Cite this article as:
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*Health Affairs* 33, no.1 (2014):161-167
doi: 10.1377/hlthaff.2013.0934 originally published online December 18, 2013

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The Health Reform Monitoring Survey: Addressing Data Gaps To Provide Timely Insights Into The Affordable Care Act

ABSTRACT The Health Reform Monitoring Survey (HRMS) was launched in 2013 as a mechanism to obtain timely information on the Affordable Care Act (ACA) during the period before federal government survey data for 2013 and 2014 will be available. Based on a nationally representative, probability-based Internet panel, the HRMS provides quarterly data for approximately 7,400 nonelderly adults and 2,400 children on insurance coverage, access to health care, and health care affordability, along with special topics of relevance to current policy and program issues in each quarter. For example, HRMS data from summer 2013 show that more than 60 percent of those targeted by the health insurance exchanges struggle with understanding key health insurance concepts. This raises concerns about some people’s ability to evaluate trade-offs when choosing health insurance plans. Assisting people as they attempt to enroll in health coverage will require targeted education efforts and staff to support those with low health insurance literacy.

The Affordable Care Act (ACA) is projected to greatly reduce the number of uninsured Americans over the next several years by employing a combination of strategies. These strategies include broader Medicaid eligibility, an individual mandate to purchase health insurance, the development of health insurance Marketplaces (exchanges), and the provision of subsidies to help low- and moderate-income people afford Marketplace coverage. Although policy makers, stakeholders, researchers, and the media will be demanding information on the ACA’s effects based on these sources in 2014.

The Health Reform Monitoring Survey (HRMS), a quarterly survey of the nonelderly population, was initiated in 2013 as a way to bridge that information gap by providing timely estimates as ACA implementation moves forward in 2013 and 2014.1 The survey’s findings will not be a substitute for those of the federal surveys. However, information from the HRMS will be available well before preliminary estimates of the early impacts of the ACA are obtained from the NHIS in late 2014 and long before estimates are obtained for the whole of 2014 from the ACS, CPS, and NHIS in mid-to-late 2015.

Based on a nationally representative, probability-based Internet panel, the HRMS collects information on insurance coverage, access feedback given the time lags in the availability of data from those surveys. This means that there will be little information on the ACA’s effects based on these sources in 2014.
Overview Of The HRMS
The HRMS is to be fielded once each quarter in English and Spanish with a sample of nonelderly adults from KnowledgePanel, a probability-based Internet panel maintained by GfK Custom Research. KnowledgePanel is based on a representative sample of US households, with laptop computers and Internet access provided for free to households without Internet access to ensure that those households are included in the panel. Recruitment into the panel is based on address-based sampling, which covers nearly all residential addresses in the United States. Each quarter a new stratified random sample of KnowledgePanel members is invited to participate in the HRMS, with oversamples for low-income adults (those with household incomes at or below 138 percent of the federal poverty level) and adults in selected states and state groups beginning in quarter 2 of 2013. The survey completion rate for the HRMS sample in each quarter is about 61.8 percent, which is similar to that of other health studies that have relied on KnowledgePanel. Poststratification weights, based on benchmarks from the CPS and the Pew Hispanic Center Survey, are used to adjust the HRMS sample to be representative of the US population. Because KnowledgePanel collects in-depth information on panel members as part of the panel recruitment process, the poststratification weights can be based on a rich set of measures, including age, sex, race and ethnicity, education, household income, homeownership, Internet access, primary language (English or Spanish), residence in a metropolitan area, and region.

Response rates for Internet panels are not comparable to those from one-time surveys, given the focus on creating a longitudinal sample to support the rapid fielding of surveys. The overall response rate for surveys based on Internet panels incorporates the survey completion rate as well as rates of panel recruitment and participation over time. The American Association for Public Opinion Research (AAPOR) cumulative response rate for the HRMS is the product of the panel household recruitment rate, the panel household profile rate, and the HRMS completion rate, or roughly 5.9 percent each quarter.

Although low, this response rate does not necessarily imply inaccurate estimates, because a survey with a low response rate can still be representative of the sample population, although the risk of response bias is, of course, higher. Other factors are also important to consider, such as levels of bias, levels of missing data, and conformity with other research findings. Studies assessing nonresponse to panel recruitment in KnowledgePanel have found little evidence of nonresponse bias in the panel on core demographic and socioeconomic variables. Similarly, studies comparing KnowledgePanel and traditional random-digit-dial telephone surveys have yielded comparable estimates for a range of measures related to demographic and socioeconomic characteristics, health status and behaviors, and other characteristics. Reflecting the assessed strength of the panel, KnowledgePanel has a track record of supporting timely policy research across academia, research organizations, and government agencies.

