Reports and Research

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UPDATED

ITUP Insure the Uninsured Project

CALIFORNIA STRATEGIES
Covering California's Remaining Uninsured and Improving Affordability

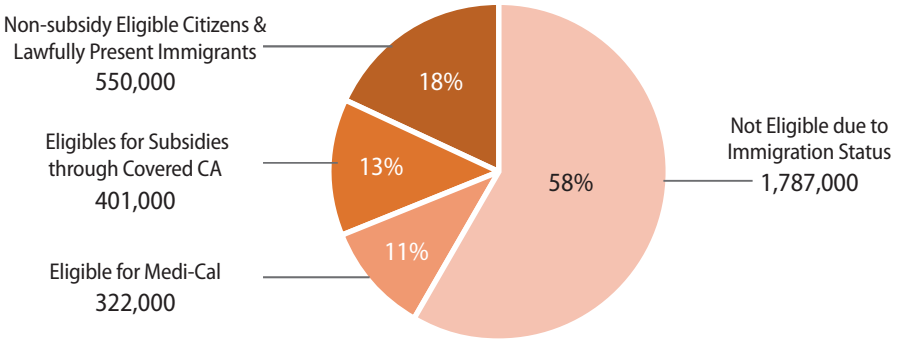
Revised OCTOBER 2018 • ISSUE BRIEF

REVIEW OF 2018 POLICY PROPOSALS

California's successful implementation of the Affordable Care Act (ACA) dramatically reduced the number of uninsured to an historic low of 7 percent, approximately three million uninsured Californians. As outlined in this ITUP issue brief and the charts below, Californians have different reasons for being uninsured, including individuals who cannot access existing coverage programs because of immigration status and low- and moderate-income individuals who cannot afford the cost of premiums or cost sharing at the point of care. Each of the subgroups of the remaining uninsured, and the coverage and affordability challenges they face, can be addressed by targeted policy changes. This issue brief analyzes policy proposals advanced in 2018 to move the state closer to universal coverage by focusing on the challenges many Californians face. Although the 2018 proposals failed passage, they are likely to return in some form in future legislative efforts.

Profile of Uninsured Californians

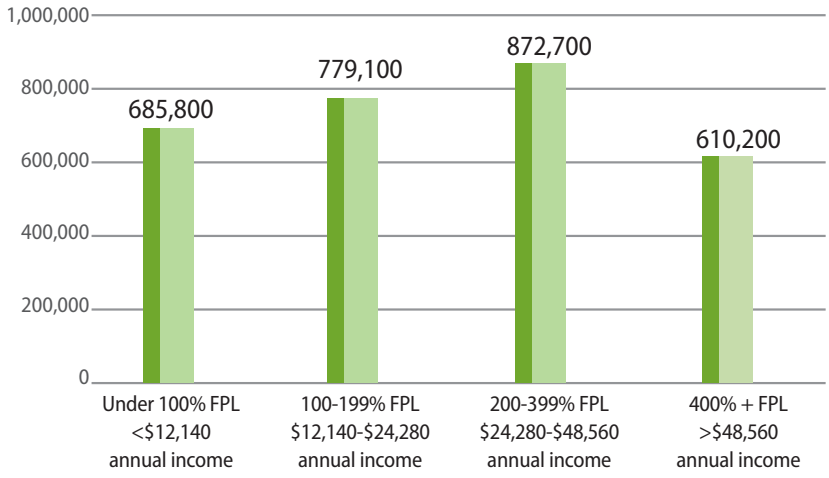
Nonelderly, 2017 Projections



Source: Miranda Dietz, Dave Graham-Squire, Tara Becker, Xiao Chen, Laurel Lucia, and Ken Jacobs, "Preliminary CalSIM v 2.0 Regional Remaining Uninsured Projections," August 2016; Chart prepared by Insure the Uninsured Project.

Uninsured Californians by Poverty Level

Nonelderly, 2016



Source: Kaiser Family Foundation estimates based on the Census Bureau's March Current Population Survey (CPS: Annual Social and Economic Supplements), 2014-2017; Chart prepared by Insure the Uninsured Project.

1 MEDI-CAL EXPANSION #1: Cover low-income undocumented adults in Medi-Cal

Problem Statement

The majority of the remaining three million uninsured Californians are undocumented adults, approximately 1.8 million, or 58 percent of the remaining uninsured. According to a recent report by the Legislative Analyst's Office (LAO), a Medi-Cal expansion for this population could cover up to 1.2 million low-income undocumented adults.

