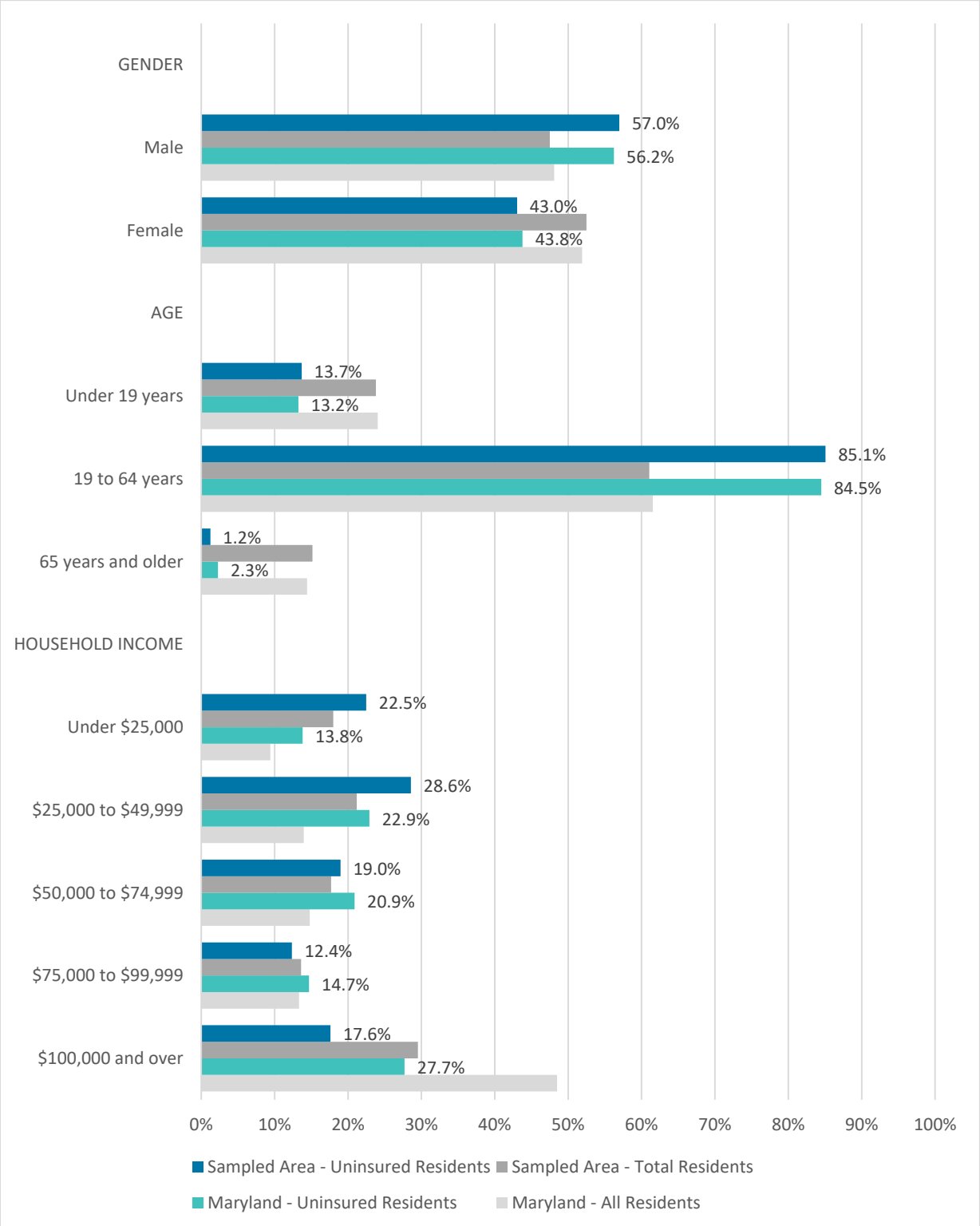


Data Source: American Community Survey Five Year Estimates, 2014-2018

Uninsured residents in the sample area generally reflect the demographics of Maryland's uninsured population as a whole (Figure 4 and Figure 5). For example, the overall population in both the state and in the sample area skews slightly female while the uninsured population in both has larger shares of men. Similarly, approximately 85% of the state's uninsured population and the sample area's uninsured population are of working age (between ages 19 and 64 years old), whereas the state and sample area overall populations have much larger share of younger and older residents (although the majority of both state and sample populations are still of working age).

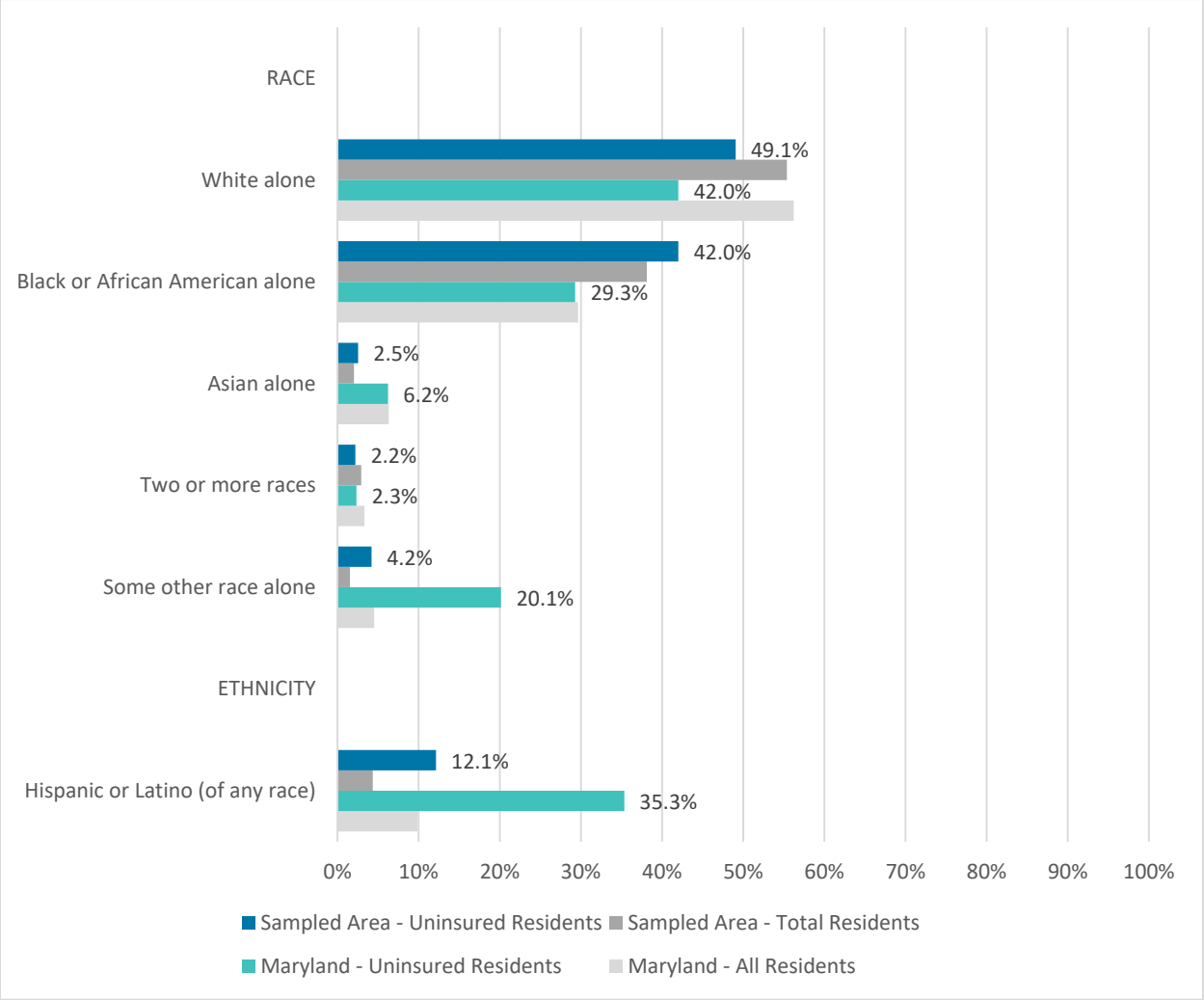
The differences in demographics between the state as a whole and the sample area are more likely in race, ethnicity, and household income. African Americans comprise a larger portion of the uninsured population in the study zip codes (42%) compared to their representation in the statewide uninsured population (29.3%). The share of the population that is of Hispanic or Latino origin also does not reflect the state uninsured or the sample area total population. Finally, as expected based on the criteria for identifying eligible zip codes for inclusion in the study, uninsured households are poorer in the sample area than in the state overall or uninsured populations and even the sample area's total population.

Figure 4: Gender, Age and Household Income of Maryland and Target Area Populations by Insurance Coverage



Source: U.S. Census Bureau American Community Survey Five-Year Estimates 2014-2018; Schaefer Center calculations.

Figure 5: Race and Ethnicity of Maryland and Target Area Populations by Insurance Coverage



Source: U.S. Census Bureau American Community Survey Five-Year Estimates 2014-2018; Schaefer Center calculations.

METHODOLOGY

The study includes a review of national, state, and local research on uninsured and underutilizing populations,[2] analysis of input received from the public during MIA public meetings, telephone and web surveys of residents in the targeted zip codes, and focus groups with residents from the targeted zip codes.

LITERATURE REVIEW

The study began with a literature review to examine national, state, and local research on why individuals do not purchase health insurance and why some individuals who have health insurance do not use it. Researchers sought to identify barriers to purchase and utilization of health insurance faced by people in areas similar to those targeted for this study. The literature review informed the development of the survey and focus group guides and provides context for the research.

MIA PUBLIC INPUT MEETINGS

Members of the research team attended three MIA public input meetings held in Baltimore City, Washington County, and Talbot County. The meetings provided members of the public and interested stakeholders the opportunity to learn about the study and to share their views on why Marylanders in the target areas do not purchase health insurance or do not use their health insurance once purchased. The information gathered during these meetings helped inform the design of the survey questionnaire and the focus group guide. Additionally, some insurance agents and at least one health advocate attending the meetings agreed to assist with promoting the focus groups and to share the web survey link. The agenda for the public input meeting is included in Appendix B.

STUDY WEBSITE

A dedicated webpage was created to improve ease of access to information about the study, provide links to the web survey in English and Spanish, and provide links to the focus group screening surveys and registration forms. The webpage was maintained by the research team and located at http://mdhealthinsurancesurvey.com/.

TELEPHONE AND WEB SURVEYS

The research team conducted a random digit (RDD) dial telephone survey. Interviewers called 42,482 cell and landline phone numbers in the targeted zip codes and completed surveys with

[2] Under-utilizer is the term used in this report to describe people who have health insurance but have not used it in the past 12 months.

1,176 individuals. The survey was administered in English with a Spanish language option available. When an answering machine was reached, interviewers left a voicemail message directing potential respondents to complete the survey the study website.[3]

The research team also made the survey available in English and Spanish on the study website to collect as much information as possible about why individuals in the study do not purchase insurance or do not use their insurance. Responses from the web survey were combined with responses from the telephone survey in the analysis. The web survey was promoted widely by the Schaefer Center, the Maryland Insurance Administration, the Maryland Health Benefit Exchange, and the League of Life & Health Insurers of Maryland. Fifty-one people completed the web survey (Table 1).

Table 1: Survey Completions by Type

Insurance Status	Survey Type		Total
	Telephone	Web	
Uninsured	39	8	47
Under-utilizers - Insured	100	12	112
Insurance Users	1,037	31	1,068
Total	**1,176**	**51**	**1,227**

FOCUS GROUPS WITH UNINSURED AND UNDER-UTILIZERS

The research team conducted seven focus groups in Baltimore, Hagerstown, Havre de Grace, and Salisbury. Participants included Maryland residents who were uninsured or who were insured but had not used their health insurance in the past 12 months.

The research team initially planned to hold six focus groups. Planned groups included: Baltimore City (poor/medically underserved), Caroline County (rural/medically underserved), Garrett County (rural/medically underserved), Harford County (poor/medically underserved), Prince George's (poor/medically underserved), and St. Mary's County (rural/medically underserved). However, recruitment proved to be more challenging than anticipated. The research team and MIA engaged in extensive outreach efforts to recruit focus group participants. Outreach efforts included fliers at health clinics and health departments, Craigslist and Facebook ads, Twitter and Facebook postings, direct email, radio interviews, and recruitment from the pool of survey respondents. The research team scheduled 19 focus groups, 11 of which were cancelled due to a lack of participants. One focus group was cancelled due to illness. In all, seven focus groups were held with a cumulative total of 42 respondents.

[3] Interviewers began leaving messages when they encountered an answering machine starting on January 8, 2020.

HEALTH INSURANCE OVERVIEW

Health insurance (as an employment-based benefit and as individual or privately purchased policy) influences the use, or avoidance, of medical services. This creates distinct challenges for persons who decline to purchase health insurance and those who have health insurance but may not use it. A selected review of literature on the use of health insurance follows to glean insights from existing information and provide a foundation for interpreting the study results.

KEY OBSERVATIONS

- The importance that people with health insurance place on cost and coverage has reversed between 2003 and 2018: cost factors (premium, deductible and co-payments) as the most important increased from 33% to 59% while coverage related benefits (extent of benefits included and provider choice) decreased from 60% to 26%, coinciding with the introduction, expansion and increased out-of-pocket cost of High Deductible Health Plans.[52] Overall nationally, 67% of insured adults worry about being able to afford an unexpected medical bill "for them and their family", 53% worry about the deductible for their health insurance, 44% worry about prescription drug costs, and 42% worry about their insurance premiums.[53]

- Health care in the United States is the costliest in the world.[54] The prices that insurance providers must pay for services influences the premiums charged while high cost-sharing means the insured are faced with ever higher out-of-pocket payments.

- The cost of private insurance increased faster (4.9%) than wages (3.4%) or inflation (2.0%) in 2019 compared to the prior year.[55]

- Substantial percentages of those with insurance reported having difficulty paying (1) their deductible (34%), (2) monthly payments (28%), and (3) co-payments (24%).[56] These percentages increased by 50% or more for those in "Fair" or "Poor: health versus "Excellent" to "Good" health.

CONTEXT: WHY DOES HEALTH INSURANCE MATTER?

Lack of health insurance or even being under-insured can be a barrier to accessing appropriate preventive care and for disease management. Health insurance buffers the full consequences of healthcare expenditures and may potentially reduce cost as an impediment to seeking care, following treatment regimens and/or remaining in care.

While having health insurance may provide some financial protection, it is costly and strains personal finances for many. Healthcare in the United States is consistently the most expensive in the world,[57] mainly due to higher prices.[58,59] Moreover, out-of-pocket costs for those with private insurance have been increasing faster than either wages or inflation: 4.9% versus 3.4% versus 2.0%, respectively, in 2019.[60] In households with employment-based health insurance, premiums were high (10% or more of income) for 11.6% of households and out-of-pocket costs were high for 6.8% of households.[61]

Whether insurance provides access to care depends on numerous factors which are often exacerbated by poverty, education, and residence – particularly in urban and rural locations with limited access to medical professionals and services. The fragmented and complex health care sector poses additional barriers for patients with acute care needs and chronic illnesses.[62] The result can be avoidable morbidity and mortality.

Insurance premiums, coverage details, and required patient cost-sharing can lead people to decline employment-based health insurance or purchase policies that provide limited protection from medically-related financial risk (products known as short-term/limited duration insurance[63]).

People with and without health insurance pursue various strategies when medical care costs and insurance cost-sharing are unaffordable. Cost is cited by 51% of adults as the primary reason for postponing care. Instead, they use one or more of the following approaches: home remedies (31%), complementary and alternative medicine (CAM) – which does not require seeing a medical practitioner, skipped care (30%) and/or medicine doses (12%), did not fill a prescription (19%), and/or postponed care (26%).[64]

Whether uninsured or underinsured, costs of care can interrupt what should be a seamless connection between health care, providers, their patients, and any necessary products or services.

UNINSURED VERSUS RECENTLY INSURED

A Connecticut study[65] examined barriers and motivations for the uninsured to get health insurance. As expected, barriers included cost and low income but also lack of knowledge and information: (i) low awareness of available premium subsidies; (ii) experience with third party, full price health insurance premiums rather than the state insurance exchange products that may have subsidies; (iii) insurance is seen as a discretionary monthly expense of low worth based on expenses for basic needs; (iv) the process of getting and retaining health insurance is

too complicated; and (v) adapting other ways to address health and illness such as using over the counter products (OTC) and home remedies (therefore thinking insurance is unnecessary).

The recently insured, by contrast, may have had insurance or more experience with it in the past but it was interrupted. They saw health insurance differently than did the uninsured, understanding it as: (1) financial protection; (2) lower cost through the state exchange; (3) supporting access to medical care; and (4) a "social obligation" for "responsible individuals". These were generally not compelling reasons for the uninsured in the study sample.

EMPLOYMENT-BASED HEALTH INSURANCE

Eligibility [for employer-based health insurance] has been relatively steady, but average take up and coverage have declined.

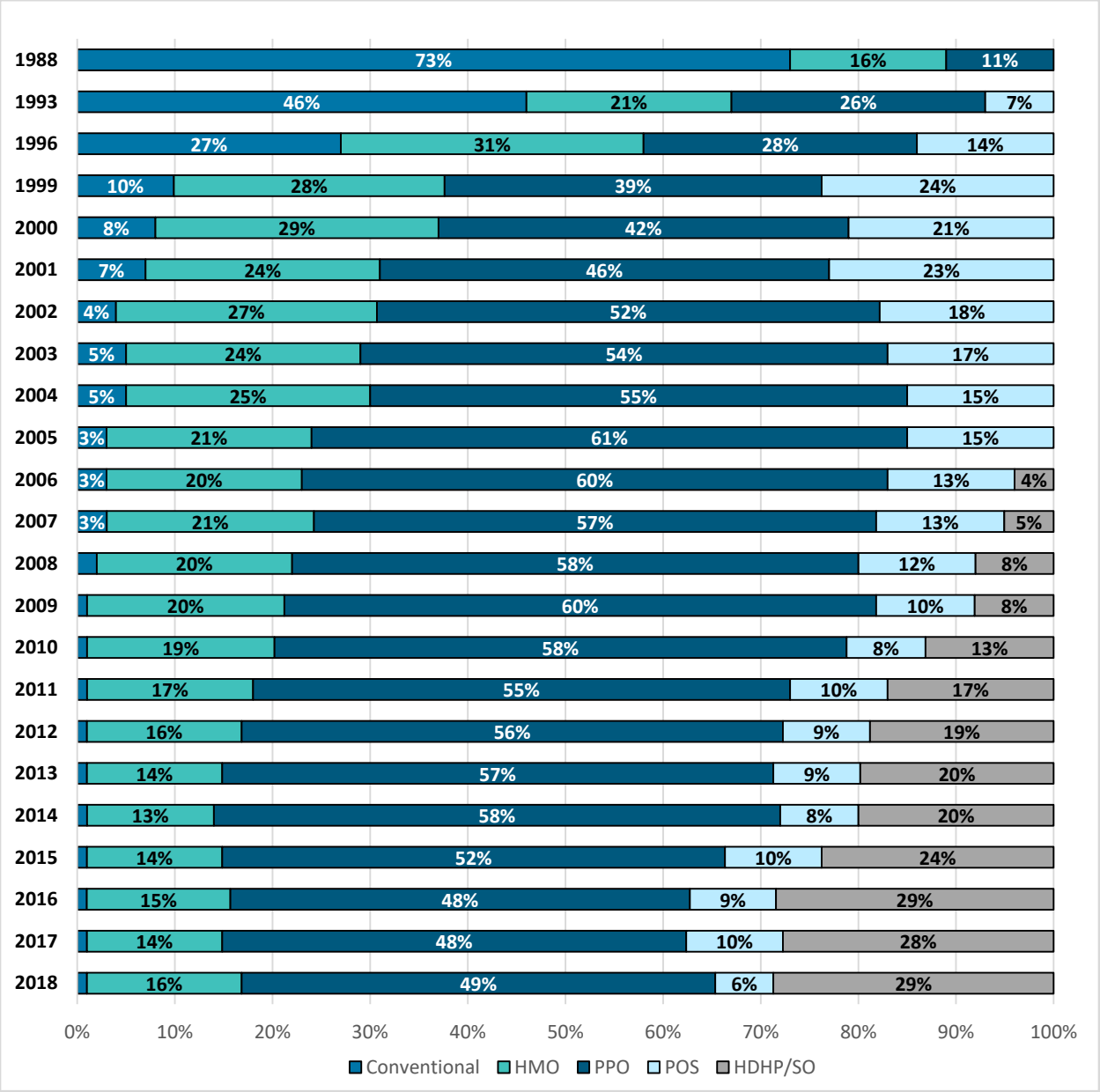
Employment-based health insurance is the foundation for most insured persons under age 65, though such coverage is declining. Sixty-six percent (66%) of all employers (98% for 100 or more employees, 63% for 3-49 employees) offered health insurance in 1999. This declined by 2018 to just 57% of all firms (96% with 100 or more employees, 54% for firms with 3-49 employees).[66] There is variation within these averages by business sector, part-time work status, temporary workers, unmarried domestic partner coverage, and the firm's employees' age and wage strata (i.e., firms with more young and low wage employees are less likely to offer health insurance). Of the small firms that did not offer a health insurance benefit, 20% had done so within the past five (5) years and 24% had shopped for health insurance within the past year.[67]