Assessment Of The HRMS Estimates
The overall assessment of KnowledgePanel provides support for the reliability of the HRMS as a data source for early monitoring of the ACA. However, it is also important to examine the credibility of the data collected in the HRMS itself by benchmarking estimates from the HRMS against federal survey data. Differences in estimates across surveys may reflect many factors, including differences in the wording of the questions and question placement and context within the particular survey; differences in survey design and fielding strategies; differences in data preparation and weighting; and differences in survey fielding time frames. The consistency of the HRMS estimates with estimates from federal survey data increases confidence in the HRMS as an early indicator of changes under the ACA.

The comparison of demographic and socioeconomic characteristics of the adults in the HRMS sample collected during quarter 2 2013 to adults who responded to the 2011 ACS, which provides the best national estimates for these measures, shows similar population characteristics (age, race and ethnicity, sex, education, employment status, and income; Appendix Exhibit 1). Along several of the characteristics, we detected statistically significant differences (such as in the age distribution). None of these differences are dramatic, although this is due in part to poststratification procedures used in the weighting of each survey.

Perhaps the most critical indicator of the initial impacts of the ACA is how the insurance
rate is changing for nonelderly adults. To examine this indicator, Exhibit 1 compares the HRMS estimate of the uninsurance rate for nonelderly adults to the estimate based on the ACS. Both surveys report 21.0 percent uninsured. The HRMS adult uninsurance rates across age, race and ethnicity, and income categories are also consistent with those observed in the ACS. In addition, the rates of employer-sponsored coverage among adults in the HRMS and the ACS are quite similar overall (58.5 percent and 62.0 percent, respectively) and by age, race and ethnicity, and income categories (data not shown).

Comparisons of the HRMS measures of health care access and affordability that overlap with the NHIS (Appendix Exhibit 2) suggest the existence of greater access and affordability problems among adults in the HRMS than in the NHIS across most of the measures, including lacking a usual source of care, problems finding a doctor, and unmet need for care because the care was not affordable. This is consistent with other comparisons of subjective measures in surveys that rely on different modes of administration (online, mail, telephone, face-to-face), which have found respondents more likely to report problems in self-administered surveys, like the HRMS, than in interviewer-administered surveys conducted by telephone or face-to-face, although the differences may also reflect other survey design issues. Even though the reported access and affordability levels may differ when we compare the HRMS and NHIS, we found, as in the NHIS, that uninsured adults in the HRMS faced greater barriers to care, on average, than adults with coverage.

In summary, the HRMS estimates track well with those of the ACS, including insurance coverage, both overall and with respect to important factors such as age, income, and race and ethnicity. Consistent with the patterns found in the NHIS, the HRMS access and affordability measures suggest much greater problems for the uninsured compared to the insured. These findings suggest that the HRMS will be a credible source for early monitoring of the effects of the ACA while awaiting the availability of federal survey data. However, as more rounds of the HRMS become available, it will be important to continue assessments of the reliability of the estimates, particularly for supporting estimates of change over time based on the quarterly data.

Timely Information From The HRMS
The ability to add supplemental questions to the HRMS each quarter means that it can be used to provide timely information to support implementation of the ACA. This section provides new findings from the HRMS based on information collected in June and July 2013 that explore health insurance literacy issues.

The new Marketplaces created under the ACA offer multiple insurance plans from which consumers can choose. Given the complexity of insurance coverage and the trade-offs that consumers may be facing, becoming an educated and effective consumer poses significant challenges, particularly for those without prior experience with health insurance. To explore consumers’ current readiness to make informed choices about their health insurance, HRMS respondents were asked to assess their level of confidence (very, somewhat, not too, or not at all confident) in their understanding of nine different insurance concepts (a measure of health insurance literacy). The specific health insurance concepts were premiums, deductibles, copayments, coinsurance, maximum annual out-of-pocket spending limits, provider networks, covered services, annual limits on services, and noncovered or excluded services.

To gain information about where people look for help when choosing a health insurance plan, respondents were asked which of twelve different sources of information they would be likely to use if they were choosing a new health insurance plan today. Possible sources included family members; health care providers; employers; insurance brokers; materials from consumer groups; materials from state and federal governments, including websites and social media;
nongovernment websites; telephone hotlines; and advertisements. Respondents could indicate that they were likely to use as many different sources as they wanted and were given the option of specifying another source as well.

**Findings on Health Insurance Literacy**

Overall, 43.9 percent of nonelderly adult respondents expressed confidence that they understood all nine health insurance terms (Exhibit 2). Uninsured adults had much less confidence in their understanding: Just 23.6 percent of uninsured adults were somewhat or very confident that they understood all nine of the concepts the survey asked about. When each concept or term, such as *premium* or *deductible*, was considered individually, 32.1–51.8 percent of the uninsured adults in the sample reported being confident that they understood it. Fewer uninsured adults were confident of their understanding of concepts related to coinsurance; more were confident of their understanding of copayments. Even for the insured, health insurance concepts are often confusing. The share of insured adults who were very or somewhat confident that they understood all nine terms was 49.3 percent.