Coverage Challenges

Undocumented adults face significant barriers to coverage including:

- Undocumented adults have limited resources to pay for health coverage. An estimated 1.2 million are eligible under existing Medi-Cal rules, with incomes at or below 138 percent of the federal poverty level (FPL), representing approximately 40 percent of the remaining uninsured.[1]
- Although in California undocumented immigrant men age 18 to 64 have the highest labor market participation of any population, at 75 percent undocumented working age men also have the highest uninsured rate in the state.[2]
- Undocumented adults are primarily eligible for Medi-Cal coverage of emergency and pregnancy-related services, and long-term care services when needed. However, emergency care is limited to the services necessary for the treatment of an emergency medical condition.[3] Emergency care is episodic and does not promote prevention and timely treatment of chronic and emerging health conditions.
- Because of immigration status, federal rules prohibit undocumented adults from buying individual coverage in the state ACA marketplace, Covered California, even if they pay the full premium, and they are unable to receive federal subsidies for coverage.

Policy Goal

Provide comprehensive coverage for the largest group of remaining uninsured Californians – undocumented, low-income adults – and promote regular access to health care services that prevent and address ongoing health care needs.

Policy Approaches

Expand eligibility for comprehensive Medi-Cal benefits (full-scope) to adults age 19 and over with incomes at or below 138 percent of the FPL ($16,754 per year), regardless of immigration status.

Alternative 1: Extend Medi-Cal coverage to income-eligible undocumented adults 19-25 years of age.

Alternative 2: Extend Medi-Cal coverage to income-eligible undocumented adults 65 and over.

Federal and State Context

Federal. Under federal rules, states choosing to provide comprehensive (full-scope) Medicaid coverage for undocumented adults must generally do so with state or local funds, except as described below.

Federal Medicaid funding is available for states to cover some undocumented immigrants for some services, primarily pregnancy-related and emergency services (restricted scope).

In addition, federal law also requires certain lawfully present immigrants to wait five years after achieving legal immigration status to be eligible for Medicaid, a requirement often referred to as the "five-year bar."[4]

State. California currently includes the following low-income immigrants in comprehensive (full-scope) Medi-Cal:

- Children under age 19 who meet specified income standards, regardless of immigration status.
- Lawfully present immigrants during the five-year waiting period for federal Medicaid.[5]
- Certain immigrant groups that are known to federal immigration authorities, including young adults with Deferred Action for Childhood Arrivals status.[6]

Undocumented adults are eligible for restricted-scope Medi-Cal. Restricted-scope Medi-Cal covers limited benefits including emergency and pregnancy-related services, breast and cervical cancer-related treatment services, family planning services, and long-term care services.[7] According to data from the California Department of Health Care Services, more than 80 percent of income-eligible undocumented adults, approximately one million, are enrolled in restricted-scope Medi-Cal coverage.[8]

Some California counties provide limited health care services to undocumented individuals through their medically indigent adult programs. (See the ITUP publication, "County Medically Indigent Care Programs, Key Characteristics.")

For additional detail on federal rules and programs regarding coverage for immigrants see National Immigration Law Center, "Overview of Immigrant Eligibility for Federal Programs," December 2015.

Prior Proposals

As part of the 2015-16 state budget, California extended comprehensive Medi-Cal coverage using primarily state funds to all low-income children under age 19, regardless of immigration status.[9]

Senate Bill (SB) 10 (Lara), Chapter 18, Statutes of 2016, directed Covered California to seek a federal waiver allowing undocumented individuals to purchase coverage on the state exchange. California withdrew its federal waiver application on January 18, 2017.

SB 1005 (Lara) of 2014 would have extended full-scope Medi-Cal eligibility coverage to low-income, undocumented adults but failed passage.

The 2017-18 State Budget Conference Committee considered extending Medi-Cal coverage to undocumented adults up to age 26 but did not include the expansion in the final budget.

2018 Proposals

Legislation introduced in early 2018 proposed the expansion of Medi-Cal to all undocumented adults. The bills were ultimately amended as follows:

- SB 974 (Lara) extends eligibility for full-scope Medi-Cal benefits to low-income adults age 65 and over who are otherwise eligible but for their immigration status. SB 974 failed passage on the Assembly Appropriations Suspense file.*
- Assembly Bill (AB) 2965 (Arambula) extends eligibility for full-scope Medi-Cal benefits to individuals ages 19-25 who are otherwise eligible but for their immigration status. AB 2965 failed passage on the Senate Appropriations Suspense file.

In addition, as part of the state budget process for 2018-19, the Legislature considered but did not include a Medi-Cal expansion for undocumented adults as follows:

- The Assembly version of the budget added $125 million for state fiscal year (FY) 2018-19 and $250 million for FY 2019-20 full-year to expand Medi-Cal to income-eligible, undocumented adults 19-25.
- The Senate added $75 million for FY 2018-19 ($150 million full-year costs for FY 2019-20) to cover income-eligible adults age 65 and over, regardless of immigration status.