Eligibility has been relatively steady for firms offering health insurance (approximately 79% from 1999 to 2018), but the average extent of "take up" by employees decreased from a high of 83% (2001) to 76% (2018), and actual coverage declined from a high of 70% (2001) to 60% (2018).[68] The "take up" rate for health benefits varies by the firm's majority of high versus low wage workers, whether there is a union, if a majority are young workers, and public (85%, the highest) versus private for-profit (75%) versus private not-for-profit (77%) employers.[69]

Smaller firms are less likely to offer health insurance with the top three reasons being: (1) the cost of health insurance is too high; (2) the firm is too small; and (3) employees are covered under another plan.[70]

As demonstrated in Figure 6, insurance products evolved from primarily indemnity (73% in 1988 to less than 1% in 2018) to managed care (HMO and PPO: 16% and 11 % respectively in 1988 to 16% and 49% in 2018). High Deductible Health Plans (HDHPs) emerged in 2006 (4%) and rapidly increased market share (29% in 2018). Note that the source survey classified HDHPs as a distinct plan type (High-Deductible Health Plan with Savings Option) even if the plan would otherwise be considered a PPO, HMO, POS plan, or conventional health plan.[71] Premiums for family plans for covered employees had increased from $5,845 to $19,972 for large firms and from $5,863 to $18,739 for small firms from 1999 to 2018.[72]

Figure 6: Distribution of Health Plan Enrollment for Covered Workers by Plan Type 1988 - 2018



Note: Information was not obtained for Point-of-Service (POS) plans in 1988 or for High Deductible Health Plan/ Savings Option (HDHP/SO) plans until 2006. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

Source: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

Qualified HDHP plans include a savings option,[73] but making contributions to an HSA presumes sufficient income and resources to meet recurring basic monthly expenses such as food, housing and transportation.

Although an employee's share of health insurance premiums is only a portion of the total premium cost (18% for individuals and 29% for family coverage),[74] premium increases plus the large HDHP deductible (which must be met annually), and additional cost-sharing features when medical services and products are used combine to place health care out of reach for many who may have health insurance.

Annual family premiums for employment-based health insurance exceeded $20,000 in 2019 with employees responsible, on average, for approximately $6,000. Deductibles and employee cost-sharing (co-payments and/or co-insurance) add, on average, thousands more.[75] These trends will continue to place high cost burdens on patients.

UNDERINSURED

Concerns are typically presented as having health insurance versus not having health insurance, but the reality is more complicated. It is possible to have health insurance but be underinsured. It is also possible to have health insurance but cost sharing requirements may make using it out of reach for someone's household finances.

The Commonwealth Foundation defines "underinsured" individuals as adults who were insured all year but experienced one of the following: (1) out-of-pocket costs, excluding premiums, equaled 10% or more of income; (2) out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of Federal Poverty Level); or (3) deductibles equaled 5% or more of income.[4]

The percent of 19-64-year-old (working age) adults with health insurance increased following implementation of the Patient Protection and Affordable Care Act. However, more adults were also underinsured by 2018, particularly those with employment-based health insurance (28%) and individual coverage (42%).[76]

[4] Note: The "total includes adults with coverage through Medicaid and Medicare. Respondents may have had another type of coverage at some point during the year but had coverage for the entire previous 12 months. For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace."

Using each state's median income as the denominator, the Commonwealth Fund analyzed the percent that employee health insurance expenses represented in 2017. Maryland, at 6.2%, is a middle-performing state. The 11 low-performing states ranged from 7.3% (Kentucky) to 10.2% (Louisiana).[77]

Research from the Kaiser Family Foundation revealed that, overall, 67% of insured adults worry about being able to afford an unexpected medical bill "for them and their family", 53% worry about the deductible for their health insurance, 44% worry about prescription drug costs, and 42% worry about their insurance premiums as shown in Table 2. These overall averages differ by gender (women have higher percentages), income (lower incomes have higher percentages), and by race (with Black and Hispanic being higher than White). For working age adults (18-64), the percent concerned about affordability of an unexpected medical bill increases whether insured (69%) or uninsured (76%), and by "Fair/Poor" health status (76%).[78] Substantial percentages of those with insurance nonetheless reported having difficulty paying (1) their deductible (34%), (2) monthly payments (28%), and (3) co-payments (24%). These percentages increased by 50% or more for those in "Fair/Poor" health vs "Excellent" to "Good" health. Difficulties were experience by a higher percentage of women than men, and, for deductible affordability, for Hispanic individuals compared to White individuals.

Table 2: Worries about Affording Basic Needs by Health Status and Health Insurance Status

	Total	Health Insurance and Age			Health Status	
		Insured, 18-64	Uninsured, 18-64	65+	Excellent/ Very good/ Good	Fair/ Poor
Percent who say they are "very worried" or "somewhat worried" about being able to afford … for them and their family: (August 2018)						
…unexpected medical bills	67%	69%	76%	55%	65%	76%
…their health insurance deductible*	53%	55%	0%	47%	50%	64%
…gasoline or other transportation costs	46%	45%	57%	42%	40%	64%
…their prescription drugs costs	44%	41%	56%	46%	27%	69%
…their monthly utilities like electricity or heat	43%	39%	60%	40%	27%	60%
…their monthly health insurance premium*	42%	42%	0%	41%	38%	56%
…their rent or mortgage	41%	42%	61%	24%	37%	56%
…food	36%	33%	57%	33%	30%	56%

Note: *Among insured adults.

Source: Ashley Kirzinger, Cailey Muñana, Bryan Wu, and Mollyann Brodie. Data Note: Americans' Challenges with Health Care Costs. Table A.2. Kaiser Family Foundation June 11, 2019.

https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/.

Some of the strategies reported by those who had problems paying for medical care include: (1) delaying major purchases or vacations (16%); (2) depleting savings (12%); (3) working more (11%); (4) increasing credit card debt (9%); (5) taking out a new loan (3%); or (6) using a payday lender (3%).[79]

Patterns were similar for those who report that they or someone in their family had postponed dental care (30%), "relied on home remedies or OTC drugs instead of going to see a doctor" (31%), delayed needed health care (26%), declined a medical test or therapy (21%), or "had problems getting medical care", as shown in Table 3. Percentages were higher for women than men, lower income versus higher, and by race/ethnicity.[80] For working age adults, being uninsured increased the use of these strategies for managing health care costs. Postponing or delaying care was particularly pronounced for households in which a member had a serious medical condition.[81]

Table 3: Postponing or Delaying Care Because of Costs by Socioeconomic Status

Percent who say that in the past year they or a family member… (March 2019)	**Total**	**Gender**		**Income**			**Race/Ethnicity**		
		Men	**Women**	**<$40K**	**$40K-$89.9K**	**$90K +**	**White**	**Black**	**His-panic**
…skipped dental care or checkups	30%	26%	34%	45%	31%	14%	28%	31%	37%
…relied on home remedies or OTC drugs instead of going to see a doctor	31%	29%	33%	38%	36%	19%	30%	26%	40%
…put off or postponed getting health care they needed	26%	24%	28%	31%	31%	18%	25%	23%	33%
…skipped a recommended medical test or treatment	21%	17%	24%	25%	23%	13%	19%	21%	24%
…had problems getting mental health care	12%	9%	14%	15%	13%	7%	13%	10%	9%
Percent who did any of the above	51%	47%	56%	62%	56%	36%	50%	54%	54
Percent who say the condition got worse as a result	13%	11%	15%	18%	15%	5%	13%	15%	10

Source: Ashley Kirzinger, Cailey Muñana, Bryan Wu, and Mollyann Brodie. Data Note: Americans' Challenges with Health Care Costs. Table A.6. Kaiser Family Foundation June 11, 2019.
https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/.

Unexpected medical bills pose a substantial threat. When faced with an unexpected bill of $400, 12% of adults could not both meet current monthly expenses and pay the medical bill. An additional 17% could not meet their existing monthly debts and planned to skip a payment or

make a partial payment.[82] This has strong implications for the use or non-use of health insurance.

The price of insulin, for example, doubled between 2012 and 2016.[83] Nicole Smith-Holt reported on a family whose son died because he could not afford prescribed insulin.[84] The son, a 26-year old patient with type 1 diabetes (i.e., insulin dependent), had aged out of being covered on his parents' insurance policy. The monthly out-of-pocket costs for insulin and necessary supplies such as testing strips and lancets approached $1,300, which was beyond his financial means.

HIGH DEDUCTIBLE HEALTH PLANS

Insurance products evolved from primarily indemnity insurance (73% in 1988 to less than 1% in 2018) to managed care (HMO and PPO: 16% and 11% respectively in 1988 to 16% and 49% in 2018).

During this period, premiums for family plans for covered employees had increased from $5,845 to $11,575 for large firms and from $5,863 to $11,306 for small firms by 2006.[85] As a strategy to restrain premium increases, High Deductible Health Plans (HDHPs) emerged in 2006 (4%) and rapidly increased market share (29% in 2018), as shown in Figure 6 above. High deductible health plans (HDHPs) are insurance products that raised the insured's deductible to substantially greater amounts than had been charged previously.[86]

High deductible health plans (HDHPs) are more effective for insured persons who enroll when they are healthy and have many years for their pre-tax funds in the associated Health Savings Account to accrue to meaningful levels. HDHPs are less effective (1) for those who had a short time for their funds to accumulate to buffer recurring high deductibles and cost sharing requirements, (2) for older persons, and (3) for insureds who have chronic or acute high cost conditions. See Table 4 for minimum and maximum annual costs for HDHPs.

Table 4: Minimum Annual Deductible and Maximum Annual Deductible and Other Out-of-Pocket Expenses for HDHPs (2019)

	Self-only Coverage	Family Coverage
Minimum annual deductible	$1,350	$2,700
Maximum annual deductible and other out-of-pocket expenses*	$6,750	$13,500

Note: * This limit does not apply to deductibles and expenses for out-of-network services if the plan uses a network of providers. Instead, only deductibles and out-of-pocket expenses for services within the network should be used to figure whether the limit applies. Source: US Department of the Treasury, Internal Revenue Service. Health Savings Accounts and Other Tax Favored Health Plans. Publication 969. March 4, 2019. https://www.irs.gov/pub/irs-pdf/p969.pdf.

Qualified HDHP plans include a savings option. Consequently, HDHPs held the promise that increasing the deductible for those insured would transfer enough expense to them that the premium rates would not need to rise as rapidly as they had been doing. However, premiums still rose for HDHPs from $10,693 in 2007 to $18,602 in 2018. During the same period premiums for non-HDHPs rose from $12,183 in 2007 to $20,035 in 2018.[87]

According to IRS guidance, "Generally, under section 223(c)(2)(A), an HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied."[88] However, section (c)(2)(C) of the Internal Revenue Code permits insurers to exclude preventive care from deductibles and still qualify as High Deductible Health Plans with the Savings Option feature that accompanies it. Prior to July 17, 2019, guidance from the Internal Revenue Service and the Treasury Department maintained that preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition. New guidance released on July 17, 2019 expanded the preventive care safe harbor to include certain medical services for 14 specific chronic conditions of individuals with specified diagnoses. Their rationale:

> The Treasury Department and the IRS are aware that the cost barriers for care have resulted in some individuals who are diagnosed with certain chronic conditions failing to seek or utilize effective and necessary care that would prevent exacerbation of the chronic condition. Failure to address these chronic conditions has been demonstrated to lead to consequences, such as amputation, blindness, heart attacks, and strokes that require considerably more extensive medical intervention.[89]

SHORT-TERM, LIMITED DURATION INSURANCE PRODUCTS (STLDI)

The Patient Protection and Affordable Care Act mandated that insurance products on exchanges must contain 10 Essential Health Benefits[90,91]: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) pregnancy, maternity and newborn care; (5) mental health and substance abuse disorder services; (6) prescription drugs; (7) rehabilitative and habilitative devices and services; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and, (10) pediatric services, including oral and vision care. "Grandfathered health plans"[5] were not required to include the 10 Essential Health Benefits. Critically, "All Marketplace plans must cover treatment for pre-existing medical conditions".[92]

[5] Grandfathered Health Plan: An individual health insurance policy purchased on or before March 23, 2010. These plans weren't sold through the Marketplace, but by insurance companies, agents, or brokers. They may not include some rights and protections provided under the Affordable Care Act. Plans may lose "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose whether it considers itself a grandfathered plan. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and family members may be added to existing

Short-term or limited duration plans that provided coverage of up to three months were exempted from these requirements, presumably permitting these as a bridge to obtaining fully creditable health insurance.

> Short-term plans do not have to comply with the Patient Protection and Affordable Care Act's (ACA's) market reforms. Short-term insurers can charge higher premiums based on health status, exclude coverage for preexisting conditions, impose annual or lifetime limits, opt not to cover entire categories of benefits, rescind coverage, and require higher out-of-pocket cost-sharing than under the ACA.
>
> Given these limitations – and the fact that short-term coverage is generally only available to consumers who can pass medical underwriting – short-term coverage is much less expensive than ACA-compliant coverage and enrollment tends to skew younger and healthier. The sale of these plans can result in adverse selection against the ACA individual market, as healthier consumers exit the ACA market to enroll in short-term coverage.[93]

With the shift of healthy and often younger purchasers out of Marketplace plans and into short-term, limited duration insurance (STLDI), it is likely that premiums for Marketplace and other insurance products will increase.[94] In addition, medical needs for unexpected high cost conditions and events arising while covered under the STLDI will likely exceed the policy coverage and individual financial resources of those insured under these policies and experiencing health events such as new cancers, severe infectious disease, trauma and emergency care.

LACK OF ACCESS TO CARE HINDERS CLINICAL GOALS

Managing chronic medical conditions requires regular check-ins, feedback on the medical consequences of lifestyle changes and, if necessary, adjustment of medication regimen and/or dose. Without access to care, inadequate condition management and side effects may go undetected while consequences such as diminished renal function, vision problems, or cardiac disease, accumulate. These can lead to loss of mobility, regular dialysis, need for renal transplant, amputations, and other costly and life altering consequences. Alternatively, even if prescription refills can be afforded, obtaining them still requires regular access to a prescriber. This may not be feasible if there is no access.

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grandfathered group plans after March 23, 2010). https://www.healthcare.gov/glossary/grandfathered-health-plan/.

RURAL HEALTH

The depths of despair over obtaining needed medical care was captured in reporting on a pop-up clinic in rural Cleveland, Tennessee.[95] Almost 300 people arrived, before the clinic could open, with multiple urgent medical conditions and numerous deferred treatments. While this is a humanitarian response to the crisis of rural medical needs, it is transient and not a solution. Had Tennessee chosen to expand its Medicaid program, it would have received federal subsidies and could have addressed much of this pent-up need.

Rural and poor communities are at risk for being under-resourced for physicians and other health care providers.

Rural and poor communities are at risk for being under-resourced for physicians and other health care providers.[96] Even if there is a health care provider within commuting distance, that means patients will have costs for visiting the practitioner, for transportation, and for any prescription(s)/refill(s). The combination of these expenses may put medical care out of reach for rural and poor patients even if facilities are within reach.

The challenges people face in affording and using health insurance and accessing medical facilities are generally amplified for rural residents and underserved urban areas. These differences are the outcome of factors other than residence: (1) socioeconomic deprivation; (2) physician shortages; and (3) lack of health insurance.[97] These conditions are associated with lower well-being[98] and produce higher rural mortality rates.[99]

Data from the NC Rural Health Research Program reveal the extent of fewer medical resources in non-metropolitan [rural] areas versus metropolitan [urban] areas: fewer primary care physicians (55.1 per 100,000 versus 79.3) and mental health providers (135.1 per 100,000 versus 213.1), as shown in Table 5. Non-metropolitan areas have 28% more preventable hospitalizations compared to metropolitan areas.

Table 5: Medical Resources in Urban versus Rural Areas – Health Behaviors, Clinical Care, Health Insurance

	Urban (Metropolitan)	**Rural** (Non-Metropolitan)		
		All Non-Metro	Micropolitan	Neither/ Non-Core
HEALTH BEHAVIORS				
Binge or heavy drinking (% in 2014)	17.9%	16.4%	16.8%	15.9%
Physically inactive (% reporting no leisure-time physical activity in 2012)	22.3%	27.8%	27.0%	28.9%
Chlamydia rate (per 100,000 in 2013)	457.1	340.2	367.5	299.4
Food insecure (% in 2013)	14.5%	15.8%	15.7%	15.9%
Insufficient sleep (% averaging <7 hours in 2014)	34.3%	33.4%	33.5%	33.3%
CLINICAL CARE				
Primary care physician (per 100,000 in 2013)	79.3	55.1	60.1	47.5
Mental health provider (per 100,000 in 2013)	213.1	135.1	158.0	101.1
Health care costs (price-adjusted Medicare reimbursements per enrollee in 2013)	$9,644	$9,260	$9,142	$9,434
Preventable hospitalization (hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees in 2013)	50.6	20.6	60.5	70.6
HEALTH INSURANCE				
Uninsured under age 65 (2014)				
Total Population	30,728,920	5,285,050	3,102,754	2,182,296
Percent of population	13.4%	14.5%	14.0%	15.2%
Medicare beneficiaries with parts A and B (2014)				
Total number	41,362,309	9,508,017	5,517,933	3,990,084
Percent of population	15.2%	20.6%	19.9%	21.7%
Health insurance marketplace enrollees (2015)				
Total number	7,565,824	1,271,961	721,470	550,491
Percent of population	2.7%	2.8%	2.6%	3.0%

Source: NC Rural Health Research Program. The Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill. Rural Health Snapshot May 2017. https://www.shepscenter.unc.edu/product/rural-health-snapshot-2017/.

Rural areas tend to have higher unemployment and poverty rates, lower attained education, higher rates of being uninsured for health care, lower health indices, and fewer medical resources (Table 6). Although improving, educational attainment remains lower for rural areas (50% with high school or less versus 38% for urban areas, 20% with bachelor's degree or above versus 34% for urban).[100] Individually and combined, these represent complex barriers to access and use of medical care.

Table 6: Medical Resources in Urban versus Rural Areas – Population Characteristics

	Urban (Metropolitan)	**Rural** (Non-Metropolitan)		
		All Non-Metro	Micropolitan	Neither/Non-Core
POPULATION CHARACTERISTICS				
Counties (% in 2015)	37.1%	62.9%	20.9%	41.9%
Population (% in 2015)	85.7%	14.3%	8.6%	5.7%
Population change (%, 2010 to 2015)	4.6%	-0.3%	0.3%	-1.2%
People aged 65 and over (% in 2014)	14.0%	17.8%	16.8%	19.2%
Household income (median in 2014)	$58,229	$43,616	$44,801	$41,852
Children in poverty (% in 2014)	21.0%	25.4%	24.6%	26.6%
Adults with some college (% of adults aged 25-44 with some post-secondary education)	64.9%	53.7%	55.5%	51.2%
MORTALITY (Age Adjusted Rate per 100,000)				
All-cause (2014)	703.5	830.5	819.7	846.0
Suicide (2014)	12.4	16.8	16.3	17.5
Unintentional injury (2014)	38.3	54.4	51.4	58.7
Drug poisoning (2014)	14.7	15.6	16.0	15.0

Source: NC Rural Health Research Program. The Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill. Rural Health Snapshot May 2017. https://www.shepscenter.unc.edu/product/rural-health-snapshot-2017/.