Among the population targeted by the health insurance Marketplaces (defined as adults with family incomes above 138 percent of the federal poverty level either with nongroup coverage or uninsured), 39.9 percent were confident of their understanding of all nine terms (Appendix Exhibit 3). Notable differentials in health insurance literacy were found among the Marketplace target population by age, which likely reflects younger adults’ lack of experience with insurance. Fewer than a third (29.0 percent) of those ages 18–30 in the Marketplace target population were very or somewhat confident in their understanding of all of the listed insurance concepts. This rate was about 20 percentage points lower than the rate found among people ages 50–64 (50.1 percent). Furthermore, roughly 27.2 percent of the Marketplace target population ages 18–30 reported being not at all confident with their understanding of *premiums*, compared to only 4.9 percent of those in the 50–64 age group (data not shown). For every concept about which they were asked, more than a third of young adults reported that they were either not too confident or not at all confident in their understanding of it. For some terms such as *coinsurance* and *maximum out-of-pocket spending limits*, 50–60 percent said that they were not confident that they understood the term.

In addition to young adults, we found lower levels of confidence in understanding basic health insurance concepts among those in the Marketplace target population who were Spanish speakers and among those who had lower levels of educational attainment (Exhibit 3). In particular, among the Marketplace target population, just 16.0 percent of those who had not completed high school and 17.9 percent of those who were Spanish speakers were confident that they understand all nine insurance terms.

While gaps appear across many different types of individuals who may be seeking exchange enrollment, confidence in understanding these concepts is lower for young adults, for Spanish speakers, and for those who lack health insurance coverage and have lower levels of education. Many of these individuals may have had very little exposure to private insurance markets and possess only limited awareness of sources of information on health insurance terminology.

Given that a recent study suggests that consumers actually understand less than they think they do when it comes to health insurance concepts and the likelihood that the HRMS underrepresents adults with lower literacy levels, these are troubling findings as outreach efforts for the ACA begin. Websites, navigators, in-personassistants, call center operators, brokers, and agents should therefore not assume high consumer comfort levels with any of these terms.

Confusion around these concepts would make it difficult for consumers to understand trade-offs between different health insurance plans and to choose the insurance plan that best meets their needs. Low health literacy could reduce the gains for consumers, particularly if enrollment in health insurance is reduced because of consumer confusion or frustration or if the consumers who do enroll face unexpected out-of-pocket health expenses and unanticipated limi-
tations on provider networks.

**Sources of Health Insurance Information**

Reaching the Marketplace target population could be challenging, because people in this population rely on a wide variety of sources of information when choosing a health plan (Exhibit 4). The most common source is family members, friends, and coworkers, which may be problematic since they are likely to share the target population’s levels of confusion about health insurance concepts. More promising for education efforts are employers; doctors and other health care providers; and health plans, insurance agents, and insurance brokers, because about half of the exchange target population relies on each of those sources. Materials from consumer groups and from government and non-government websites are less commonly used sources of information: Fewer than a third of the members of the target population reported relying on those resources. However, most adults are relying on multiple sources of information, which suggests that multiple opportunities exist to reach them through broad education and outreach efforts. Further, these patterns may change over time as new sources of information become available.

**Looking Ahead**

Although the HRMS cannot replace the ongoing federal government surveys, the findings presented in this article suggest that evidence from the HRMS will be a valuable early source of feedback on the ACA in 2014, well before federal data are available. Although the HRMS carries with it more risks and potential errors than the ongoing federal surveys, the hope is that timely findings from this new survey will give federal and state policy makers early insights into ACA implementation that will allow them to fine-tune their policy choices in “real time” so as to maximize the benefits of the ACA. For example, the findings presented here indicate the need for targeted education efforts and additional support staff to assist those with low health insurance literacy in selecting coverage through the Marketplaces.

Forthcoming analyses of data from the HRMS will facilitate understanding of the public’s changing knowledge of and experiences with the ACA that can inform future outreach and enrollment efforts. Such information is especially important given the rocky rollout of the federal and some of the state-based Marketplace websites.
**EXHIBIT 4**

Sources Of Information That Consumers Say They Are Likely To Use When Choosing A Health Insurance Plan, Among The Marketplace Target Population And The Rest Of The Population, 2013