Potential Costs

This expansion must be financed primarily with state funds, beyond the federal funds the state receives for restricted-scope Medi-Cal for undocumented adults.

According to the LAO, the additional state cost of covering low-income, undocumented adults in full-scope Medi-Cal would be $3 billion ($4.7 billion total funds, including federal Medicaid and existing General Fund spending for restricted-scope Medi-Cal services).[10]

The LAO also estimated the state costs in FY 2018-19 to provide comprehensive Medi-Cal coverage for an estimated 111,000 undocumented adults age 19-25 at $140 million and for an estimated 36,000 undocumented adults age 65 and over at $330 million.[11]

Implementation Issues and Key Questions

As a state-only Medi-Cal expansion, the ongoing costs will be subject to the annual state budget process. Like other Medi-Cal programs that rely on state funds, this expansion could be vulnerable to elimination during future fiscal downturns.

Providing state coverage for undocumented adults could have implications for other state and federal funding that currently supports care for the remaining uninsured at the local level.

For example, the Assembly Appropriations Committee analysis of AB 2965 pointed out that a 2013 budget agreement between the state and counties to realign funding for county indigent health care might need to be reexamined if Medi-Cal is expanded to all undocumented adults. The 2013 agreement reallocated funds from the counties to the state because the ACA Medi-Cal expansion reduced county indigent care costs.[12] Covering undocumented adults in Medi-Cal could also reduce indigent care costs in some counties, depending on the scope of the expansion.

* The Assembly and Senate Appropriations Committees operate under committee-adopted rules that require most bills with a projected annual cost of more than $150,000 to be placed on a "Suspense File" prior to final action. Each Committee then considers and votes on Suspense File bills at one hearing after the state budget is enacted.

The shift in the federal immigration climate under the new federal administration appears to be having a chilling effect on immigrant access to health care in many California communities and could also discourage undocumented adults from applying for Medi-Cal if newly eligible. (See the ITUP publication, "Notes from the Field: Immigrant Communities in California Under the Cloud of Immigration Enforcement.")

In September 2018, the U.S. Department of Homeland Security released a proposed rule that, among other things, adds use of non-emergency federal Medicaid, and other specified federally-funded health and social services programs, as a factor in the determination of whether the immigrant can be expected to be a "public charge." However, undocumented individuals generally remain ineligible for non-emergency Medicaid. In addition, the proposed rule does not apply to ***state-only*** Medi-Cal coverage, such as California's coverage of undocumented children in Medi-Cal or a future state Medi-Cal expansion for undocumented adults.[13] Although not a barrier to state coverage expansion, the complexity of the rule may increase confusion and intensify the chilling effect of federal policy on immigrant access to health care. (For more detail on the proposed rule, see the ITUP publication, "Proposed Federal Rule on Immigrants and Public Charge.")

Other States

No state currently provides comprehensive, state-only Medicaid coverage to undocumented adults.

Six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and the District of Columbia use state-only funds to cover undocumented, income-eligible children through the state Medicaid program.[14]

Only California and New York provide state-funded medical assistance to otherwise eligible, lawfully residing immigrants, regardless of date of entry.[15] Thirty-two states, including California and the District of Columbia, administer the federal option to eliminate the five-year bar for lawfully present children. Thirty-four states, including California, use the federal option to provide prenatal care for lawfully present pregnant women.[16]

Hawaii and Massachusetts provide state subsidies for marketplace coverage of newly legalized, low-income, lawfully residing immigrants. Colorado provides medical assistance to lawfully residing immigrants with incomes under 250 percent FPL through the Colorado Indigent Care Program.[17]

Other states, such as Pennsylvania and Minnesota, provide medical assistance to some newly legalized, low-income, lawfully residing immigrants, such as seniors and individuals with specific health conditions.[18]

Fifteen states, including California, administer the federal Children's Health Insurance Program option to provide prenatal-care to income-eligible, undocumented women.[19]

2 MEDI-CAL EXPANSION #2: Eliminate monthly out-of-pocket costs for certain low-income seniors and disabled persons enrolled in Medi-Cal

Problem Statement

Approximately 27,000 seniors and persons with disabilities with incomes between 124 and 138 percent FPL are eligible for Medi-Cal, but for these individuals Medi-Cal coverage begins only after they pay a monthly out-of-pocket amount (share of cost) for medical care, similar to a health insurance deductible.[20]