Nationally, rural unemployment declined from 9.2% in the 2010 financial crisis to 4.2% in 2018, but remains higher than that for urban areas (3.9%)[101] and the rate of recovery since the 2010 financial crisis is slower in rural areas.[102] Poverty remains higher in rural than in urban areas (16.4% vs 12.9%, 2017).[103]

PATIENT PROTECTION AND AFFORDABLE CARE ACT AND REDUCING THE UNINSURED RATE

Under the Patient Protection and Affordable Care Act, states could expand their Medicaid program eligibility to include persons with incomes up to 138% of the federal poverty level. This would reduce a state's uninsured for health care rate. However, the Supreme Court ruled in *National Federation of Independent Business (NFIB) v. Sebelius* that expansion was optional. Thirty-six states chose to expand Medicaid eligibility by 2019, but some states chose not to do so.[104] There is a divergence of changes in uninsured rates between expansion and no expansion state experiences.

Maryland, an expansion state, is well above the national average for the percent of residents who have health insurance with a rate of 93.5% compared to the 90.6% rate nationwide.

As shown in Table 7, states which expanded Medicaid eligibility saw substantial decreases in the percent of their population that was uninsured. There are differences between and within states; however, the drop was consistent for areas categorized as Completely Rural, Mostly Rural, and Mostly Urban. Maryland, an expansion state, experienced a rapid decline in the uninsured from 2013 to 2017 in Mostly Rural areas (from 11.1% to 6.5%) and in Mostly Urban (from 11.7% to 7.1%).

Table 7: Uninsured Rates in Urban and Rural America for Persons under Age 65

Community Type	State Medicaid Expansion				
	Yes			No	
	2013	2017		2013	2017
Completely Rural	17.7	9.0		19.7	14.9
Mostly Rural	14.6	7.8		19.0	14.2
Mostly Urban	14.9	7.6		19.8	14.3

Source: U.S. Census Bureau. 2019 April 9. "Uninsured Rates in Urban and Rural America." https://www.census.gov/library/visualizations/interactive/rural-urban-uninsured-2017.html (United States Census Bureau, 2019).

Table 8: Uninsured Rates in Urban and Rural Maryland for Persons under Age 65

Community Type	Maryland	
	2013	2017
Mostly Rural	11.1	6.5
Mostly Urban	11.7	7.1

Categories: Mostly urban: < 50% of the population resides in rural areas; Mostly rural: 50 – 99% live in rural areas; completely rural: all live in rural areas. Source: U.S. Census Bureau. 2019 April 9. "Uninsured Rates in Urban and Rural America." https://www.census.gov/library/visualizations/interactive/rural-urban-uninsured-2017.html

From November 2019 through January 2020, the research team surveyed 1,227[6] Maryland residents who lived in the study zip codes via a random digit dial (RDD) telephone survey and an open access web survey. The surveys were designed to answer the study's overall research questions:

1. Why do Maryland residents living in areas considered low income, rural, or medically underserved decline to purchase health insurance?
2. Do Maryland consumers living in areas considered low income, rural, or medically underserved utilize their existing health insurance coverage, and if not, why?

Telephone survey

The population of the target zip codes is 71,020. The telephone sample for the survey contained 50,000 numbers, 71% of which were cell phone numbers. The research team called 42,482 numbers and completed 1,176 interviews. Many of those numbers were called multiple times. The sample disposition table is included in Appendix C.

Web survey

In addition to the telephone survey, the research team created an open access link for the web survey that could be broadly disseminated to the targeted population by advocates, agents, and MIA. While not scientific, this type of snowball sampling provided an additional method to collect feedback from the target population, particularly from uninsured residents who were the smallest group of respondents in the phone survey. The web survey was available in English and Spanish and was hosted on the research team's secure Qualtrics survey platform. The web survey was promoted broadly as part of focus group promotion.

Table 9 shows survey responses came mostly from a random digit dial (RDD) telephone survey (1,176). Fifty-one responses came from the web survey. The majority of respondents (96.2%) reported having health insurance (9.1% reported not using it) and 3.8% were uninsured.

Table 9: Survey Responses by Mode and Insurance Status

Mode	No Health Insurance	Under-utilizers	Have Insurance	Total
Telephone survey	39	100	1,037	**1,176**
Web Survey	8	12	31	**51**
Total	**47**	**112**	**1,068**	**1,227**

[6] Of the 1,277 completed surveys, 1,176 came from the RDD telephone survey and 51 came from the web survey. Of the 51 web survey respondents, one reported completing the survey as a result of a message left on their voicemail from a telephone interviewer attempting to contact them to complete the survey.

PERSPECTIVES FROM PEOPLE WHO DECLINE TO PURCHASE HEALTH INSURANCE

Of the cumulative telephone and web survey responses, 87.0%, (1,068 responses) were from health insurance users. Under-utilizers made up 9.1 % (112 responses) of responses, and 3.8% (47 responses) did not have insurance. The percentage of uninsured survey respondents (3.8%) is slightly greater than the percent of low-income, uninsured individuals (3.0%)[7] in the 160 zip codes sampled for this study. The following section will briefly review the findings of the survey, focusing on the two research questions.

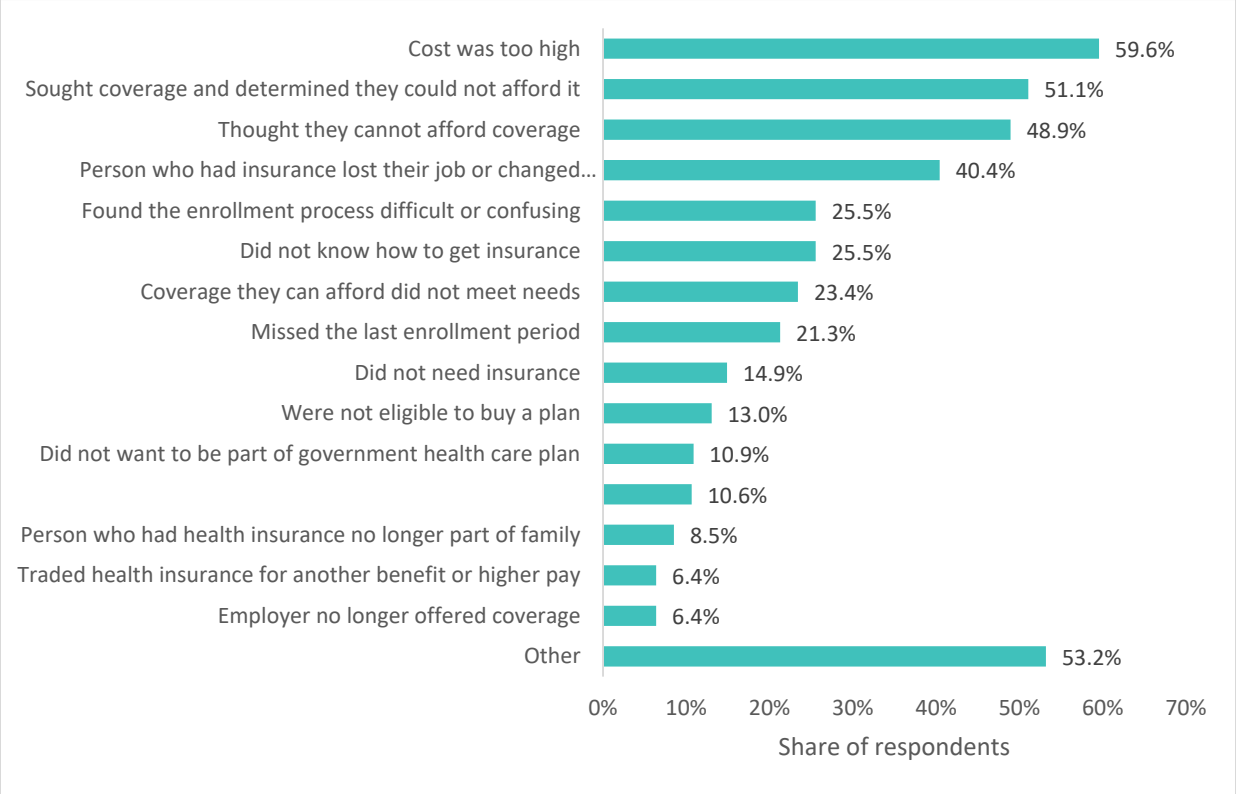
WHY INDIVIDUALS DECLINE TO PURCHASE HEALTH INSURANCE

Of the 47 respondents who did not currently have health insurance, 32 (68.1%) said 1) the cost was too high, 2) they determined they could not afford coverage after seeking coverage, or 3) they thought they could not afford coverage. Looked at individually, these were also the top three reasons why respondents did not have coverage (Figure 7).[8] Nineteen respondents did not have insurance because the person in the household who obtained the insurance had lost their job or changed employers while 12 respondents found the enrollment process difficult or confusing. Twelve respondents did not know how to get insurance. Of those who responded "other," nine respondents gave a reason related to the cost of health insurance and three respondents said the reason was related to switching or losing jobs. There were also respondents who indicated they had insurance in another state, who already received service at the Veterans Administration and did not pay for insurance, and who "just do not want it."

[7] This calculation is based on data from the U.S. Census Bureau American Community Survey Five-Year Estimates, 2014-2018, and calculations by the Schaefer Center. The rate for low-income, uninsured residents is based on those with incomes between 138% and 399% of the Federal Poverty Level (FPL).

[8] Respondents were allowed to identify more than one reason why they did not have health insurance. Sixteen respondents cited the three cost reasons for why they did not have insurance.

Figure 7: Why Respondents Did Not Have Health Insurance



Note: Respondents were allowed to identify more than one reason.

For some, health insurance is too expensive; affordable coverage does not meet needs

Of the 28 respondents who specifically answered that the cost was too high, 24 respondents (85.7%) said the premium was too high, 16 (57.1%) said the deductible was too high, and 10 (35.7%) said the co-pay was too high. Two respondents identified another reason the cost was too high, with one saying "all" was too high and the other saying "the whole thing" was too expensive. On a related note, just under one quarter (23.4%) of those without health insurance said that the coverage they can afford does not meet their needs.

Getting health insurance is confusing for some

Just over one quarter (25.5%) of the respondents who did not have health insurance found the enrollment process to be confusing. An equal number responded that they did not know how to get health insurance. Responses were also evenly divided between those who found the Maryland Health Connection website helpful, while those who visited a local health department, called an authorized insurance broker, or attended a local sign-up event found the services not helpful for getting insurance on the Marketplace.

Health insurance is perceived to be unnecessary by some

Of the seven respondents who indicated that they did not need health insurance, four respondents said it was because they were healthy, four said they could get care at the emergency room, four said they can get care at another provider without insurance, and one belonged to a faith-based cost-sharing organization. Two of the three respondents indicating there was another reason they did not have health insurance gave an answer similar to the response that they did not need insurance.

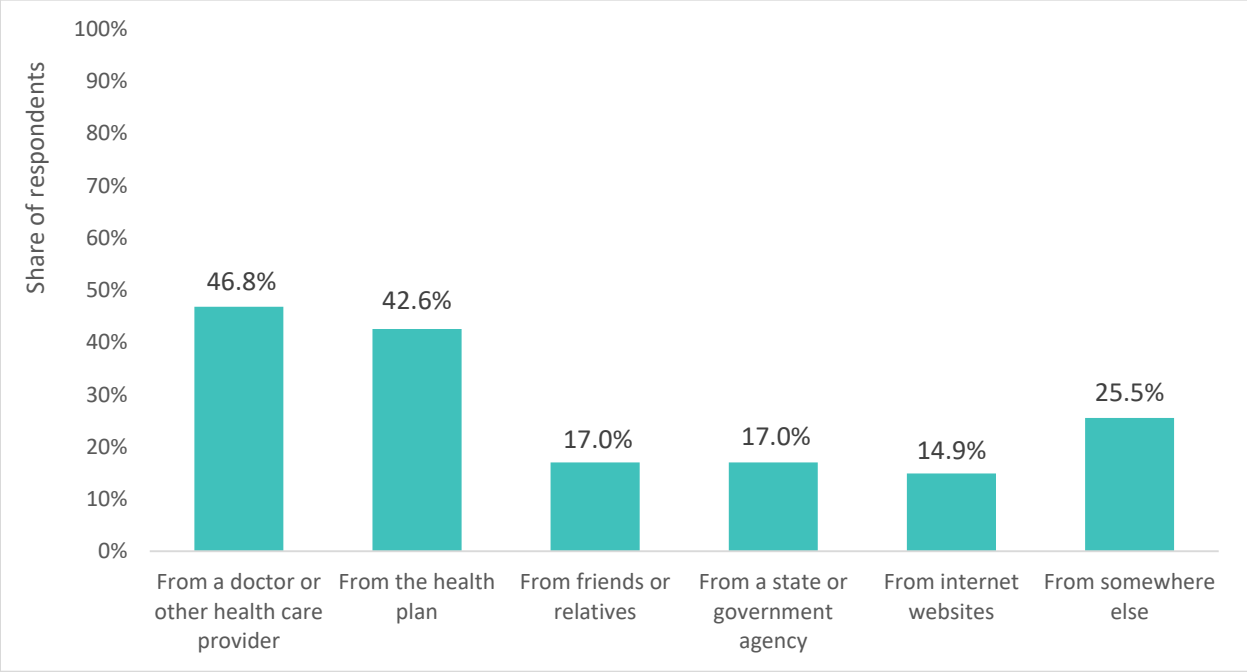
Being employed does not always mean being insured

Of the uninsured respondents who are employed, self-employed, or an unpaid worker at a family business, 11 respondents (44.0%) work more than one job, with most working two jobs, one individual working three jobs and one individual working four or more jobs. Eleven uninsured respondents work in companies with more than 50 employees at all locations. Twelve uninsured respondents' primary job is in a company that offers health insurance as a benefit to its employees.

GETTING INFORMATION

When asked where they got information when last choosing a provider, the most common response from uninsured respondents was that they got the information from a doctor or other health care provider (Figure 8); twenty-two uninsured respondents (46.8%) used this source. Many obtained information from their health plan (20 respondents; 42.6%). Those who said they got information from some other source said that the hospital gave them a doctor or that they had the same doctor since they were a child.

Figure 8: Where Respondents Went for Information When Last Choosing a Provider

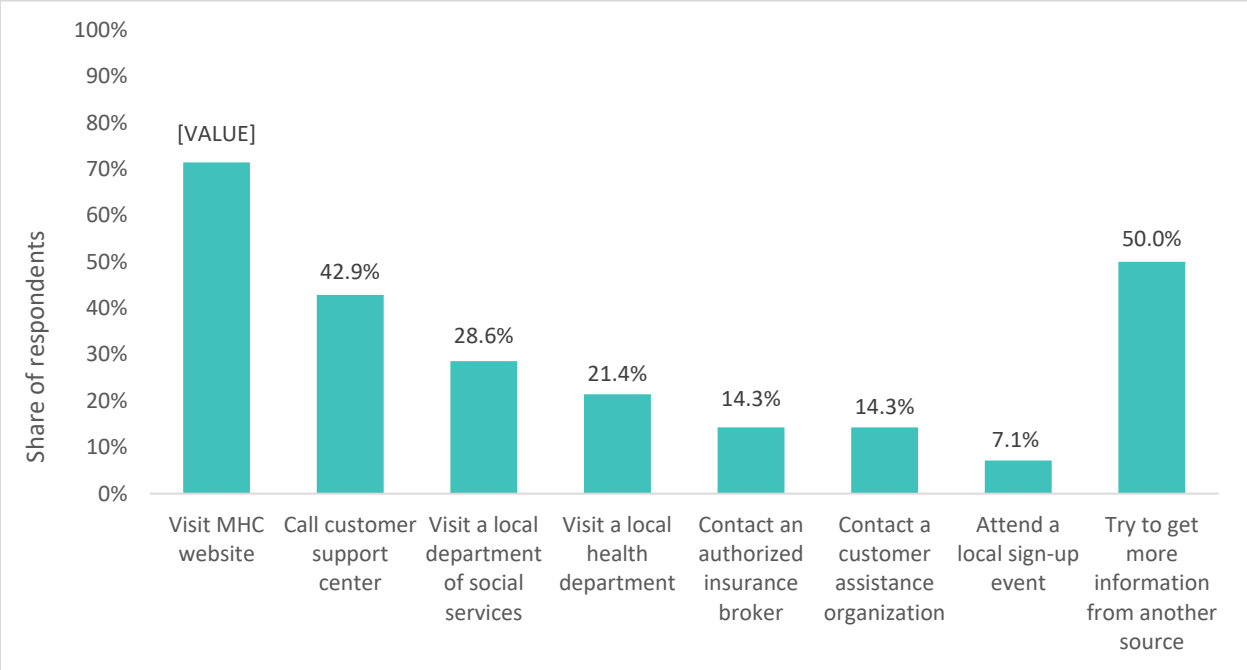


Note: Respondents were allowed to name more than one source.

KNOWLEDGE OF MARYLAND HEALTH CONNECTION

Of those asked, 28 respondents (70.0%) said they had heard of the Maryland Health Connection. Fourteen respondents (42.4%) had tried to get more information about health insurance through the Maryland Health Connection since becoming uninsured. Of these respondents, the most common way they used to get information was through the Maryland Health Connection website, with 10 respondents (71.4%) saying they used the website (Figure 9). Calling customer support was the second most common way to get more information and 6 respondents (42.9%) said they tried this method. The seven respondents who tried to get information from another source identified the other source(s) as internet searching or "social service" at the University of Maryland.

Figure 9: How Respondents Attempted to Get Information about Maryland Health Connection



Helpfulness of Information from Maryland Health Connection

Respondents provided mixed views on the sources of information they accessed regarding obtaining insurance through the Maryland Health Connection. Those who visited the Maryland Health Connection website were evenly divided between those for whom it was very helpful or helpful and those for whom it was not at all helpful (Table 10). Four respondents found the customer support center "very helpful" or "helpful" compared to two respondents who found it "not at all helpful". Three respondents said their visit to a local social services department for assistance was "very helpful" or "helpful", compared to one respondent who said it was "not at all helpful".