<table>
<thead>
<tr>
<th>Information source</th>
<th>Rest of population</th>
<th>Total</th>
<th>18-30</th>
<th>31-49</th>
<th>50-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family members, friends, or coworkers</td>
<td>73.0%</td>
<td>66.8%</td>
<td>71.4%</td>
<td>66.2%</td>
<td>62.0%</td>
</tr>
<tr>
<td>A person from a community group or religious organization</td>
<td>23.4</td>
<td>22.8</td>
<td>21.6</td>
<td>25.4</td>
<td>21.1</td>
</tr>
<tr>
<td>Your employer or a family member’s employer</td>
<td>62.3</td>
<td>48.2%</td>
<td>53.5%</td>
<td>53.9%</td>
<td>35.1%</td>
</tr>
<tr>
<td>Your doctor or other health care provider</td>
<td>62.5</td>
<td>54.1%</td>
<td>50.5%</td>
<td>57.0%</td>
<td>54.9%</td>
</tr>
<tr>
<td>A health plan, insurance agent, or insurance broker</td>
<td>47.2</td>
<td>48.2%</td>
<td>39.4%</td>
<td>48.7%</td>
<td>58.1%</td>
</tr>
<tr>
<td>Consumer Reports or materials from other consumer groups</td>
<td>44.2</td>
<td>37.6%</td>
<td>31.6%</td>
<td>37.5%</td>
<td>44.8%</td>
</tr>
<tr>
<td>Materials from state or federal government (including Internet websites and social media, such as Facebook, Twitter, and YouTube)</td>
<td>35.1</td>
<td>30.4%</td>
<td>30.2%</td>
<td>29.7%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Other nongovernment Internet websites</td>
<td>33.2</td>
<td>30.8%</td>
<td>28.7%</td>
<td>31.3%</td>
<td>32.8%</td>
</tr>
<tr>
<td>A telephone hotline, help line, or referral service</td>
<td>19.9</td>
<td>18.3%</td>
<td>16.3%</td>
<td>18.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Advertisements (TV, radio, print)</td>
<td>20.6</td>
<td>20.4%</td>
<td>20.2%</td>
<td>17.6%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Other sources</td>
<td>4.3</td>
<td>4.6%</td>
<td>4.5%</td>
<td>4.5%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Sample size</td>
<td>6,381</td>
<td>1,069</td>
<td>275</td>
<td>337</td>
<td>457</td>
</tr>
</tbody>
</table>

**Marketplace target population**

<table>
<thead>
<tr>
<th>Age (years)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
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<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**NOTES**

2. The quarter 2 2013 HRMS included questions on understanding of health insurance concepts, important factors in choosing a health plan, and willingness to trade benefits for lower premium payments. The quarter 3 2013 HRMS included questions on awareness of major ACA provisions and experiences with early ACA changes, expected changes in coverage and care in 2014, and the sources of information on the ACA. Future special-topic questions are likely to focus on experiences with health insurance Marketplaces and health plan choice, the Medicaid expansion, provider availability and access, and health care delivery issues and care management, among others.
3. The design of the HRMS has evolved from an initial plan for a monthly national survey in January 2013 to a quarterly survey with oversamples by income and state groups by the second quarter of 2013. Data for quarter 1 2013 data were collected in two waves: January/February 2013 and February/March 2013. Data for quarter 2 2013 were collected in June/July 2013. In the future, data are to be collected in the last month of each quarter (for example, September 2013 for quarter 3).
4. There are two types of Internet-based surveys: surveys based on probability samples, and opt-in surveys based on convenience samples. Those based on a probability samples provide the stronger design.
6. The household recruitment rate in KnowledgePanel (whereby someone in a sampled household expresses a willingness to participate in the panel) is currently about 15.0 percent. Those individuals are asked to complete an initial survey to provide background information. The completion rate for that background survey is about 63.9 percent. The samples for surveys based on KnowledgePanel are drawn from people who have completed the background survey.
7. Gollust SE, Dempsey AF, Lantz PM, Ubel PA, Fowler EF. Controversy undermines support for state man-
9 The quarter 2 2013 HRMS has a national design effect of 2.11, with a sampling margin of error for a 50 percent statistic with 95 percent confidence of plus or minus 1.6 percentage points for the full sample of nonelderly adults (weighted). We report on quarter 2 because it reflects the current design of the survey.
10 Groves M. Nonresponse rates and nonresponse bias in household surveys. Public Opin Quart. 2006;70(5):646–75.
15 Garret J, Dennis JM, DiSogra CA. Non-response bias: recent findings from address-based panel recruitment. Presented at: American Association for Public Opinion Research 2010 Annual Conference; 2010 May; Chicago, IL.
18 The Time Sharing Experiments for Social Sciences (TESS), which is supported by nine different divisions of the National Science Foundation and housed at Northwestern University’s Institute for Policy Research, has provided more than 400 researchers with access to the KnowledgePanel to support innovative research studies. TESS was awarded the 2007 Warren J. Mitofsky Innovators Award by the American Association for Public Opinion Research.
20 We benchmarked to the ACS on health insurance coverage because the structure of the health insurance question in the HRMS is much closer to that of the ACS than the CPS.
21 To access the Appendix, click on the Appendix link in the box to the right of the article online.