Coverage Challenges

- Under the ACA, California expanded Medi-Cal to cover adults under 65 with incomes at or below 138 percent FPL using simplified eligibility rules that primarily consider income. However, seniors must still qualify under more complicated eligibility criteria and if their countable income (see below for more detail) is over 123 percent FPL, may have to pay a share of cost.
- Under the Share of Cost Medi-Cal program, individuals over 65 still qualify for full-scope Medi-Cal but must spend as much as $600 each month on medical care before Medi-Cal coverage begins.[21]
- Seniors and persons with disabilities age 65 and older with incomes over 123 percent FPL can purchase coverage through Covered California but are ineligible for ACA premium and cost sharing subsidies.
- Given the likelihood that seniors and persons with disabilities have ongoing health care needs, the monthly share of cost could serve as a significant barrier to care.

Policy Goals

- Apply a uniform income standard (up to 138 percent FPL) in Medi-Cal for eligible low-income adults, regardless of age.
- Replace the complex and dated formula that imposes the Medi-Cal share of cost for this population with simplified eligibility rules based on income.
- Improve access to care for affected seniors and persons with disabilities by eliminating financial barriers to accessing care.

Federal and State Context

Federal. Federal law establishes a Medicaid option for states to cover seniors and persons with disabilities with incomes above the federal Supplemental Security Income (SSI) eligibility level of 75 percent FPL up to a maximum of 100 percent FPL.[22]

Subject to some federal limitations, states have flexibility to establish the process for determining countable income for eligibility purposes, including specific exclusions of income and standard dollar deductions, known as income disregards.[23]

State. In 2000, California elected to implement the federal option and created the Medi-Cal Aged and Disabled Federal Poverty Level (A&D FPL) program.[24] The Medi-Cal A&D FPL program covers seniors and persons with disabilities with incomes up to 100 percent FPL, plus a standard income disregard of $230 for an individual and $310 for a couple. The resulting formula for countable income disregards (deducts) $230 from monthly income, along with any other applicable deductions or exclusions, and individuals are eligible if the remaining monthly income is at or below 100 percent FPL.

The formulas and income exclusions in the Medi-Cal A&D FPL program have not been updated over time and what started out as eligibility at 133 percent FPL is now effectively 123 percent FPL ($14,834 per year for an individual and $19,975 for a couple).

Prior Proposals

California policymakers have considered different strategies to improve affordability of the Medi-Cal program for seniors with incomes above 123 percent FPL including the following unsuccessful legislative efforts:

- AB 763 (Burke) of 2015 and AB 2025 (Dickinson) of 2014 increased the income eligibility for the Medi-Cal A&D FPL program to 138 percent FPL.
- As originally introduced, AB 55 (Dymally) of 2006 increased the Medi-Cal A&D income threshold to 133 percent FPL.
- AB 969 (Chan) of 2001 incorporated annual cost of living adjustments in the Medi-Cal A&D FPL program formula.

As part of the budget process for the last three years, the Legislature considered but did not include changes to the Medi-Cal A&D FPL program eligibility rules.

2018 Proposals

AB 2430 (Arambula) expands Medi-Cal eligibility in the Medi-Cal A&D FPL program by increasing income disregards so that individuals would be eligible up to 138 percent FPL. AB 2430 failed passage on the Senate Appropriations Suspense file.

The Legislature also considered but did not adopt budget proposals that adjust the program eligibility to 138 percent FPL.

Potential Costs

If the state adjusts the income eligibility to cover this group of uninsured, the state will receive 50 percent federal matching funds.

In 2015, AB 763 (Burke) increased the income eligibility to 138 percent FPL. At the time, the Assembly Appropriations Committee estimated the cost at $60 million ($30 million state General Fund) and projected enrollment at approximately 20,000.[25] AB 763 failed passage in the Assembly Appropriations Committee.

The Assembly version of the 2018-19 Budget added $30 million state General Fund to expand eligibility up to 138 percent FPL. The Senate added $15 million in FY 2018-19 to implement the eligibility expansion effective January 1, 2019, and $30 million annually thereafter. Neither proposals were included in the final 2018-19 budget.

Implementation Issues and Key Questions

Since the program exists, changing the formulas to cover all eligible adults up to 138 percent is primarily an issue of policymaker priorities for state funding. Simplifying eligibility based primarily on income would make the program easier for individuals to apply for and understand.

Seniors and people with disabilities are a relatively high-cost population to cover compared to younger, healthier groups.