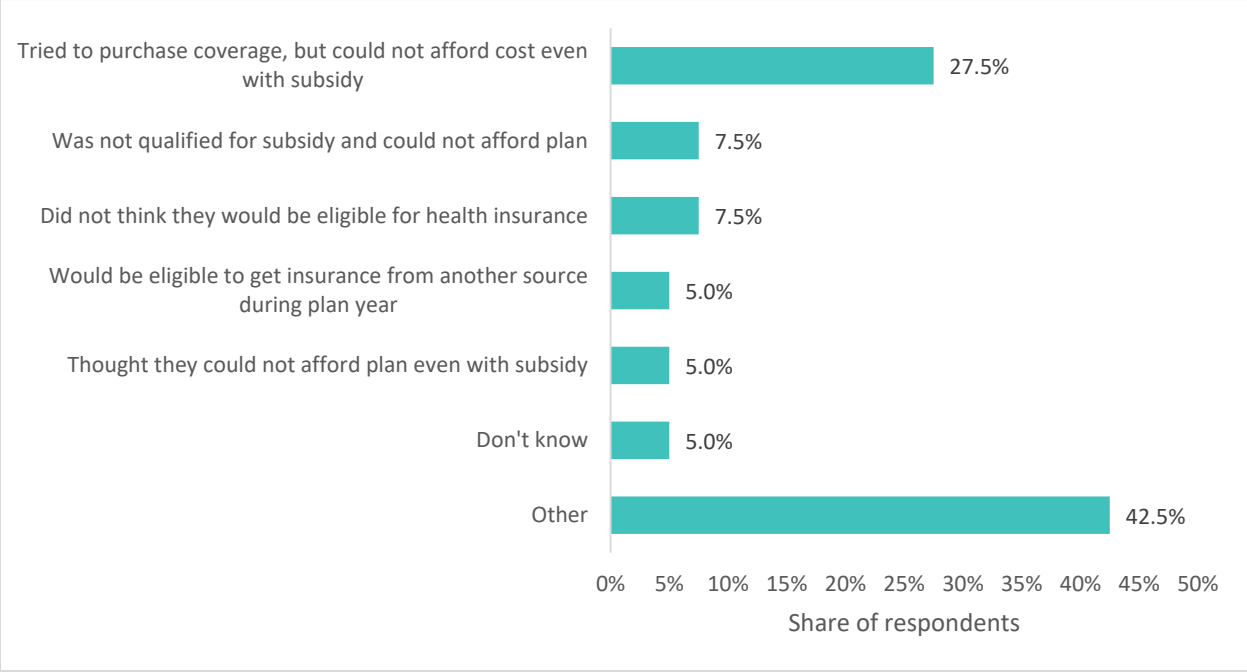
Table 10: Helpfulness of Sources of Information

Source	Number using source	Very helpful	Helpful	Somewhat helpful	Not at all helpful
Visit Maryland Health Connection website	8	37.5%	12.5%	0.0%	50.0%
Call customer support center	6	33.3%	33.3%	0.0%	33.3%
Visit a local department of social services	4	50.0%	25.0%	0.0%	25.0%
Visit a local health department	3	0.0%	33.3%	0.0%	66.7%
Contact an authorized insurance broker	3	0.0%	33.3%	0.0%	66.7%
Contact a customer assistance organization	2	50.0%	0.0%	0.0%	50.0%
Attend a local sign-up event	1	0.0%	0.0%	0.0%	100.0%
From another source	1	0.0%	0.0%	100.0%	0.0%

Why respondents do not purchase insurance from Maryland Health Connection

The most frequent reason that respondents gave for not purchasing insurance from Maryland Health Connection was because they tried to purchase it but could not afford the cost even with a subsidy (Figure 10). Eleven respondents gave this reason. Respondents gave "other" reasons including that they: could not afford or did not want the insurance; had insurance in another state or through the military; experienced a website crash before they could get information; were not eligible; or had not heard about Maryland Health Connection.

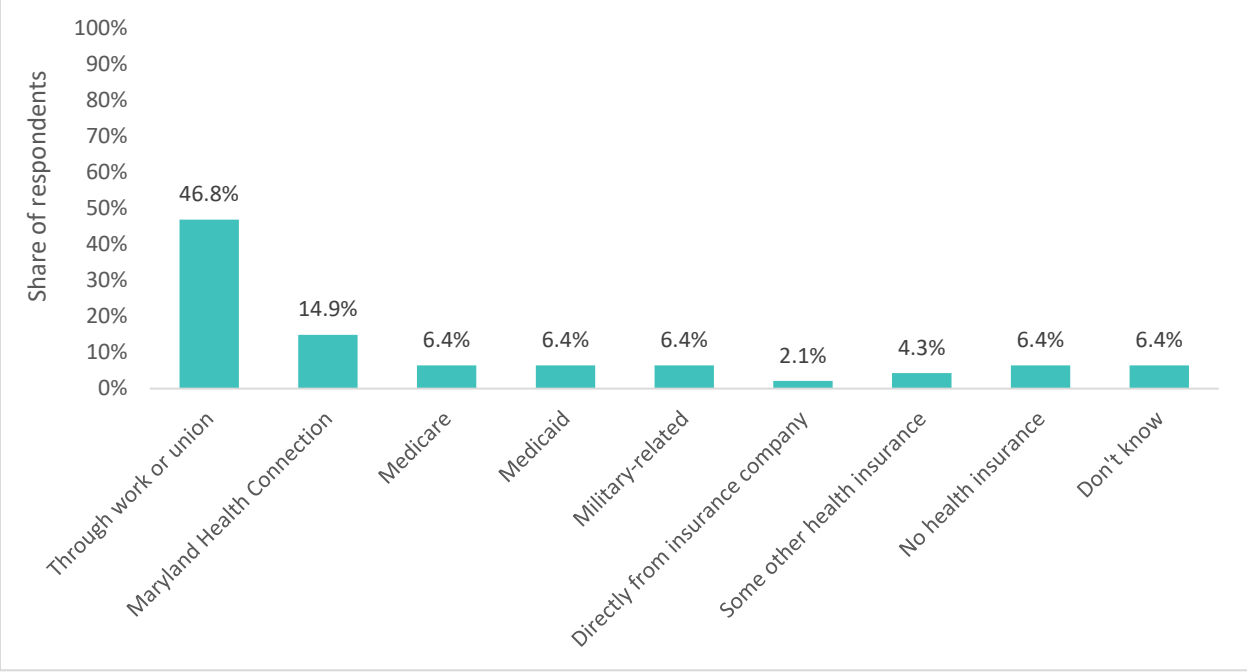
Figure 10: Why Respondents Did Not Purchase Insurance from Maryland Health Connection



PREVIOUS HEALTH INSURANCE

Of respondents without health insurance, almost half (22 respondents; 46.8%) previously had health insurance through their own or someone else's work or union (Figure 11). Seven respondents (14.9%) purchased their previous health insurance through the Maryland Health Connection, while three had insurance through Medicare and three through Medicaid. Of those who purchased through the Exchange or directly from an insurer, five respondents (62.5%) no longer had coverage because they could not afford it. The other three reasons for the end of coverage were because one respondent missed the deadline to re-enroll, the plan one had was no longer offered, and one lost coverage because of a problem in the billing department. Those who previously had Medicaid no longer used the program because they were no longer eligible, they moved, or because they did not feel they received enough in return after a dependent moved out.

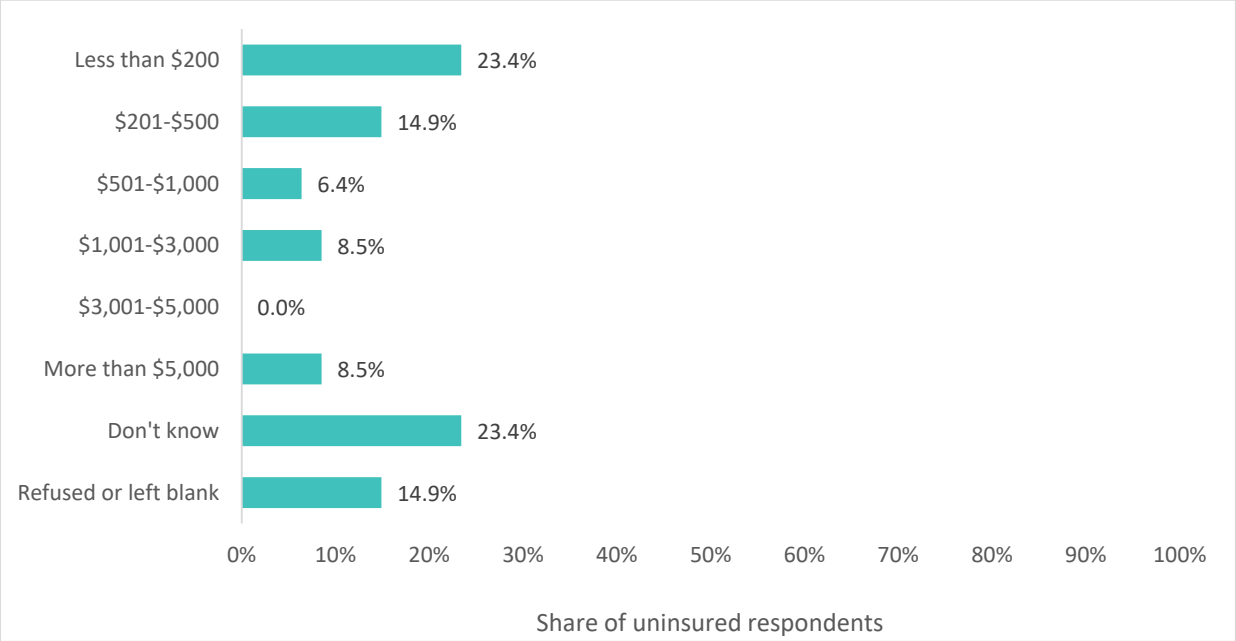
Figure 11: Respondents Previous Health Insurance Sources



FINANCIAL IMPACT OF LACK OF INSURANCE

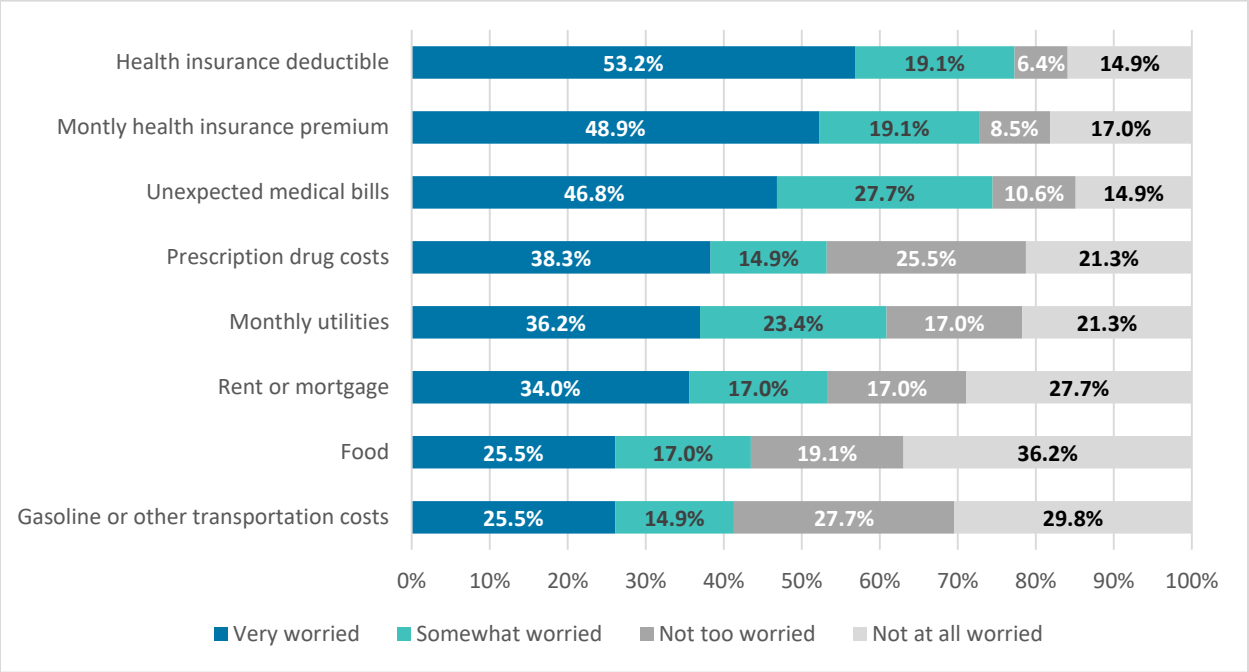
Almost one-quarter (23.4%) of uninsured respondents spent less than $200 on out-of-pocket health care costs in the prior 12 months (Figure 12). Four respondents (8.5%) spent more than $5,000 on health care, while none said they spent between $3,001 and $5,000. Another quarter (23.4%) of respondents did not know how much they spent, and 14.9% refused to answer the question or left it blank.

Figure 12: Total Out-of-Pocket Health Care Costs in Prior 12 Months



Uninsured respondents were more worried about affording their health insurance costs than day-to-day expenses (Figure 13). Over half of respondents (25 respondents; 53%) worried about their deductible, and half (23 respondents, 49%) worried about the monthly premium. In comparison, the top non-insurance worry was about monthly utilities, which concerned 17 respondents (36%).

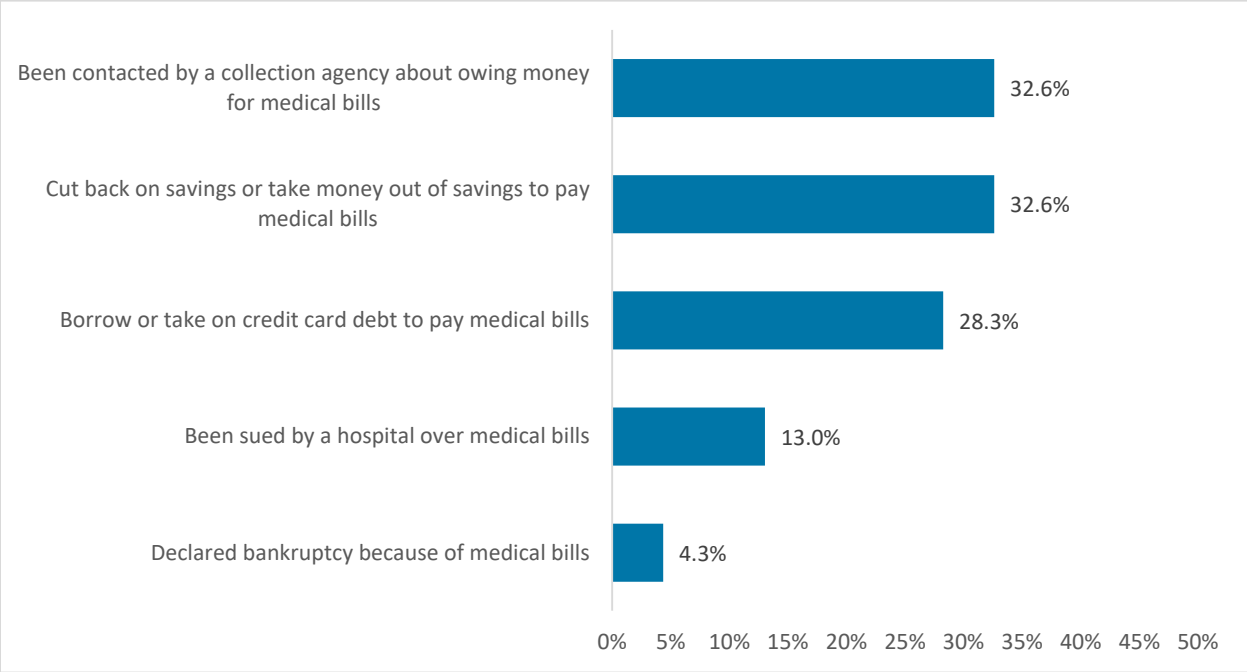
Figure 13: Uninsured Respondents Worried about Affording Insurance or Other Expenses



Note: Excludes responses that were left blank or respondents said they did not know or refused to answer.

As show in Figure 14, approximately one-third (32.6%) of respondents reported they were contacted by a collection agency about owing money for medical bills in the prior 12 months, and one-third (32.6%) said that they had cut back on their savings or taken money out of savings to pay for medical bills. Six respondents had been sued by a hospital over medical bills, and two respondents had declared bankruptcy because of medical bills.

Figure 14: Respondents' Problems Paying Medical Bills in Past 12 Months

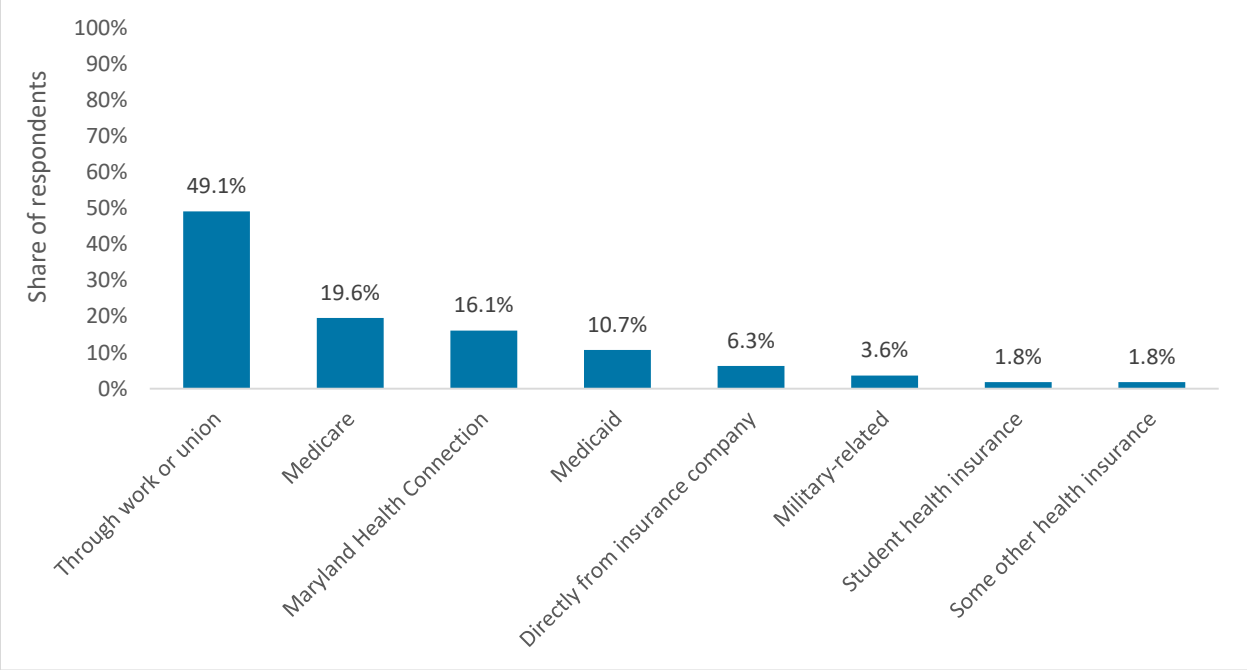


Note: Excludes responses that were left blank or respondents said they did not know or refused to answer.

PERSPECTIVES FROM INDIVIDUALS WHO DO NOT USE THEIR HEALTH INSURANCE

Of the 112 respondents who underutilize their health insurance, 55 respondents (49.1%) had insurance through their or someone else's work or union (Figure 15). Eighteen respondents (16.1%) purchased their care through the Maryland Health Connection, and seven respondents (6.3%) purchased directly from a health insurance provider. A total of 38 respondents (33.9%) had Medicare, Medicaid, or military-related health insurance, and two respondents had a student insurance plan. "Other" responses generally were options already named, such as Medicare or health insurance companies. Over half of respondents had an individual plan (66 respondents, 58.9%) rather than a family plan (44 respondents; 39.3%).

Figure 15: Types of Insurance Held by Under-utilizers



Note: Respondents could choose more than one type of insurance.

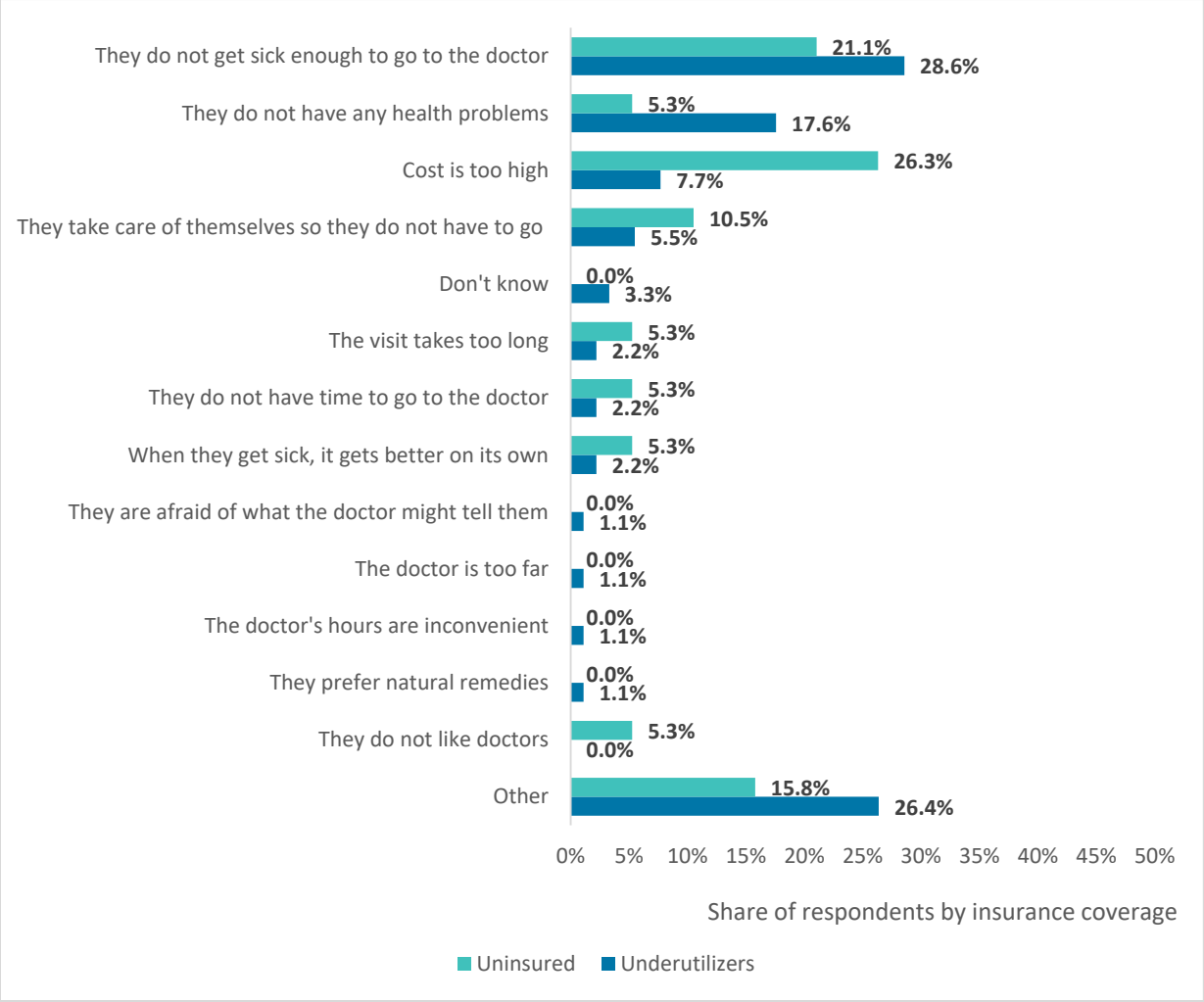
Of the respondents who did not use their health insurance at their last provider visit, three respondents said it was because the doctor did not accept their insurance, one said the doctor charges less than the copay or coinsurance, and one uses a concierge service (where they pay a flat fee to see a doctor and their insurance is not billed). Those who wrote in an "other" response stated they did not use insurance because they were also covered by the Veterans Administration (VA) service or used a VA hospital, they were on worker's compensation, had been in a car accident, or purchased insurance from the dentist.

COMPARING INSURANCE UNDER-UTILIZERS AND THOSE WITHOUT INSURANCE

Figure 16 shows reasons why respondents did not visit a provider in the last 12 months.[9] Of those who responded to the question, the most common reason among those who underutilized their health insurance was that they did not get sick enough to go to the doctor (26 respondents; 28.6%). In comparison, the most common reason among uninsured respondents was that costs were too high (5 respondents, 26.3%), with the second most common reason being that they do not get sick enough (4 respondents, 21.1%). For the underutilizing respondents, the concern about costs being too high was fourth most common. "Other" responses included that the" doctor just gives pills" or that the respondent used telemedicine.

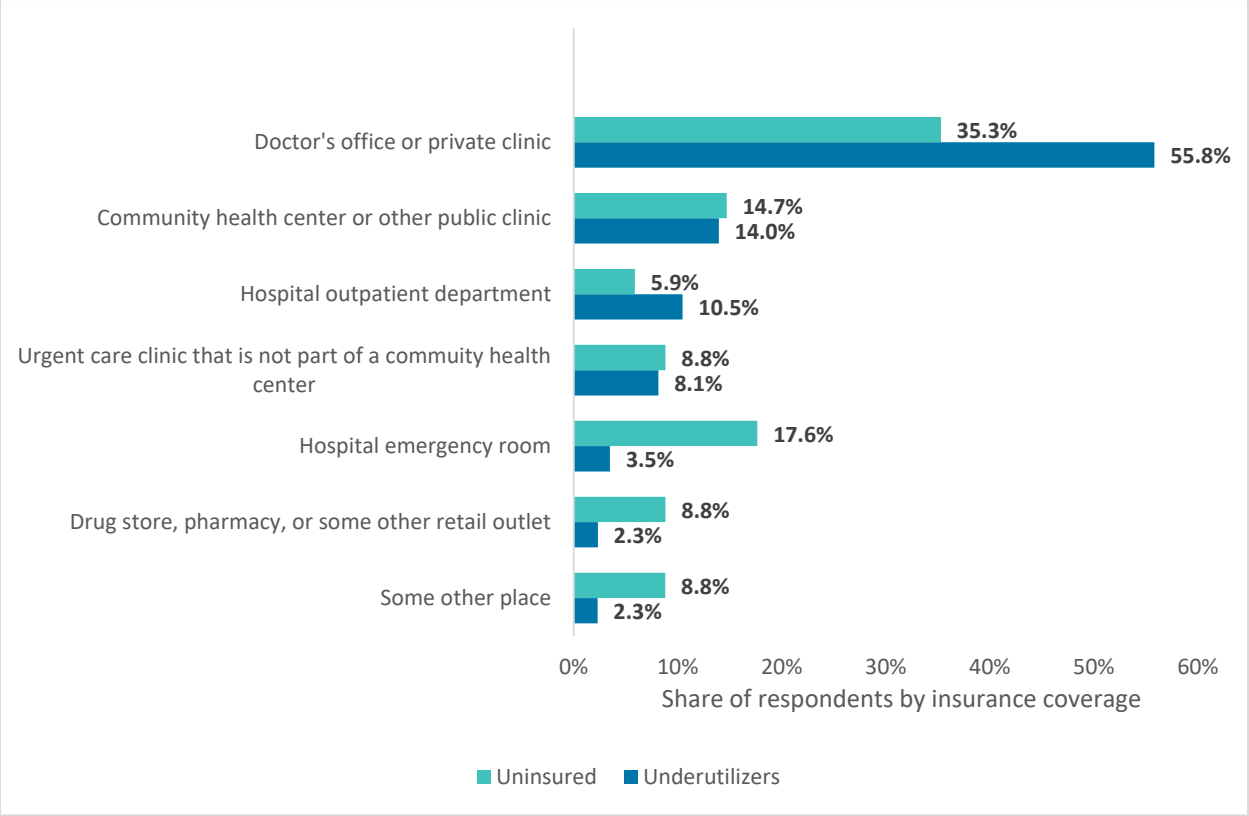
[9] If respondents provided more than one reason they did not visit a provider they were asked to identify the main reason, which was the response recorded by the survey interviewer and presented here. The percentages reported here exclude those who did not respond to this question or refused to answer.

Figure 16: Why Respondents Have Not Visited a Health Provider in 12 Months



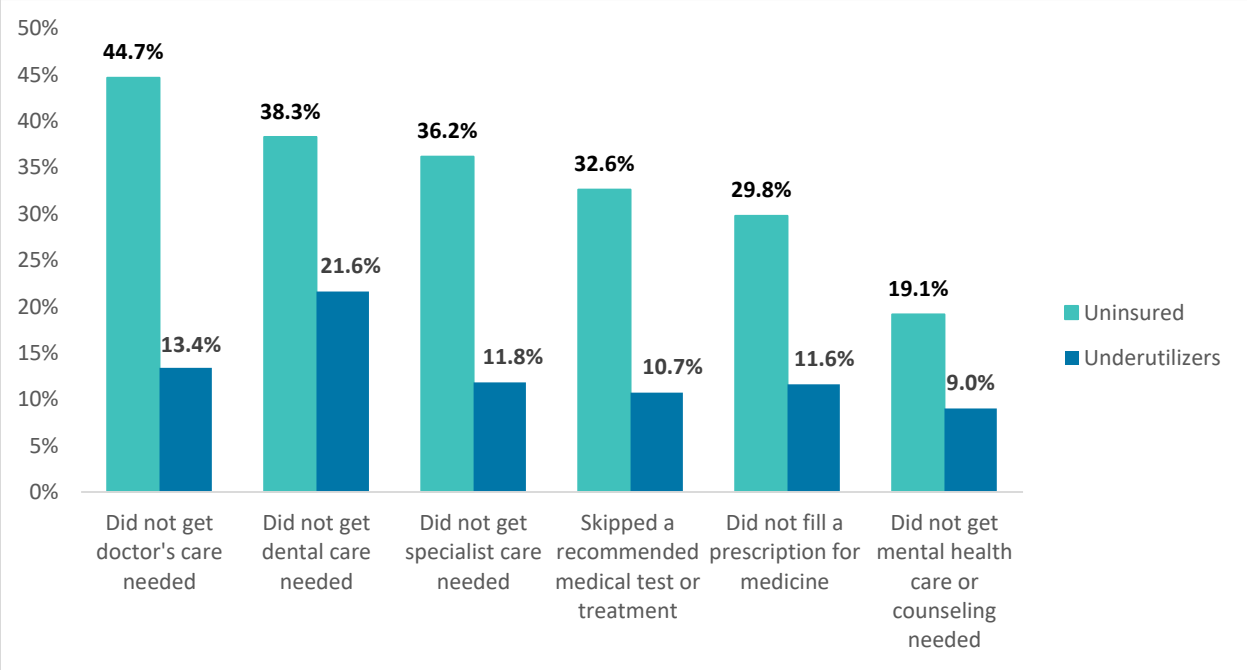
Both uninsured and insured but underutilizing respondents were most likely to go a doctor's office or private clinic when they got sick or needed health advice (Figure 17). This was the choice of over half of the under-utilizers who answered this question (48 respondents, 55.8%) and more than one-third of the uninsured (12 respondents, 35.3%). About the same share of respondents in each group were likely to go to a community health center or other public clinic (14.0% of under-utilizers and 14.7% of uninsured respondents), and the second-most frequent response among uninsured respondents was a hospital emergency room (6 respondents, 17.6%).

Figure 17: Where Respondents Usually Go When Sick or Needing Health Advice



Those who were uninsured were more likely to report skipping needed health care due to cost than those who had insurance but under-used it (Figure 18). Twenty-one uninsured respondents (44.7%) said they did not get care they needed from a doctor, 18 respondents (38.3%) did not get needed dental care, and 17 respondents (36.2%) did not get care they needed from a specialist. The under-utilizers were most likely to skip needed dental care (24 respondents, 21.6%).

Figure 18: Share of Respondents Who Skipped Health Care Because of Cost



Note: Respondents could indicate more than one type of health care they skipped.

Over half of uninsured respondents tried to lower their health care spending in the last year compared to just over one-quarter of those who underutilized their health insurance (Figure 19). Of the 27 uninsured respondents who tried to lower spending, 23 (85.2%) said they went without health insurance coverage (Figure 20). The same number also tried harder to stay healthy, which was also the most common method of lowering savings among the 31 respondents who underutilized their health insurance. Three-quarters (74.1%) of uninsured respondents and 58.1% of underutilizing respondents went without needed health care. Among the "something else" methods tried by respondents were: telemedicine; buying generic prescriptions or over the counter; exercise or not drinking alcohol; and "just didn[']t go."

Figure 19: Share of Respondents Who Tried to Lower Health Care Spending Over Past Year

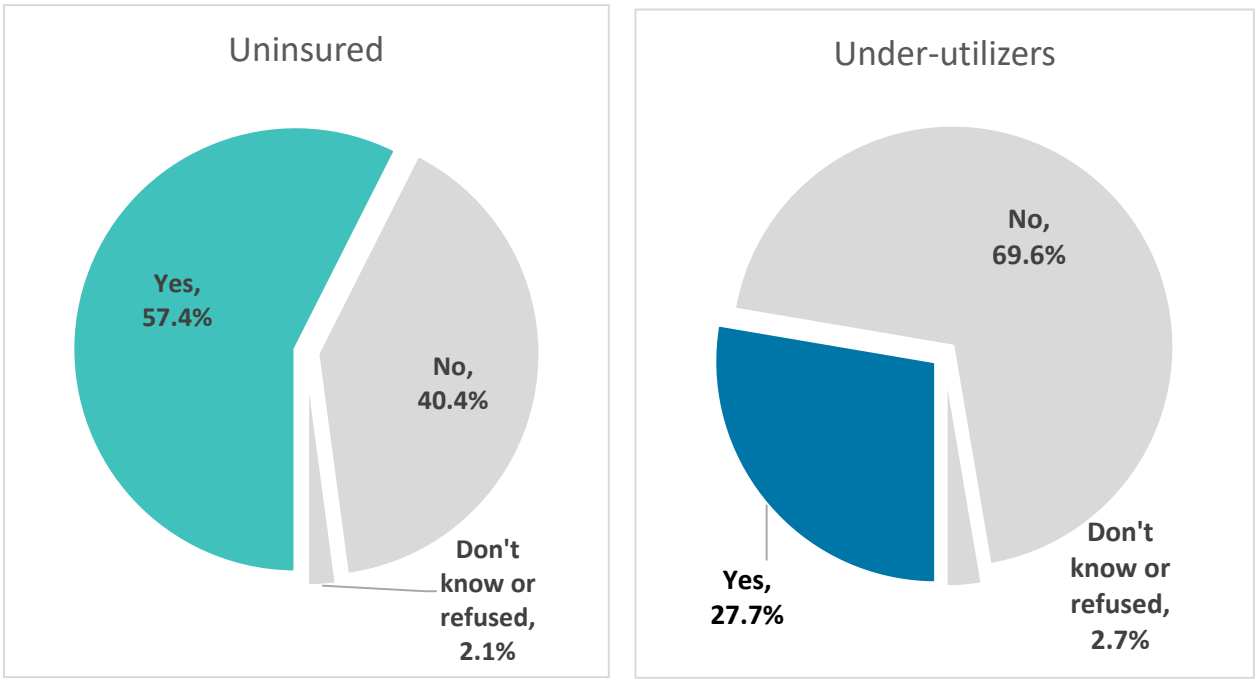
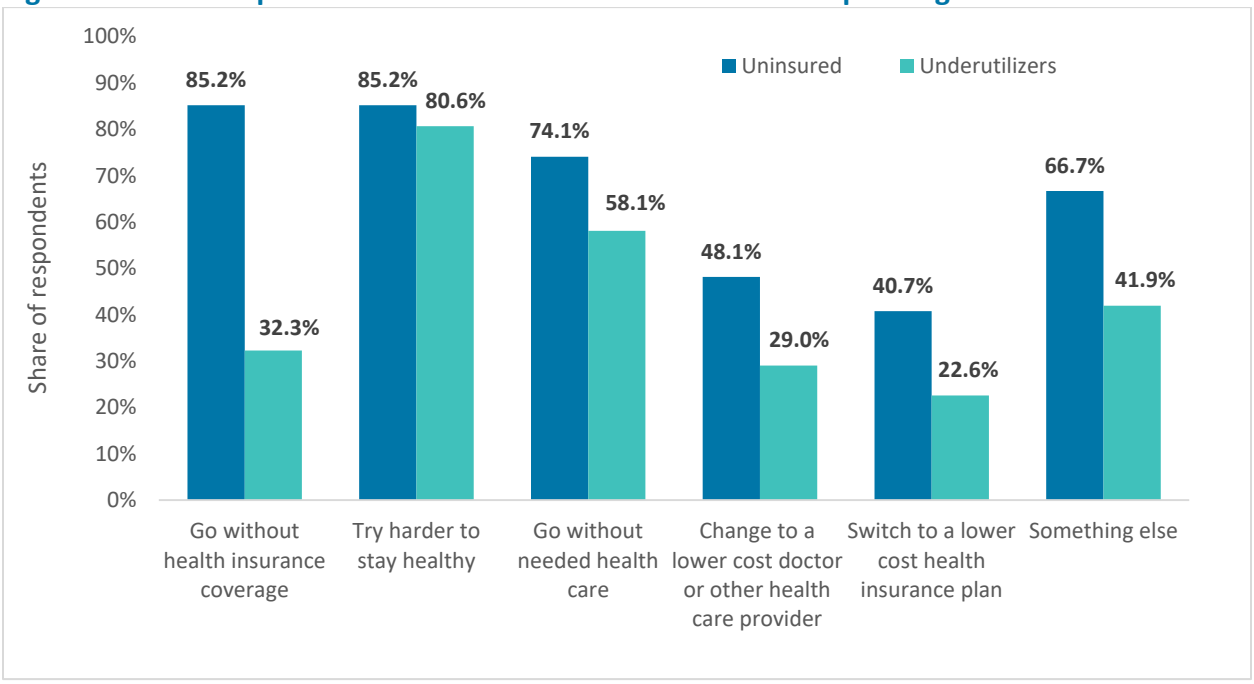


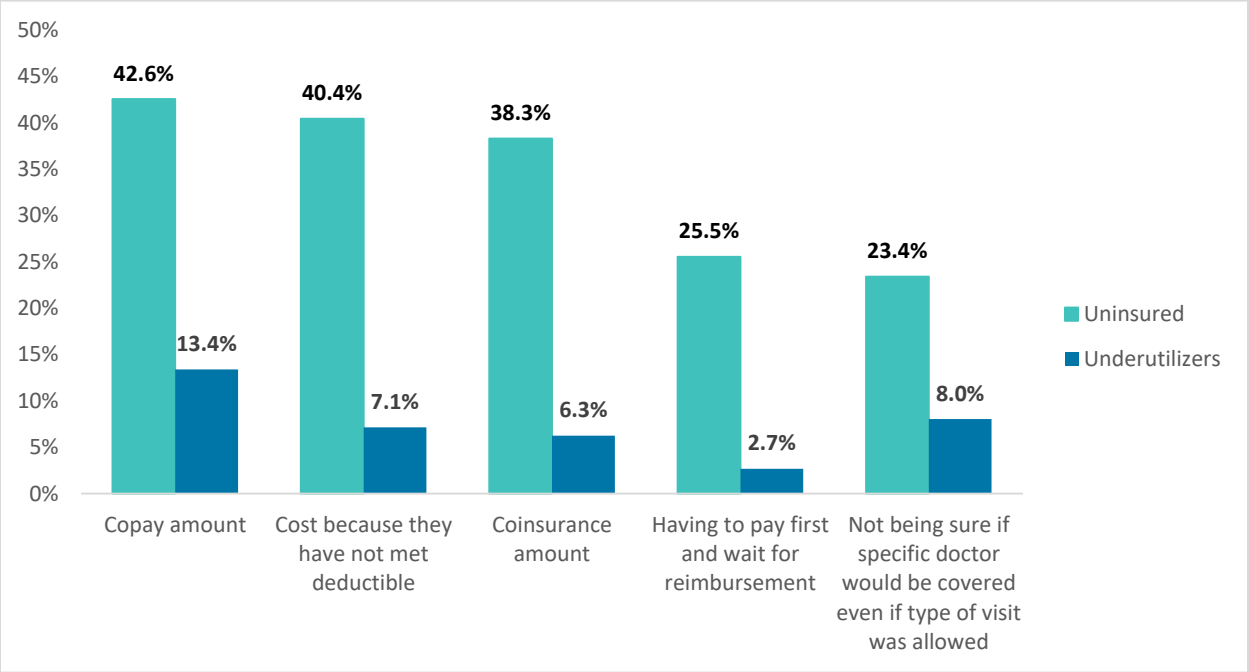
Figure 20: How Respondents Have Tried to Lower Health Care Spending



Note: Respondents could choose more than one method.

Over 40% of uninsured respondents said that copay amounts or not having met a deductible prevented them from seeking health care and the coinsurance amount was a barrier for 38.3% (Figure 21). Much smaller shares of respondents underutilizing their health insurance agreed that one of the costs or factors prevented them from seeking health care with the most common response being the copay amount (13.4%).