Other States

By 2015, 21 states implemented the state option to expand Medicaid to low-income seniors and persons with disabilities. Eighteen states, including California, set the income eligibility level at the federal maximum of 100 percent FPL.[26]

Of the 18 states at the federal maximum income eligibility level, California has the highest level of income disregards and is the only state with income disregards over $100. Fifteen of the 18 states have $20 income disregards, one state has a $25 income disregard and another a $75 disregard. In contrast, California's income disregards are $230 for an individual and $310 for a couple.[27]

Because a higher amount of income is disregarded in California, seniors with incomes up to 123 percent, not just those at 100 percent FPL, qualify for the Medi-Cal

A&D Program. Because California has higher disregards, the income eligibility in other state Medicaid A&D Programs is lower than California.

3 INDIVIDUAL MARKET AFFORDABILITY #1: Provide financial assistance in the form of state subsidies to lower premiums for coverage through Covered California

Problem Statement

Of the remaining 3 million uninsured, an estimated 401,000 are currently eligible for subsidized coverage and another 550,000 are eligible to purchase unsubsidized coverage.[28] While federal ACA subsidies lower the cost of obtaining coverage, they may fall short of making coverage affordable for many Californians.

Affordability Challenges

- Cost is the primary reason Californians report for being uninsured. In 2016, among California Health Interview Survey respondents who reported they were uninsured and tried to purchase coverage through Covered California, the majority cited affordability as the main reason they remained uninsured.[29]
- The FPL standard for determining subsidies does not account for the higher cost of living in California and the discrepancy is greater in high-cost regions such as the San Francisco Bay Area.
- Federal ACA subsidies for coverage in Covered California may still leave individuals with significant costs in premiums, deductibles, and copayments.

Policy Goals

- Reduce the financial hardship of obtaining or retaining coverage by further lowering the share of monthly premium for low and moderate-income Californians who buy coverage in Covered California, thereby reducing the rate of uninsured Californians.
- Make premiums more affordable to encourage healthier people to seek and retain coverage.
- Attract younger and healthier individuals to improve the overall health of the risk pool (the group of individuals covered in a policy or market); a more favorable mix of healthy and higher-cost individuals can lower premiums for everyone in the individual market.

Federal and State Context

Federal. Under the ACA, federal tax credits that lower the monthly premium for coverage in Covered California are available to Californians with annual incomes up to 400 percent FPL ($48,420 for an individual, or $98,400 for a family of four) who meet all eligibility requirements and purchase coverage through Covered California. The amount of the tax credit is based on a federal formula using household income and family size; individuals generally pay some monthly premiums based on a sliding income scale.

Those over 400 percent FPL receive no financial assistance for coverage. While premiums vary by age and geographic region, a married couple in their early 60s with incomes above $66,000 face annual premiums of $14,000-$19,000.[30]

As of March 2018, 87 percent of Covered California enrollees qualified for subsidized coverage. In 2017, the federal government contributed $4.6 billion to subsidize premiums for 1 million eligible Covered California enrollees.[31]

Before Congress reduced the federal individual mandate penalty to $0 starting in 2019, taxpayers could avoid the penalty for being uninsured if the only coverage available to them was unaffordable, defined for this purpose as more than 8.16 percent of the taxpayer's income. The UC

Berkeley Labor Center estimates that in 2017 hundreds of thousands of Californians *over* the 400 percent FPL threshold ineligible for federal subsidies spent more than 8.16 percent of their income on premiums for coverage in the individual market.[32]

State. In 2010, California passed state legislation to implement the ACA, including the establishment of the state exchange, Covered California, which administers eligibility for federal subsidies in accordance with federal law.[33] As an active purchaser, Covered California negotiates with health plans to lower premium costs.

A 2015 study conducted for Covered California showed that access to subsidized coverage increases the likelihood that Californians will purchase coverage.[34] Those who receive subsidies through Covered California rated their subsidies as "very or extremely important" in the decision to purchase coverage.

2018 Proposals

AB 2459 (Friedman) establishes a state premium tax credit for individuals with incomes between 400 and 600 percent FPL who purchase coverage through Covered California, contingent on annual appropriations to the state Franchise Tax Board (FTB). This bill sunsets in seven years and requires a report by the LAO after five years. AB 2459 failed passage on the Senate Appropriations Suspense file.

AB 2565 (Chiu) requires Covered California to offer enhanced premium assistance to consumers with incomes between 138 and 400 percent FPL eligible for federal tax credits, ranging from reductions to zero premium at 139 percent FPL up to a maximum premium of 8.16 percent of income for those between 299 and 400 percent FPL. AB 2565 failed passage on the Senate Appropriations Suspense file.