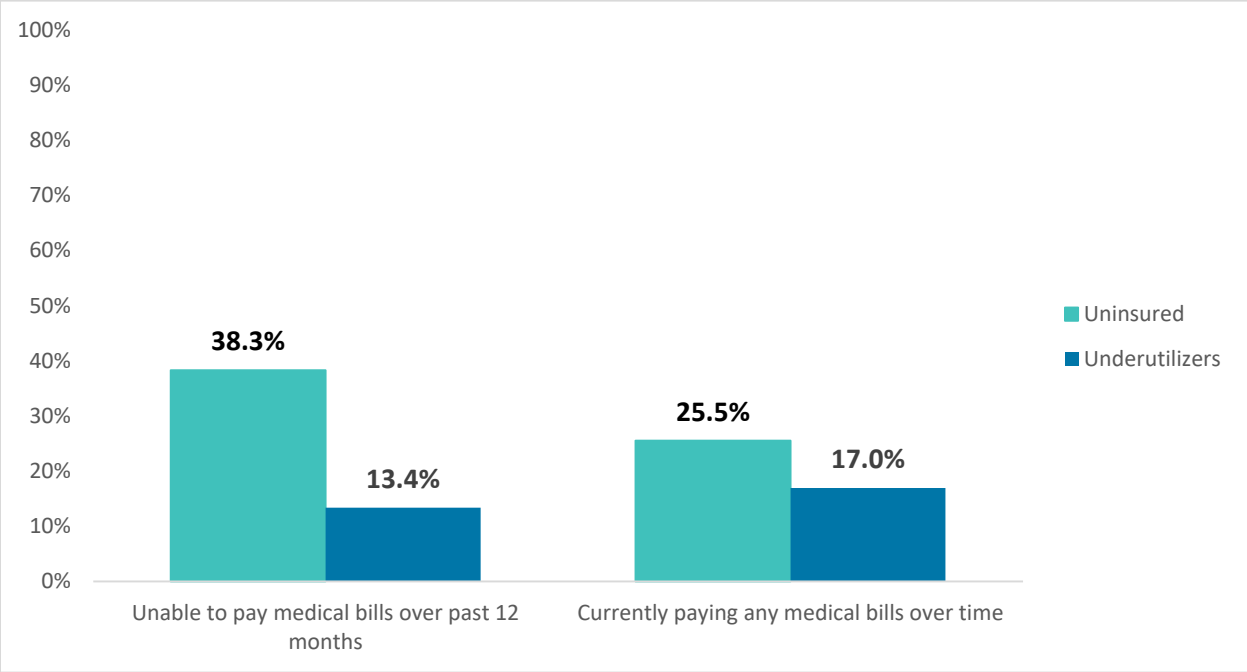
Figure 21: Cost or Factor Preventing Respondents from Seeking Health Care



Note: Respondents were allowed to identify more than one cost or factor.

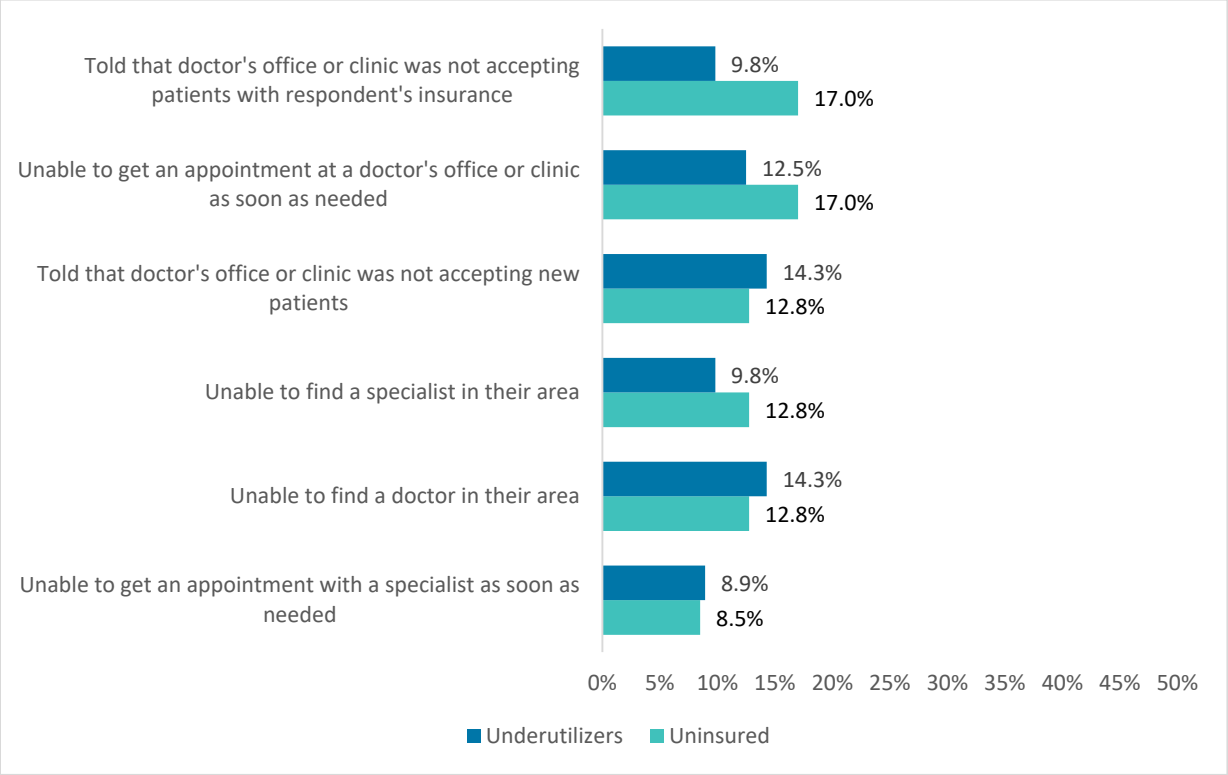
Uninsured respondents were more likely to report that they had been unable to pay some medical bills over the prior 12 months. Over one third (38.3%) of uninsured respondents experienced this problem compared to 13.4% of those underutilizing their insurance (Figure 22). A larger share of uninsured respondents compared to underutilizing respondents also reported that they were currently paying some medical bills over time.

Figure 22: Problems Paying Medical Bills



Eight uninsured respondents (17.0%) were told that a doctor's office or clinic was not accepting patients with their insurance and eight were unable to get an appointment at a doctor's office or clinic as soon as they needed it (Figure 23). The most common experience of respondents who underutilized their insurance was being told that the doctor's office or clinic was not accepting new patients or that they were unable to find a doctor in their area. Sixteen (14.3%) respondents experienced both situations.

Figure 23: Respondents Experiencing Problems Accessing Health Care Access in Past 12 Months



COMPARING THE UNINSURED AND UNDER-UTILIZERS TO THOSE WHO USE INSURANCE

Respondents who underutilized their insurance were much less likely to visit a general practice (GP) doctor in the prior 12 months than those with or without insurance. Just over one tenth (11.6%) of those who underutilized their insurance saw a GP doctor compared to 42.6% of respondents without insurance and 93.3% of respondents who used their insurance (Table 11). Under-utilizers were much less likely to visit a hospital emergency room or see a specialist or mental health professional than respondents who used their insurance and respondents without insurance. Respondents who were uninsured were more likely to visit a hospital emergency room than those who used their insurance (36.2% of the uninsured compared to 28.9% of those who used insurance) but were otherwise less likely to use the other providers than those who used their insurance. The only exception was the similar share of uninsured respondents and those who used their insurance who saw mental health professionals.

Table 11: Providers Visited in Last 12 Months

	Overall		Used Insurance		Under-utilizers		Uninsured	
	N	Share of Total	N	Share of Users	N	Share of Under-utilizers	N	Share of Uninsured
Hospital emergency room	330	26.9%	309	28.9%	4	3.6%	17	36.2%
General doctor	1,029	83.9%	996	93.3%	13	11.6%	20	42.6%
Specialist	703	57.3%	686	64.2%	4	3.6%	13	27.7%
Mental health professional	156	12.7%	147	13.8%	3	2.7%	6	12.8%
Dentist or dental hygienist	726	59.2%	669	62.6%	42	37.5%	15	31.9%

Notes: Respondents were allowed to indicate if they visited more than one provider type. Highlighted cells are above the overall share.

Respondents who did not use their health insurance when visiting a provider were more likely to say their health was "Excellent" (25.0%) or "Very good" (33.0%) compared to those without insurance (19.1% and 27.7%, respectively) and those who used insurance (11.8% and 30.1%, respectively), as shown in Table 12. Over 86% of those who did not use their insurance rated their health as excellent, very good, or good, compared to 76.4% of those who used their insurance and 76.6% of those without insurance.

Table 12: Respondents' General Health

	Overall		Used Insurance		Under-utilizers		Uninsured	
	N	Share of Total	N	Share of Users	N	Share of Under-utilizers	N	Share of Uninsured
Excellent	163	13.3%	126	11.8%	28	25.0%	9	19.1%
Very good	372	30.3%	322	30.1%	37	33.0%	13	27.7%
Good	414	33.7%	368	34.5%	32	28.6%	14	29.8%
Fair	211	17.2%	191	17.9%	11	9.8%	9	19.1%
Poor	61	5.0%	56	5.2%	3	2.7%	2	4.3%
No response	4	0.3%	3	0.3%	1	0.9%	0	0.0%
Do not know	2	0.2%	2	0.2%	0	0.0%	0	0.0%
Total	**1,227**	**100.0%**	**1,068**	**100.0%**	**112**	**100.0%**	**47**	**100.0%**

Note: Highlighted cells show the group most likely to report each health condition.

DEMOGRAPHICS OF RESPONDENTS

Insured respondents tended to be older than either the uninsured or underutilizing respondents, with over half of insured respondents over age 60 (Table 13). In comparison, 38.4% of the respondents who underutilized their insurance were over age 60 and less than 14.9% of the uninsured were over age 60. Uninsured respondents tended to be younger, with 63.8% under age 49 (and 29.8% under age 35); 43.8% of under-utilizers and 27.3% of the insured were under age 49.

Table 13: Age of Respondents

	Overall		Used Insurance		Under-utilizers		Uninsured	
	N	Share of Total	N	Share of Users	N	Share of Under-utilizers	N	Share of Uninsured
18-20	13	1.1%	11	1.0%	1	0.9%	1	2.1%
21-25	37	3.0%	20	1.9%	11	9.8%	6	12.8%
26-35	107	8.7%	84	7.9%	16	14.3%	7	14.9%
36-49	213	17.4%	176	16.5%	21	18.8%	16	34.0%
50-59	231	18.8%	205	19.2%	17	15.2%	9	19.1%
60-64	172	14.0%	156	14.6%	13	11.6%	3	6.4%
65 or older	433	35.3%	399	37.4%	30	26.8%	4	8.5%
Do not know	3	0.2%	2	0.2%	1	0.9%	0	0.0%
Refused	18	1.5%	15	1.4%	2	1.8%	1	2.1%
Total	**1,227**	**100.0%**	**1,068**	**100.0%**	**112**	**100.0%**	**47**	**100.0%**

Note: Highlighted cells are higher than the average for the total sample.

Over half of respondents who underutilized their health insurance were employed by someone other than themselves or the military; 34.0% of the uninsured and 39.8% of those who used their insurance worked for someone other than themselves or the military (Table 14). There was also a substantial share of the insured respondents who were retired, which corresponds to the age of the respondents as discussed in the last paragraph. Almost one-quarter of uninsured respondents were unemployed and looking for work.

Table 14: Current Employment of Respondents

	Overall		Used Insurance		Under-utilizers		Uninsured	
	N	Share of Total	N	Share of Users	N	Share of Under-utilizers	N	Share of Uninsured
Self-employed	100	8.1%	87	8.1%	6	5.4%	7	14.9%
Employed by military	15	1.2%	14	1.3%	0	0.0%	1	2.1%
Employed by someone else	486	39.6%	411	38.5%	59	52.7%	16	34.0%
Unpaid worker for a family business	7	0.6%	6	0.6%	0	0.0%	1	2.1%
Retired	445	36.3%	411	38.5%	29	25.9%	5	10.6%
Unemployed and looking for work	68	5.5%	48	4.5%	9	8.0%	11	23.4%
Unemployed and not looking for work	88	7.2%	75	7.0%	8	7.1%	5	10.6%
Do not Know	5	0.4%	5	0.5%	0	0.0%	0	0.0%
Refused	13	1.1%	11	1.0%	1	0.9%	1	2.1%
Total	**1,227**	**100.0%**	**1,068**	**100.0%**	**112**	**100.0%**	**47**	**100.0%**

Note: Highlighted cells are higher than the average for the total sample.

Uninsured respondents tended to have lower incomes than the other two groups, with 53.1% of respondents reporting household incomes below $50,000 compared to 37.6% of under-utilizers and 38.6% of the insured (Table 15). In comparison, there were no uninsured respondents reporting household incomes over $150,000, while 6.8% of insured respondents and 3.6% of those who underutilized their insurance had incomes over this amount.

Table 15: Household Income of Respondents

	Overall		Used Insurance		Under-utilizers		Uninsured	
	N	Share of Total	N	Share of Users	N	Share of Under-utilizers	N	Share of Uninsured
Less than $20,000	174	14.2%	151	14.1%	15	13.4%	8	17.0%
$20,000 to $34,999	167	13.6%	155	14.5%	7	6.3%	5	10.6%
$35,000 to $49,999	139	11.3%	107	10.0%	20	17.9%	12	25.5%
$50,000 to $74,999	164	13.4%	141	13.2%	15	13.4%	8	17.0%
$75,000 to $99,999	112	9.1%	99	9.3%	7	6.3%	6	12.8%
$100,000 to $149,999	119	9.7%	105	9.8%	12	10.7%	2	4.3%
$150,000 or more	77	6.3%	73	6.8%	4	3.6%	-	0.0%
Do not Know	121	9.9%	100	9.4%	17	15.2%	4	8.5%
Refused	154	12.6%	137	12.8%	15	13.4%	2	4.3%
Total	**1,227**	**100.0%**	**1,068**	**100.0%**	**112**	**100.0%**	**47**	**100.0%**

Note: Highlighted cells are higher than the average for the total sample.

Those who underutilized their insurance were least likely to report having to limit their activities due to physical, mental, or emotional problems, while those who used their insurance were most likely to report such limitations (Table 16).

Table 16: Limited Activities Because of Physical, Mental, or Emotional Problem

	Overall		Used Insurance		Under-utilizers		Uninsured	
	N	Share of Total	N	Share of Users	N	Share of Under-utilizers	N	Share of Uninsured
Yes	315	25.7%	292	27.3%	14	12.5%	9	19.1%
No	898	73.2%	765	71.6%	95	84.8%	38	80.9%
Do not Know	7	0.6%	6	0.6%	1	0.9%	0	0.0%
Refused	7	0.6%	5	0.5%	2	1.8%	0	0.0%
Total	**1,227**	**100.0%**	**1,068**	**100.0%**	**112**	**100.0%**	**47**	**100.0%**

Note: Highlighted cells are higher than the average for the total sample.

FINDINGS FROM FOCUS GROUPS

The research team scheduled 19 focus groups in locations in the study areas around Maryland. Across all groups, 108 people registered for a focus group, but only 42 people actually attended.

This section of the report includes an overview of the focus groups including topics covered, list of locations where the groups were held, and a profile of who participated in the focus groups. Presented next is an analysis of reasons why people do not purchase health insurance, barriers to purchasing health insurance, and reasons why people do not use health insurance. Also included in this section is discussion of participants' understanding of common insurance terms. Finally, there is a discussion of participants' thought process for selecting a health insurance plan.

Like the telephone and web survey, the focus groups sought to understand way people decide to not purchase health insurance and why people with health insurance elect to not use it. The focus groups included individuals who did not currently have health insurance and individuals who have health insurance but do not use it. One group was comprised exclusively of people who have health insurance but do not use it. The remaining groups were mixed with people who do not have health insurance and people who do not use their health insurance.

Why Individuals Decline to Purchase Health Insurance

Several themes emerged across focus groups when discussing reasons why people do not purchase health insurance. Table 17 summarizes the reasons that focus group participants identified for not purchasing health insurance.

REASONS FOR NOT HAVING HEALTH INSURANCE

Each focus group moderator asked participants for reasons why they or people they know do not purchase health insurance. Overall, cost – including out-of-pocket costs and relative value received for the price paid for insurance – was the primary reason for not having health insurance. A lack of information and confusion about health insurance options was another significant reason for not having health insurance. Coverage limitations, including services and providers, also

> *The high cost of health insurance (premium, deductible, and copay) put health insurance out of reach for many including those who qualify for subsidies.*

played a role in people's decisions along with the belief that they are treated differently, including being over-treated, required to have multiple unnecessary visits, or being treated worse because of type of insurance they have. For many, good health and the perception that they did not need insurance was the reason why they did not have health insurance.

Table 17: Themes - Reasons Not to Purchase Health Insurance

Topic/Issue	Number of Groups
Cost of insurance (i.e., premium, deductible, out-of-pocket)	6
Lack of information and confusion about health insurance options	5
More affordable to pay out-of-pocket than have health insurance	4
Overall good health makes insurance unnecessary	4
Confusion about or challenges with affording sufficient coverage	3
Inability to select doctor of choice	3
Distrust or fear of doctors	3
Difference in service, billing, or treatment based on insurance type/status	2
Burdensomeness of application and process	2
Challenge of being homeless and having no address for forms	2
Being covered by parent or parents' health insurance	1
Previous income makes individuals ineligible for income-based insurance plans	1
Total number of focus groups	**7**

Note: There were seven groups, but no one theme was present in all groups.

Cost as a factor in not purchasing health insurance for some

The cost of insurance (premium, deductible, and out-of-pocket expenses) was identified as a reason for not purchasing health insurance in six of the seven groups. Many participants said that insurance was "too expensive." Some cited high deductibles as a reason for not purchasing insurance. Others worried about the cost of using insurance and worried about high bills for costs not covered by their plan. Others believed that the services that were available for what they can afford does not meet their needs. Several said that with limited income or low incomes, insurance was not a priority compared to more urgent needs such as rent or food. Some participants believe that doctors charge more when patients are insured and, related to this, is the experience that at least one participant had with being required to make multiple trips to the doctor instead of addressing all of their issues in one visit so the doctor's office could increase the amount it bills to the insurance company.

> *Once participant from the Salisbury group expressed the sentiment of many, "Bottom line for me is money. I don't have the money to get it. Like, even if my employer was to tell me tomorrow, "Hey, come on, let me sign you up for this," I can't afford for you to take three dollars out of my check, because I'm barely getting' by with what I got."*

Confusion and lack of knowledge during application process discourage some from getting health insurance

A lack of information about insurance options, what is covered, and the application process were identified as reasons for not purchasing health insurance in five of the focus groups. Some felt that the process of applying was hard to understand and that help was not available. Others did not know what was covered in the various plans, while still others thought it was difficult to decide what to purchase because the coverage was different with each plan. Some participants said there was a lack of advocates looking out for their best interests.

Application process is perceived as barrier to getting insurance for some

Some participants thought the application process was a barrier to having health insurance. For some, the process was too time consuming, while, for others, the requirements such as an employer coverage waiting period and being required to have an address (especially for homeless people) were barriers. Some were challenged by the need for required documentation or certain eligibility requirements, and for some the application window was too short, especially for people who work. In at least one group, participants indicated that starting applications for health insurance can lead to an onslaught of calls from insurance agents (described as and perceived by participants as "harassment").

Coverage limitations discourage some individuals from getting insurance

Health insurance coverage limitations in terms of services covered and allowed providers were identified as a reason for not purchasing health insurance. Some participants expressed concern that the coverage they can afford does not meet their health care needs, with a related concern that "not everything" will be covered and patients would end up with an unexpected bill. Participants also said they were limited on their choice of providers, and the provider they liked or selected did not accept all insurance plans. Conversely, another person disliked the providers and staff at the location that accepted their insurance. At least one participant indicated that not being allowed to select a doctor within a network was a reason for not purchasing health insurance.