SB 1255 (Hernandez) requires Covered California to administer state financial assistance (defined as premium tax credits or reductions in cost-sharing) with priority for (1) consumers whose share of premium is more than 8 percent of income and (2) those with incomes 200 percent FPL or above who are subject to significant cost-sharing responsibilities. SB 1255 failed passage on the Assembly Appropriations Suspense file.

The Legislature also considered, but did not adopt, a budget augmentation of $150 million General Fund in 2018-19 and $300 million ongoing for state premium assistance in Covered California.

Potential Costs

This policy change will need to be financed using 100 percent state funds.

Based on preliminary estimates from the UC Berkeley Labor Center, the Assembly Appropriations Committee estimates the revenue loss from providing a state tax credit for individuals over 400 percent FPL ($48,240 per year) at approximately $500 million.[35]

In addition, the FTB would incur costs of $2.2 million to administer the new tax credit. Covered California would incur additional undetermined costs to certify and manage the credits, and reprogram the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is the technology platform that supports Covered California eligibility and enrollment and calculates credits for eligible individuals as part of the enrollment process.

Based on preliminary cost estimates from the UC Berkeley Labor Center, the Assembly Appropriations Committee estimates the cost for AB 2565 in the several hundred million up to $500 million. Changes to CalHEERS associated with AB 2565 are estimated to cost in the millions.[36]

The Senate Appropriations Committee estimates indeterminate costs, likely in the low-mid hundreds of millions, for the financial assistance required under SB 1255, and CalHEERS costs in the low-mid tens of millions.[37]

Prior Proposals

While there have been no legislative or budget proposals to offer additional state premium assistance prior to this year, one of the highest cost counties in the state provides additional financial assistance to certain workers. SF Covered Medical Reimbursement Account (SFCovered MRA) offers premium subsidies to certain San Francisco workers with incomes under 500 percent FPL who purchase coverage through Covered California. Enrollees in the program pay 40 percent of the Covered California premiums, with the remainder subsidized by the program.[38]

Implementation Issues and Key Questions

The costs of offering additional financial assistance will be ongoing and subject to the annual state budget process.

As the cost estimates indicate, both Covered California and FTB will incur costs to set up and administer a new state tax credit for the purchase of individual coverage through Covered California.

Covered California will incur costs to develop administrative processes for state-supported subsidies, train staff, and add new functionality to the technology platform in CalHEERS. To date, major changes to CalHEERS have been costly and time consuming, often resulting in implementation delays associated with policy changes and system improvements.

Other States

Massachusetts and Vermont offer state financial assistance in the form of additional exchange subsidies.

In Massachusetts, individuals under 300 percent FPL are eligible for state-funded subsidies, and those under 150 percent FPL receive fully subsidized coverage (no premium cost to the consumer). In Vermont, those under 300 percent FPL are eligible for a state-funded subsidy to lower the maximum percentage of income paid on premiums by an additional 1.5 percent.[39]

In Hawaii, individuals ineligible for Medicaid with incomes under 100 percent FPL receive state premium assistance in addition to federal subsidies.[40]

4 INDIVIDUAL MARKET AFFORDABILITY #2: Provide financial assistance in the form of state subsidies to lower out-of-pocket costs for Covered California enrollees

Problem Statement

High out-of-pocket costs for health care services are a barrier to accessing health care. Even with coverage, Californians may experience hardship accessing care due to cost at the point of service, and as a result, delay or forego necessary health care services. High costs for health care services may discourage individuals from purchasing or retaining coverage.[41]

Affordability Challenges

- A 2014 study of Covered California enrollees found that roughly 4 out of 10 found it difficult to pay for out-of-pocket costs.[42] In 2016, 28 percent of adults in California reported cost problems that inhibited their access to care.[43]
- Low-income enrollees in Covered California are particularly likely to purchase a Bronze plan – one in four individuals with incomes at or below 400 percent FPL, and one in three with incomes between 200 and 400 percent FPL. Bronze plans offer lower premiums than other choices but require enrollees to pay a sizable portion of health care services out-of-pocket, including an annual deductible of $6,300.[44]
- Research by the Kaiser Family Foundation has shown that most U.S. households in the subsidy-eligible income range do not have sufficient savings to cover a $6,300 deductible.[45]
- Federal ACA subsidies for coverage in Covered California may still leave individuals with significant out-of-pocket costs in deductibles and copayments. The federal FPL standard does not account for the higher cost of living in California and the discrepancy is greater in high-cost regions such as the San Francisco Bay Area.[46]

Policy Goals

- Improve affordability of health care by reducing the amount consumers pay for health care in the form of deductibles and copayments at the point of service.
- Ensure that out-of-pocket costs at the point of service do not discourage individuals from seeking necessary care, including preventive services and ongoing treatment of chronic health conditions.
- Incentivize individuals to purchase coverage by increasing the value and impact of having coverage through lower out-of-pocket costs.