Health insurance is perceived by some as unnecessary for getting health care

A number of participants said that health insurance was not necessary for health care. Some participants get free or low cost care at the local health department while others rely on the emergency room for immediate care. Some thought it was cheaper to pay for care out-of-pocket, especially for healthy people, than to be insured, since individuals may not use their insurance even though they pay for it.

Good health makes health insurance unnecessary for some

In at least four of the focus groups, participants thought that being in overall good health was a reason for not having health insurance. Some thought it was cheaper to pay for occasional health care than to purchase health insurance.

> *"I'm, kind of, a healthy person so I don't really need to go to the doctor's that often and I find that health insurance gets a little pricy. Especially, I have three children so you can't just get health insurance for you[.]"*
> *Female participant, Baltimore City*

Having health insurance is perceived by some to negatively impact health care

Participants also expressed concerns about the impact of health insurance on their health care. At least one participant said that Medicaid patients have to wait longer for service and are treated over multiple visits instead of having all of their issues addressed in one visit. This same participant said that Medicaid patients are in general treated differently from other patients. There was concern expressed that insurance billing and coding process determines the type of care patients receive, and others expressed concern that patients with insurance are "over-treated" so doctors can collect additional payments.

Technology can be a barrier to getting health insurance for some

Technology was perceived as a barrier to having health insurance. Some participants said that insurance plans and providers rely heavily on online portals, but individuals lack technology or technical ability to access a portal while others lack internet access.

BARRIERS TO PURCHASING HEALTH INSURANCE

The reasons why people do not purchase health insurance provide clear indications of barriers to purchasing health insurance. When focus group participants were asked specifically to identify barriers to purchasing health insurance, several themes emerged (Table 18). However, almost half of the barriers identified were identified in one focus group only.

Online portals used by Maryland Health Connection and many health care providers require access to the internet and the ability to navigate a website. For many, this poses a major barrier to getting and using insurance.

Table 18: Themes - Barriers to Purchasing Health Insurance

Topic/Issue	Number of Groups
Lack of technological familiarity and/or access; lack of physical offices for insurance companies for people to get assistance	5
Documentation and time required to apply are prohibitive (having an address, waiting periods)	4
Transportation (to and from physical offices, to access technology, to access care)	3
Eligibility (confusion, lack of clarity)	3
Political climate; government health programs (difficult to enroll, remain enrolled, eligibility requirements unclear, benefits change)	3
Language barriers, immigration status	2
Employment status (employed or unemployed, unable to apply for insurance or access care because of work schedule)	2
Lack of advocates for individuals seeking insurance	2
Marital status (affects eligibility, discourages getting insurance)	1
Race/ethnicity	1
Employers limit hours to avoid providing insurance coverage	1
Education level and familiarity	1
Religion	1
Stigmas related to transsexual health	1
Total number of focus groups	**7**

Unique comments included:

- Frustration with being charged a fine for being uninsured but being unable to afford insurance; and
- A need for affordable gap coverage for short-term periods between different health insurance coverage sources.

REASONS FOR NOT USING HEALTH INSURANCE

One of the Baltimore City focus groups was comprised exclusively of people who have health insurance but do not use it. Cost and confusion are primary reasons why these focus group participants do not use their health insurance. For some it was cheaper to pay for care out-of-pocket than to use insurance. Others said using insurance was too expensive because people do not always meet their deductibles.

One participant from Baltimore said, "If I haven't met the deductible, I'm not going to use it anyway. So, what I'll do is I go to...I'll find out, because a lot of them, if you self-pay, you know, they'll lower the price. They'll make it affordable, so you can come in and self-pay."

Some participants said insurance is confusing and they do not understand what will be covered, while others felt that the billing itself is too confusing. There was also concern about unexpected bills resulting from treatment and a distrust of doctors who "care more about billing than patient care." In the words of another participant from Baltimore, *" . . .[W]e're talking about all these billing issues, and billing versus quality of healthcare. So, it's like, am I going to go in here and, you know, get the appropriate treatment, or treatment based on what I can pay at the time?"*

LACK OF UNDERSTANDING ABOUT KEY INSURANCE TERMS

Focus group participants were asked to write down what they thought copays, deductibles, and premiums were. Their answers were collected and then participants were shown general definitions (Figure 24). Table 19 shows an estimate of how many participants understood what copays, deductibles and premiums are based on the definitions they gave.[10] Approximately two-thirds (64.7%) of participants could explain what a copay is and less than half (41.2%) could explain the terms deductible or premium. Some who could not correctly explain deductible

[10] Table 27 in Appendix E contains the verbatim definition responses from the 34 focus group participants who submitted responses.

confused or comingled deductible and copay, while one thought it was a discount they receive, another thought it was what insurance paid, and one thought it was a surcharge paid by patients to get service. Four of the respondents said they did not know what the term meant, two respondents thought it was the cost for the "best" health insurance, and two thought it was what the insurance pays.

Figure 24: Definition of Common Insurance Terms

Copay: payment made by beneficiary in addition to that made by an insurer (ex: before a doctor visit or for medications)

Deductible: a specified amount of money that the insured must pay before an insurance company will pay a claim

Premium: an amount to be paid for an insurance policy (ex: monthly or yearly payment)

Table 19: Focus Group Participant Understanding of Terms

	Copay	Deductible	Premium
Number of responses	34	34	34
Accurate responses	22	14	14
Percent of Responses that were accurate	64.7%	41.2%	41.2%

PRIORITIES WHEN SELECTING AN INSURANCE PLAN

Focus group participants were asked to explain their thought process for selecting a health insurance plan while reviewing real Maryland Health Connection plans for their zip code. The definitions for copay, deductible, and premium were left on display for this activity to reduce confusion about what each term meant when participants considered what was important to them.

Table 20 shows which key items were mentioned in each group. Deductibles, monthly premiums, out-of-pocket maximum, and emergency room coverage were identified as priorities when selecting health coverage in six of the seven focus groups. Copays were only mentioned as a priority in two out of seven focus groups. At least one participant talked about weighing the risks versus perceived benefits when deciding the right out-of-pocket maximum for their needs. At least two groups identified having the lowest annual deductible as a priority so their insurance would "kick in" as soon as possible.

Table 20: Priorities When Selecting an Insurance Plan

Group	Date	Annual	Co-pay	Emergency	Monthly	Out-of-

		deductible		room coverage	premium	pocket maximum
Baltimore City	11/05/20	X		X	X	X
Baltimore City	11/07/20	X		X	X	X
Havre de Grace	12/19/20	X				
Salisbury	12/19/20			X	X	X
Baltimore City (Uninsured)	01/23/20	X		X	X	X
Baltimore City (Under-utilizers)	01/23/20	X	X	X	X	x
Hagerstown	01/24/20	X	X	x	x	x
Total (of 7 groups)		**6**	**2**	**6**	**6**	**6**

ABOUT THE FOCUS GROUPS

FOCUS GROUP RECRUITMENT EFFORTS

As summarized in Table 21, the Schaefer Center engaged in extensive outreach to recruit focus group participants, including posting over 30 Craigslist ads, posts to Facebook groups in the target areas, inviting people who completed the telephone and web survey to join focus groups, and requesting 23 health departments and clinics to display posters and postcards that invited their clients to participate in the focus groups and web surveys. Additionally, in mid-January, the focus group incentive was increased from a $50 gift card to a $100 gift card. This did improve attendance at the remaining focus groups.

Table 21: Focus Group Recruitment Efforts

Schaefer Center	**Maryland Insurance Administration**
• Flyers and Postcards to 23 Health Clinics and health departments in targeted areas • 30+ Craigslist ads • Postings to 10 Facebook groups • Invitation to phone and web survey respondents	• Press release • 3 GovDelivery emails (38,068 emails sent) • 2 Facebook posts • 2 Twitter posts • 2 Heaven 600 Radio Interviews
League of Life & Health Insurers of Maryland	**Maryland Health Benefit Exchange**
• Weekly social media posts and reminders encouraging people to participate. • Request to members to help promote.	• Promotion of the focus groups.

The Maryland Insurance Administration also vigorously promoted the web survey and focus groups through a press release, GovDelivery emails to interested constituents, Facebook posts, Twitter posts, and two interviews on Heaven 600 radio station.

Nineteen focus groups were scheduled in locations around Maryland. Across all groups, 108 people registered for a focus group, but only 42 people actually attended. As shown in Table 22, seven focus groups were held – four in Baltimore, one in Hagerstown, one in Havre de Grace, and one in Salisbury. The Baltimore City groups on January 23, 2020, were originally scheduled as one group, but an unexpectedly high number of registrations allowed for the group to be split into two groups (one for uninsured and one for under-utilizers) for increased depth and dialogue. Eleven focus groups were cancelled due to a lack of participants and one was cancelled due to illness.

Table 22: Focus Group Registrants and Attendees by Location and Date

Focus Group Location	Jurisdiction	Date	Registered Respondents	Attendees
Baltimore City	Baltimore City	November 5, 2019	11	4
Baltimore City	Baltimore City	November 7, 2019	17	5
Salisbury	Wicomico	November 9, 2019	3	0
Lexington Park	St. Mary's	November 16, 2019	0	0
Bel Air	Harford	November 19, 2019	1	0
Havre de Grace	Harford	December 19, 2019	6	1
Hagerstown	Washington	December 19, 2019	0	0
Hagerstown	Washington	December 19, 2019	3	0
Salisbury	Wicomico	December 19, 2019	11	4
Leonardtown	St. Mary's	December 20, 2019*	4	0
Frostburg	Allegany	January 11, 2020	2	0
Cecilton	Cecil	January 11, 2020	1	0
Lexington Park	St. Mary's	January 17, 2020	0	0
Baltimore City	Baltimore City	January 23, 2020	17	6
Baltimore City	Baltimore City	January 23, 2020	14	11
Hagerstown	Washington	January 24, 2020	14	11
Owings	Calvert	January 25, 2020	0	0
Chestertown	Kent	January 25, 2020	2	0
Leonardtown	St. Mary's	January 30, 2020	2	0
Total			**108**	**42**

** Cancelled due to moderator illness – 1 attendee registered.*

WHO PARTICIPATED IN THE FOCUS GROUPS

Focus group participants were heavily representative of Baltimore City (26 participants), followed by Hagerstown (11 participants), Salisbury (4 participants), and Havre de Grace (1 participant). Table 23 shows the gender, racial, and age distribution of the focus group participants by location. The income distribution of participants by location is presented in Table 24.

Focus group participants by gender

Collectively, Baltimore City focus group participants included nine females and 17 males. Hagerstown had six females, four males, and one participant who did not respond. The Havre de Grace participant was male. Salisbury had one female and three male participants.

Focus group participants by race

Focus group participants were diverse, with 53% identifying as Black or African-American and 33% identifying as White or Caucasian. Two identified as Asian (5%) and 4 (10%) identified as being of two or more races. The Baltimore City groups were the most diverse of the groups.

Focus group participants by age

As shown in Table 23, the focus groups were relatively diverse in terms of age. More than half (61.5%) of Baltimore City participants were between the ages of 21 and 39. Approximately one fifth of participants (19.2%) were between the ages of 50 and 59. Hagerstown participants were more evenly spread across the spectrum, with 54.5% between the ages of 40 and 59. The Havre de Grace focus group had one participant who reported being between the age of 21 and 29. Salisbury was evenly split at 25% each falling in the age ranges of 21-29, 30-30, 40-49, and 50-59.

Table 23: Gender, Race, and Age of Focus Group Participants

	Group Location					
Demographic	**Baltimore City** ***(4 groups)***	**Hagerstown**	**Havre de Grace**	**Salisbury**	**Total**	**Percent of Total Responses**
Gender						
Female	9	6		1	16	39%
Male	17	4	1	3	25	61%
No Response	0	1	0	0	1	-
Total Responses	26	10	1	4	41	100%
Total	26	11	1	4	42	-
Race						
Asian	2	0	0	0	2	5%
Black or African American	17	2	0	2	21	53%
White or Caucasian	4	7	0	2	13	33%
Two or more races	2	2	0	0	4	10%
Prefer not to answer	1	0	1	0	2	-
Total Responses	25	11	0	4	40	100%
Total	26	11	1	4	42	-
Age						
18-20	1	1	0	0	2	5%
21-29	7	1	1	1	10	24%
30-39	9	2	0	1	12	29%
40-49	3	3	0	1	7	17%
50-59	5	3	0	1	9	21%
60-64	0	0	0	0	0	0%
Over 65	1	1	0	0	2	5%
Total Responses	26	11	1	4	42	1
Total Participants	26	11	1	4	42	1

Focus group participants by income range

As shown in Table 24, focus group participants' indicated incomes were diverse but clustered primarily under $40,000 per year. Baltimore City participants making less than $5,000 per year made up 17.5% of the sample. Just over one third of participants (35%) reported annual incomes of $25,000 - $34,999. Four participants were outliers from the rest of the groups, with two reporting an annual income of $50,000 - $54,999 and two reporting an annual income of $70,000 - $74,999.

Table 24: Focus Group Participants' Income

Income	Baltimore City (4 groups)	Hagerstown	Havre de Grace	Salisbury	Total	Percent of Total Responses
$0-$4,999	7	0	0	0	7	18%
$5,000-$9,999	1	1	0	0	2	5%
$10,000-$14,999	1	2	0	0	3	8%
$15,000-$19,999	2	2	0	0	4	10%
$20,000-$24,999	0	0	0	2	2	5%
$25,000-$29,999	4	2	1	0	7	18%
$30,000-$34,999	5	1	0	1	7	18%
$35,000-$39,999	3	0	0	1	4	10%
$40,000-$44,999	0	0	0	0	0	0%
$50,000-$54,999	2	0	0	0	2	5%
$55,000-$59,999	0	0	0	0	0	0%
$60,000-$64,999	0	0	0	0	0	0%
$65,000-$69,999	0	0	0	0	0	0%
$70,000-$74,999	0	2	0	0	2	5%
No response	1	1	0	0	2	-
Total responses	25	10	1	4	40	100%
Total participants	26	11	1	4	42	

Focus group participants by household size

Participants from Hagerstown had the largest average household size (3.1), followed by those from Baltimore City (2.04). Salisbury participants had slightly smaller households with 1.8 members on average, although Havre de Grace had the smallest households (1.0).

APPENDIX A: ZIP CODES INCLUDED IN THE STUDY

Table 25: Zip Codes Included in the Study

Jurisdiction	Zip Code	Number of Criteria Meet	Low Income	Rural	Medically Underserved
Allegany	21502	3	Yes	Yes	Yes
	21521	3	Yes	Yes	Yes
	21524	3	Yes	Yes	Yes
	21529	2		Yes	Yes
	21530	3	Yes	Yes	Yes
	21532				
	21539	3	Yes	Yes	Yes
	21540	3	Yes	Yes	Yes
	21542	3	Yes	Yes	Yes
	21543	2		Yes	Yes
	21545	3	Yes	Yes	Yes
	21555	3	Yes	Yes	Yes
	21557	3	Yes	Yes	Yes
	21562	3	Yes	Yes	Yes
	21766	3	Yes	Yes	Yes
Anne Arundel	21225	2	Yes		Yes
Baltimore City	21201	2	Yes		Yes
	21202	2	Yes		Yes
	21205	2	Yes		Yes
	21206	2	Yes		Yes
	21213	2	Yes		Yes
	21215	2	Yes		Yes
	21216	2	Yes		Yes
	21217	2	Yes		Yes
	21218	2	Yes		Yes
	21222	2	Yes		Yes
	21223	2	Yes		Yes
	21225	2	Yes		Yes
	21229	2	Yes		Yes
	21239	2	Yes		Yes
Baltimore County	21221	2	Yes		Yes

Zip Codes Included in the Study - Continued					
Jurisdiction	Zip Code	Number of Criteria Meet	Low Income	Rural	Medically Underserved
Calvert	20615	2		Yes	Yes
	20629	2		Yes	Yes
	20639	2		Yes	Yes
	20657	2		Yes	Yes
	20676	2		Yes	Yes
	20678	2		Yes	Yes
	20685	2		Yes	Yes
	20688	2		Yes	Yes
	20689	2		Yes	Yes
	20714	2		Yes	Yes
	20732	2		Yes	Yes
	20736	2		Yes	Yes
	20754	2		Yes	Yes
Caroline	21629	2		Yes	Yes
	21632	3	Yes	Yes	Yes
	21636	2		Yes	Yes
	21639	3	Yes	Yes	Yes
	21640	2		Yes	Yes
	21641	2		Yes	Yes
	21649	3	Yes	Yes	Yes
	21655	2		Yes	Yes
	21660	3	Yes	Yes	Yes
Cecil	21913	2	Yes		Yes
	21920	2	Yes	Yes	
Charles	20632	2	Yes		Yes
	20658	2	Yes		Yes
Dorchester	21622	2	Yes	Yes	
	21626	2	Yes	Yes	
	21634	2	Yes	Yes	
	21643	2	Yes	Yes	
	21648	2	Yes	Yes	
	21664	2	Yes	Yes	
	21669	2	Yes	Yes	
	21672	2	Yes	Yes	
	21675	2	Yes	Yes	
	21835	2	Yes	Yes	
	21869	2	Yes	Yes	
Frederick	21714	2	Yes	Yes	
	21790	2	Yes	Yes	

Zip Codes Included in the Study - Continued					
Jurisdiction	Zip Code	Number of Criteria Meet	Low Income	Rural	Medically Underserved
Garrett	21520	3	Yes	Yes	Yes
	21522	2		Yes	Yes
	21523	3	Yes	Yes	Yes
	21531	3	Yes	Yes	Yes
	21536	3	Yes	Yes	Yes
	21538	3	Yes	Yes	Yes
	21541	2		Yes	Yes
	21550	3	Yes	Yes	Yes
	21561	3	Yes	Yes	Yes
Harford	21005	2	Yes	Yes	
	21040	2	Yes	Yes	
	21130	2	Yes	Yes	
Kent	21610	2		Yes	Yes
	21620	2		Yes	Yes
	21635	2		Yes	Yes
	21645	2		Yes	Yes
	21650	3	Yes	Yes	Yes
	21651	2		Yes	Yes
	21661	2		Yes	Yes
	21667	2		Yes	Yes
	21678	3	Yes	Yes	Yes
Queen Anne's	21607	2		Yes	Yes
	21623	2		Yes	Yes
	21628	2	Yes	Yes	
	21644	3	Yes	Yes	Yes
	21668	2		Yes	Yes
Somerset	21817	3	Yes	Yes	Yes
	21821	3	Yes	Yes	Yes
	21824	3	Yes	Yes	Yes
	21838	2		Yes	Yes
	21853	3	Yes	Yes	Yes
	21866	2		Yes	Yes
	21867	2		Yes	Yes
	21871	2		Yes	Yes
	21890	2		Yes	Yes

Zip Codes Included in the Study - Continued					
Jurisdiction	Zip Code	Number of Criteria Meet	Low Income	Rural	Medically Underserved
St. Mary's	20606	2		Yes	Yes
	20619	2		Yes	Yes
	20620	2		Yes	Yes
	20628	2		Yes	Yes
	20630	2		Yes	Yes
	20634	2		Yes	Yes
	20636	2		Yes	Yes
	20650	2		Yes	Yes
	20653	2		Yes	Yes
	20660	2		Yes	Yes
	20667	3	Yes	Yes	Yes
	20670	3	Yes	Yes	Yes
	20674	2		Yes	Yes
	20680	2		Yes	Yes
	20684	2		Yes	Yes
	20686	2		Yes	Yes
	20687	2		Yes	Yes
	20690	2		Yes	Yes
	20692	2		Yes	Yes
Talbot	21612	2		Yes	Yes
	21624	3	Yes	Yes	Yes
	21647	2		Yes	Yes
	21652	2		Yes	Yes
	21653	2		Yes	Yes
	21663	2		Yes	Yes
	21665	2		Yes	Yes
	21671	2		Yes	Yes
	21676	3	Yes	Yes	Yes
Washington	21711	2	Yes	Yes	
	21719	2	Yes		Yes
	21734	2	Yes	Yes	
	21740	2	Yes		Yes
	21750	2	Yes	Yes	
	21756	2		Yes	Yes
	21767	2	Yes		Yes
	21779	2		Yes	Yes
	21781	2	Yes	Yes	

Zip Codes Included in the Study - Continued					
Jurisdiction	Zip Code	Number of Criteria Meet	Low Income	Rural	Medically Underserved
Wicomico	21804	2	Yes		Yes
	21814	2	Yes		Yes
	21822	2	Yes		Yes
	21826	2	Yes		Yes
	21837	2	Yes	Yes	
	21849	2	Yes	Yes	
	21850	2	Yes	Yes	
	21856	2	Yes		Yes
	21874	2	Yes	Yes	
Worcester	21811	2		Yes	Yes
	21813	2		Yes	Yes
	21829	2		Yes	Yes
	21841	2		Yes	Yes
	21842	2		Yes	Yes
	21851	3	Yes	Yes	Yes
	21862	2		Yes	Yes
	21863	3	Yes	Yes	Yes
	21864	3	Yes	Yes	Yes
	21872	2		Yes	Yes

APPENDIX B: MIA PUBLIC INPUT MEETING DATES AND SAMPLE AGENDA

The Maryland Insurance Administration conducted three public forums;

1. May 2, 2019 at Hagerstown Community College with 8 in attendance
2. May 7, 2019 at the MIA with 11 in attendance
3. May 16, 2019 at Chesapeake College with 6 in attendance

A fourth forum was scheduled to be held in Southern Maryland but was canceled due to poor turnout and a lack of substantial public feedback during the first three meetings.

The purpose of these public meetings was to engage with the public to get ideas on how to reach the population of Marylanders needed to conduct this study. Insurance brokers, elected officials, advocacy groups and any other interested parties were invited to attend.

MIA representatives discussed the purpose of the study and wanted to find out why people not enrolled for health benefits or use the benefits that they are paying for.

MIA representatives asked attendees to share their insight about and experiences with barriers for enrolling and/or using their coverage. The following prompts were provided to initiate discussion.

1. Cost
2. Lack of provider networks
3. Are the plans worth it?
4. Social Determinants

Time was available during the meeting for open questions and discussion.

Very little useful information was provided during these meetings on how to conduct the study. People who did speak spoke about the reasons why they believe people do not purchase or use health insurance.

MIA invited everyone who attended to provide a written testimony unfortunately none were submitted.

Figure 25: Sample Agenda - MIA Community Meetings

Study of Access and Use in Maryland's Individual Health Insurance Market

Public Meeting Agenda

May 16, 2019

10:30AM-12:30PM

Chesapeake College
Health and Professions and Athletics Center Room 127

Conference Call Telephone number:
Dial: 1-216-930-8838
Pin: 298 217 688#

I. Introductions

II. Overview:

- A. Health Insurance Market Place
- B. Individual Marketplace
- C. Role of the Maryland Health Benefit Exchange

III. Purpose of study:

- A. Availability of health benefit plan coverage
- B. Why people do not enroll?
- C. What are barriers to people using their coverage once enrolled?

IV. Barriers to enrollment:

- A. Economic/Cost
- B. Doctor & provider networks
- C. Are the plan benefits worth it, including dental?
- D. Social Determinants
- E. Other

V. Barriers to people using their coverage:

- A. Economic/Cost
- B. Doctor & provider networks
- C. Are plan benefits worth it, including dental?
- D. Social Determinants
- E. Other

VI. What else should we know or include as part of our study?

APPENDIX C: TELEPHONE SURVEY DISPOSITION

The telephone sample included 50,000 random numbers for people who live in the study zip codes. Cell phone numbers comprised 76% of the sample and landlines were 24%. Working numbers were called multiple times at various times of the day and week.

Table 26: Telephone Sample Disposition Summary

Final Disposition	Number
Complete: No insurance	39
Complete: Under use insurance	100
Complete: Use Insurance	1,037
Voice Mail/Answering Machine	20,504
No Answer	7,037
Refusal	6,624
Non-working number	5,057
Busy	3,496
General Callback	1,574
Business/Gov't	549
Non in Zip code list	247
FAX/Modem	167
Language Barrier	139
Termination	105
Do Not Live in MD	101
Language Barrier Spanish *	95
No one over 18	61
Did not call	3,068
Total Numbers in the Sample	50,000

[*] All potential participants who indicated they spoke Spanish received an additional call by a Spanish speaking interviewer.

APPENDIX D: SAMPLE MARYLAND HEALTH CONNECTION INSURANCE PLANS

Maryland Health Connection – Health Insurance Plans

Age: 37 **Marriage Status: Single**
Gender: N/A **Pregnant: No**
Annual Income: $21,008
Zip Code: 21078 **County: Harford (Havre de Grace)**

Plans	Monthly Premium (after tax credit)	Annual Deductible	Annual Out-of-Pocket Maximum	Primary Care Co-Pay	Emergency Room
BlueChoice HMO Bronze $7,900	$1.55	$7,900.00	$7,900.00	No Charge After Deductible	N/A
KP MD Bronze 6200/20%/HAS/Dental	$2.89	$6,200.00	$6,550.00	20% Coinsurance after deductible	20.00% Coinsurance after deductible
KP MD Bronze 6000/50/Dental	$4.07	$6,000.00	$7,900.00	40% Coinsurance after deductible	40.00% Coinsurance after deductible
KP MD Silver 6000/35/Dental	$81.52	$0.00	$2,600.00	$15.00 Copay	30.00% Coinsurance
KP MD Gold 1500/20/Dental	$85.28	$1,500.00	$6,850.00	$20.00 Copay	35.00% Coinsurance after deductible
KP MD Gold 1000/20/Dental	$90.64	$1,000.00	$6,850.00	$20.00 Copay	$500.00 Copay
KP MD Silver 3200/20%/HSA/Dental	$96.04	$500.00	$2,250.00	10.00% Coinsurance after deductible	10.00% Coinsurance after deductible
KP MD Gold 0/20/Dental	$103.44	$0.00	$6,850.00	$20.00 Copay	$500.00 Copay
HealthyBlueHMO Gold $1,750	$113.76	$1,750.00	$6,650.00	No Charge	$300.00 Copay after deductible
KP MD Silver 2500/30/Dental	$115.51	$0.00	$2,600.00	$10.00 Copay	30.00% Coinsurance
KP MD Platinum 0/5 Dental	$152.42	$0.00	$4,000.00	$5.00 Copay	$250.00 Copay
BlueChoice HMO HSA Silver $3,000 VisionPlus	$163.76	$0.00	$2,250.00	$10.00 Copay after deductible	$200.00 Copay after deductible
BluePreferred PPO Bronze $7,900	$225.08	$7,900.00	$7,900.00	No Charge after deductible	No Charge after deductible
HealthyBluePPO Gold $1,750	$332.32	$1,750.00	$6,650.00	No Charge	$300.00 Copay after deductible
BluePreferred PPO HSA Silver $3,000 VisionPlus	$361.71	$0.00	$2,250.00	$10.00 Copay after deductible	$200.00 Copay after deductible

APPENDIX E: DETAILED ANALYSIS OF FOCUS GROUPS

This appendix presents the summary of the reasons why people do not purchase health insurance, why insured people do not use their health, barriers to getting health insurance, and participants' understanding of common health insurance terms. Nineteen focus groups were scheduled between November 5, 2019 and January 31, 2020. Eleven groups were cancelled and/or rescheduled due to few or no registrations. One Baltimore group was unusually large and it was split into two groups (uninsured; under-utilizers) for increased depth and dialogue.

REASONS FOR NOT PURCHASING HEALTH INSURANCE

Focus group participants were asked to identify reasons for not purchasing health insurance. The following reasons were identified at each focus group.

NOVEMBER 5, 2019 – BALTIMORE CITY

Baltimore City participants identified the following reasons for not purchasing health insurance:

- Medicaid patients wait longer, receive service over several visits (instead of addressing all issues in one visit), and are generally treated differently compared to other patients;
- Lack of information about insurance options;
- Different coverage with each plan makes it difficult to decide what to purchase;
- Insurance is too expensive;
- Dislike doctors or staff at locations which accept insurance;
- Laziness toward putting in the time and effort to select an insurance plan;
- Too time-consuming to research and select an insurance plan
- Fearing a bill because insurance might not cover everything; and
- Doctor they like or select does not accept all insurance plans.

NOVEMBER 7, 2019 – BALTIMORE CITY

Baltimore City participants identified the following reasons for not purchasing health insurance:

- Insurance is too expensive;
- Low income makes it difficult to afford additional expenses associated with health insurance;
- Services available with insurance they can afford do not meet needs;
- Individuals who are rarely sick or generally healthy do not feel they need insurance;
- Prefer out-of-pocket expenses to insurance because they may not use insurance even though they pay for it;
- Insurance plans with doctor networks do not allow individuals to pick doctors;
- Some individuals rely exclusively on home remedies; and

- Some individuals distrust doctors.

DECEMBER 19, 2019 – HAVRE DE GRACE

The Havre de Grace participant identified the following reasons for not purchasing health insurance:

- Being covered by parents' insurance plan until turning 26;
- Rarely needing health care or being healthy overall; and
- Fear of doctors.

DECEMBER 19, 2019 – SALISBURY

Salisbury participants identified the following reasons for not purchasing health insurance:

- Insurance is too expensive;
- Insurance is not a high priority;
- Other needs take precedent with limited income;
- Some individuals prefer the hospital or emergency room if they need immediate care;
- Insurance plans are confusing;
- Starting applications can lead to an onslaught of calls from insurance agents;
- Different coverage with each plan makes it difficult to decide what to purchase;
- Lack of knowledge about insurance plans and coverage; and
- Individuals who are rarely sick or generally healthy do not feel they need insurance.

JANUARY 23, 2020 – BALTIMORE CITY (UNINSURED)

Baltimore City participants identified the following reasons not to purchase health insurance:

- Insurance is too expensive;
- Being homeless and having no address for paperwork makes it difficult to apply;
- Confusing to apply with no one to ask questions;
- Being unemployed or recently losing a job means loss of insurance but other priorities take precedence;
- Previous income affecting eligibility by being too high, despite no longer receiving that income; and
- Cheaper to pay for occasional health care because of overall good health.

JANUARY 23, 2020 – BALTIMORE CITY (UNDER-UTILIZERS)

Baltimore City participants identified the following reasons not to purchase health insurance:

- Insurance is too expensive (high deductibles);
- Not all doctors or clinics accept all types of insurance;
- Some individuals do not feel like they need health insurance;

- Some individuals prefer to go to a local health department for free or reduced cost services;
- Some individuals suggested that men do not go to the doctor;
- Doctors bill insurance patients more (especially with Medicare/Medicaid);
- Specialists expect patients to pay before receiving care, and individuals fear a "superbill" from the doctor charging a high price but insurance only reimburses a portion;
- Billing is too confusing, and patients are unsure how procedures will be billed;
- Insurance can determine care received because of billing and coding processes (e.g. making a patient come to multiple appointments to maximize insurance payments rather than addressing all issues in one appointment; and
- Patients can get over-treated with insurance (e.g. go for excessive testing and appointments) for doctors to collect additional payments.

Reasons for Not Using Health Insurance

Baltimore City participants in this group were asked about reasons for not using health insurance once they had purchased it. They identified the following reasons:

- Cheaper to pay for occasional health care needs than pay for insurance;
- Insurance is too expensive because individuals do not always meet deductibles;
- Billing is too confusing, and patients are unsure how procedures will be billed;
- Patients worry about high bills after receiving treatment;
- Insurance is confusing and individuals often do not understand what will be covered; and
- Some individuals do not trust doctors because they seem to care more about billing than patient care.

JANUARY 24, 2020 – HAGERSTOWN

Hagerstown participants identified the following reasons not to purchase health insurance:

- Insurance is too expensive (high copays, high deductibles, cheaper to self-pay if healthy);
- Many insurance plans and providers rely heavily on online portals, but individuals lack technology, technological abilities, and/or internet access;
- Enrollment periods are difficult for people to work with and should be extended;
- The documentation required to apply for insurance is prohibitive (including waiting periods and having an address);
- Transportation makes it difficult to get insurance, particularly if not all practices accept it;

- The time it takes to apply for insurance is prohibitive;
- Insurance plans are confusing and there is little or no communication to help understand them; and
- Individuals are unclear on what will be covered by insurance plans.

BARRIERS TO PURCHASING HEALTH INSURANCE

Focus group participants were asked to identify barriers to purchasing health insurance. The following barriers were identified at each focus group.

NOVEMBER 5, 2019 – BALTIMORE CITY

Baltimore City participants identified the following barriers to purchasing health insurance:

- Individuals felt there are a lack of advocates for their best interests;
- Individuals' race makes it difficult to purchase health insurance;
- Insurance plans that individuals can afford do not cover everything individuals needed;
- Politics surrounding health insurance, particularly at the national level (i.e. Patient Protection and Affordable Care Act), make it difficult to find affordable health insurance;
- Religious factors play a role in insurance not covering everything (e.g. birth control);
- Transportation makes it difficult to get insurance, especially given the limited number of facilities;
- Many insurance plans and providers rely heavily on online portals, but individuals lack technology, technological abilities, and/or internet access;
- There is a significant stigma related to transsexual health;
- Language barriers (e.g. Spanish-speaking populations); and
- Varying levels of education and familiarity.

NOVEMBER 7, 2019 – BALTIMORE CITY

Baltimore City participants identified the following barriers to purchasing health insurance:

- No physical locations to access health insurance providers;
- Tedious process requiring research to identify and understand plans;
- Not being able to use health insurance due to work schedule;
- Documentation burden; and
- Employment status.

DECEMBER 19, 2019 – HAVRE DE GRACE

The Havre de Grace participant identified the following barriers to purchasing health insurance:

- Politics surrounding health insurance, particularly at the national level (i.e. Patient Protection and Affordable Care Act), make it difficult to find affordable health insurance;

- High cost of prescriptions; and
- Many insurance plans and providers rely heavily on online portals, but individuals lack technology, technological abilities, and/or internet access.

DECEMBER 19, 2019 – SALISBURY

Salisbury participants identified the following barriers to purchasing health insurance:

- Insurance is too expensive, and individuals who are healthy feel it is cheaper to self-pay than buy insurance;
- Employers may opt to limit employee work hours to avoid providing benefits;
- Health insurance costs are too high for jobs which pay lower wages;
- Being an immigrant;
- Marital status affects eligibility and may discourage getting insurance; and
- Balancing multiple priorities (e.g. paying rent, eating).

JANUARY 23, 2020 – BALTIMORE CITY (UNINSURED)

Baltimore City participants identified the following barriers to purchasing health insurance:

- Insurance is too expensive;
- Insurance plans are confusing;
- Eligibility for plans can be confusing or prohibitive;
- Insurance plans that individuals can afford do not cover everything individuals need;
- Individuals need affordable gap coverage for in between policies;
- Individuals pay fines for not having coverage, but cannot afford an insurance policy; and
- Not all doctors or clinics accept the all types of insurance.

JANUARY 23, 2020 – BALTIMORE CITY (UNDER-UTILIZERS)

Baltimore City participants in this group were asked what reasons they had for not using insurance once purchased. Identified reasons were explained in the previous section (see *Reasons for Not Using Health* Insurance).

JANUARY 24, 2020 – HAGERSTOWN

Hagerstown participants identified the following barriers to purchasing health insurance:

- Many insurance plans and providers rely heavily on online portals, but individuals lack technology, technological abilities, and/or internet access;
- Transportation makes it difficult to get insurance, especially given the limited number of physical facilities;
- It can be difficult to 1) get into a government health insurance program and 2) stay on the program. Eligibility requirements are unclear, and benefits change depending on politics;

- Confusing to apply for health insurance with no one to ask questions, particularly about what terms mean and what is covered; and
- The time required to complete the complex health insurance application process is prohibitive.

UNDERSTANDING INSURANCE TERMINOLOGY

Focus group participants were asked to define three terms: 1) copay, 2) deductible, and 3) premium. Table 27 shows the exact definitions provided by participants. Please note that any spelling or grammatical errors are a deliberate, accurate representation of answers provided.

Table 27: Focus Group Participants' Definitions of Insurance Terms[11]

Copay	Deductible	Premium
The amount of money/payment one shares with the insurance	Amount of money one has to pay out-of-pocket before the insurance kicks in to cover the expenses of the health care they received	Premium would be the monthly payment you make for coverage
What the patient pays when provided services at the doctor or hospital	How much the patient must pay out-of-pocket before insurance will pay for their part	I forgot
Small amount paid for services	Fee that's left or which is not covered	The cost of the best insurance
Your share of the bill from what the insurance does not pay	Amount you have to meet for the insurance to kick in	Your insurance premium is the max dollar amount allotted for a given medical procedure by your provider
A down payment to begin services	It's a fee they immediately apply to the cost of the services provided	The amount of monthly insurance cost
Payment that is required at the time of visit	The amount of money you pay that is covered by your provider	The total amount of coverage available
Copay is the payment you make for services on each visit	A deposit/ more money	Probably the highest payment of all three. Or over all amount.
A "co-pay" is the payment you pay out-of-pocket for med care; it's not covered by your provider	Deductible is a payment you make as a patient for visits to hospital	Cost of insurance payment
Copay is a price you pay in order to get a service done along with potential bill.	When they take money from u	Yearly cost ins.
Is when u aint got to pay full price for health insurance	The price paid as a minimum in order to get service. The rest is covered up to a certain maximum	I don't know
Payment out-of-pocket , included with your insurance	Out-of-pocket expenses, that your insurance doesn't cover	A premium is the overall cost for a particular health care provider
A copay is your out-of-pocket per visit	A deductible is the debt you have to go in before your covered	Top of the line coverage and options
Percentage you pay for the medication	Money taken out of your monthly income	A premium is your monthly cost
What you pay out-of-pocket at the time of visit	The minimum you pay to use your insurance even tho your already paying per month	The total amount of money you will for the insurance
What you pay	What you pay at the end	Not sure
What you pay out-of-pocket after insurance	No clue	What they pay
The amount you pay each time you go to doctor based on your insurance plan	The minimum amount before that has to be met before your insurance picks up any amount of your treatment.	Still not sure - maybe what you pay each month?
The amount I pay the day I am seen at a dr office	The amount I have to spend before my ins. kicks in	The amount you pay to the insurance company

[11] Comments were transcribed verbatim as written by focus group participants.

Copay	Deductible	Premium
What is left for you to pay after insurance pays	Amount you need to pay before insurance will take over	The total amount
Copay is where you have to pay before you see the doc.	The deductible is what they take off and your left with a lil balance	Monthly amount
Out-of-pocket expense paid by patient to dr. at time of service	Amt patient pays before insurance company starts to pay coverage	Premium is where its all covered
Pay the balance of what your insurance didn't pay	Off of what you pay	Cost of being insured - paid to insurance company
My portion of bill	Amount that has to be paid before insurance kicks in	Pay full price
What you have to pay up front out-of-pocket	What gets cut out of the bill that you don't have to pay	What we pay for insurance
Is what you pay when you go to dr. office	How much you paid in out-of-pocket for the year before insurance picks up	?
This is what the consumer pays after insurance have paid their part	This is what the insurance covers	How much you pay for your insurance
Have to pay each visit at the doctor	What you have to pay til you don't have to make that payment anymore for that year.	This is the part that the insurance doesn't cover
For patient to pay toward his/her doctor maint.	For the doctor to defer his cost	Main cost
Cost to pay for medicines and services	Cost left over that insurance don't cover	Is when insur. co. cover cost
The amount you/person is responsible for pay (what they feel is affordable for you/person)	$ has to be paid before insurance will pay	Life insurance for health care
The amount that you pay added to what the insurance pays to satisfy the bill (80% insurance, 20% co pay)	Amount removed from actual total	The amount with everything included
Fee assessed to the patient for visits to the doctor	The amount you have to pay before the insurance will kick in	The amount you pay monthly
$ per dr visit	Amount to be paid before insurance kicks in	Fee assessed for potential need of services
Amount you pay for visits, procedures	Surcharge assessed against the patient toward services rendered	Your monthly payment for insurance

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