State and Federal Context

Federal. The ACA establishes specific levels of coverage aimed at helping consumers more easily compare coverage options. Sometimes referred to as "coverage tiers" or "metal tiers," the ACA levels of coverage reflect a plan's actuarial value – the percent of benefit costs covered by the policy across an average population. For example, a silver level plan covers 70 percent of the cost of benefits, on average, with the consumer paying the remainder through deductibles and copayments, while a bronze level plan covers 60 percent of the benefit costs.[47]

In addition, the ACA establishes cost-sharing reductions (CSRs) – payments to insurers to reduce the out-of-pocket costs for individuals between 138 and 250 percent FPL who purchase a "silver plan" in the exchange. The Trump

Administration discontinued CSR payments to insurers in 2017 and litigation is pending to reinstate the payments. Insurers must, however, provide the cost reductions even if they do not receive the CSR payments.

State. As of March 2018, 68 percent of Covered California enrollees qualified for CSRs based on income, and 50 percent enrolled in a silver plan with CSRs.[48]

When the federal government discontinued CSR payments in October 2017, Covered California worked with participating health plans to add the cost of losing the payments to silver plan premiums, which are offset by increased premium subsidies for those eligible to receive assistance.

For individuals not eligible for subsidies, health plans developed silver level coverage plans in the individual market outside of Covered California, without the additional cost of the CSR workaround.

Prior Proposals

While there have been no statewide efforts to offer additional state financial assistance to lower out-of-pocket costs prior to this year, one of the highest cost regions in the state offers additional financial assistance to certain workers. SF Covered Medical Reimbursement Account (SFCovered MRA) provides cost-sharing subsidies to certain San Francisco workers that purchase coverage in Covered California and are under 500 percent FPL but not eligible for Medi-Cal or Medicare. Covered San Francisco MRA enrollees receive funding in their MRA sufficient to keep their deductibles below 5 percent of income.[49]

2018 Proposals

SB 1255 (Hernandez) requires Covered California to administer state financial assistance (defined in the bill as premium tax credits or reductions in cost-sharing) with priority for (1) consumers whose share of premium is 8 percent of income and (2) those with incomes 200 percent FPL or above who are subject to significant cost-sharing. SB 1255 failed passage on the Assembly Appropriations Suspense file.

AB 3148 (Arambula) requires Covered California to offer additional cost sharing assistance to individuals with incomes between 200 and 400 percent FPL who are eligible for federal premium tax credits. AB 3148 failed passage on the Assembly Appropriations Suspense file.

Potential Costs

This policy change will need to be financed with 100 percent state funds.

The Senate Appropriations Committee estimates indeterminate costs, likely in the low-mid hundreds of millions, for the financial assistance required in SB 1255. Changes to CalHEERS associated with SB 1255 are estimated to cost in the low-mid tens of millions.[50]

Implementation Issues and Key Questions

Covered California will incur costs to develop administrative processes for state-supported subsidies, train staff, and adjust the technology platform in CalHEERS. To date, major changes to CalHEERS have been costly and time consuming, often resulting in implementation delays associated with policy changes and system improvements.

Other States

Massachusetts and Vermont offer state financial assistance to lower out-of-pocket costs for consumers under 300 percent FPL who purchase coverage on the exchange.[51]

5 INDIVIDUAL MARKET AFFORDABILITY #3: Provide state-funded assistance for dependent coverage through Covered California where the employee share for dependent coverage is a financial hardship

Problem Statement

The ACA definition of affordability that determines a family's eligibility for marketplace premium assistance excludes employee costs for dependent coverage. Federal rules only consider employee costs for their own coverage. This results in some families being unable to afford coverage for all family members while others enroll in employer-sponsored insurance that they struggle to afford.

Affordability Challenges

- Federal law prohibits an employee (and dependents) from accessing ACA subsidies in the marketplace if the employee is offered "affordable" employer-sponsored insurance (ESI). Affordable is defined for this purpose as the cost of coverage for the employee only and excludes the employee's cost for dependent coverage.

- Many employees can afford ESI for themselves but may not be able to afford the additional costs to cover dependents or the full cost of coverage in the marketplace for their dependents. This affordability challenge has become known as the "family glitch."

Policy Goals

- Address the family glitch by improving the affordability of coverage in the exchange for dependents of employees with annual incomes under 400 percent FPL.
- Equitably apply a uniform income eligibility standard for marketplace premium and cost sharing subsidies. Currently, some families with incomes under 400 percent FPL are unable to access subsidies because of the family glitch as outlined above.
- Improve the risk mix in Covered California by encouraging families to cover all family members, including younger healthier members, through assistance to lower premiums and reduce cost sharing for dependent coverage.

Federal and State Context

Federal. Federal law requires large employers to offer affordable ESI to full-time employees and their dependent children up to age 26 or pay a penalty.

The U.S. Internal Revenue Service (IRS) defined affordable coverage for an employee and their dependents in a 2013 final rule. The rule defines an employee-only, job-based health plan that costs 9.56 percent or less (in 2018) of the employee's household income as affordable. The percentage is adjusted annually.

Under this definition, if an employee is offered ESI at the cost of 9.56 percent of the family's household income for employee-only coverage, coverage for the entire family is considered affordable and the family is ineligible for ACA subsidies in the marketplace.

According to research by the Urban Institute, the family glitch results in families facing total costs for coverage up to 15.8 percent of income, or 12 percent after the tax advantages of ESI are factored in.

State. California passed state legislation to implement the ACA, including the establishment of the state exchange, Covered California, which administers eligibility for federal subsidies in accordance with federal law.[52]

Prior Proposals

Congress has considered federal legislation to fix the family glitch, but the bills ultimately failed to pass. For example, former Senator Al Franken (D-MN) introduced the Family Coverage Act in 2014 (S.2434) to eliminate the family glitch.

There have been no prior state efforts to address the family glitch in California.

Implementation Issues and Key Questions

California lawmakers introduced legislation to address affordability concerns for individual market consumers already eligible for ACA premium subsidies and for those with incomes above 400 percent FPL, but no legislation currently seeks to address the family glitch for dependents in families under 400 percent FPL.

According to estimates from the UC Berkeley Labor Center and UCLA Center for Health Policy Research, addressing the family glitch will result in 30,000 uninsured Californians gaining coverage. However, the largest group that would benefit from this proposal (110,000) will be individuals enrolled in ESI transitioning to more affordable coverage in the marketplace.[53]

Cost Estimates

To fix the family glitch for 6 million people nationwide, Urban Institute estimated the additional costs to the federal government for premium tax credits and cost-sharing reductions to be between $3.7 billion and $6.5 billion in 2016.

Other States

No state has addressed the family glitch.

SF Covered Medical Reimbursement Account (SFCovered MRA) provides premium and cost sharing subsidies for specific employees and their adult dependents enrolled in Covered California. It is not known to what extent individuals affected by the family glitch have enrolled in this program.

RELATED BUDGET ACTION IN 2018-19

Although none of the legislative coverage and affordability proposals introduced in 2018 advanced, the 2018-19 final state budget includes the following:

Council on Health Care Delivery Systems. The 2018-19 budget allocates $5 million in one-time funding to create the Council on Health Care Delivery Systems (Council). The accompanying legislative language tasks the five-member independent Council (two legislative and three gubernatorial appointees) with developing "options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system." The language allows the Council to establish advisory committees and lays out in some detail the issues the final plan must address. The Council must provide the first status report on January 1, 2020, and every six months thereafter, and submit the final plan to the Legislature and the Governor on or before October 1, 2021.

Options for Providing Financial Assistance in Covered California. The 2018-19 budget directs Covered California to develop options for administering financial assistance for low- and middle-income Californians to help them access affordable coverage. Legislative language tasks Covered California with exploring assistance options for low-income individuals spending significant amounts of their household income on coverage, even with federal financial assistance, and for individuals with incomes up to 600 percent of the federal poverty level ineligible for federal assistance. Requires Covered California to provide a report to the Legislature with at least three options on or before February 1, 2019.

CONCLUSION

Even before the ACA, California adopted coverage programs beyond federal mandatory programs, and covered additional populations, extending coverage to many of the state's lowest income residents. The California Legislature is likely to consider policy changes in the future to address the coverage and affordability challenges of the uninsured. This issue brief makes clear that many of the proposals would rely on state funds with no federal financial participation available. California can continue moving toward universal coverage by adopting incremental policy changes to cover subgroups of the remaining uninsured.

OVERVIEW OF POLICY PROPOSALS

Covering California's Remaining Uninsured and Improving Affordability

	Medi-Cal Expansion #1	Medi-Cal Expansion #2	Individual Market Affordability #1	Individual Market Affordability #2	Individual Market Affordability #3
Policy	Cover low-income undocumented adults in Medi-Cal	Expand eligibility in the Medi-Cal Aged and Disabled Federal Poverty Level (FPL) Program to 138 percent FPL	Provide financial assistance in the form of state subsidies to lower premiums for coverage through Covered California	Provide financial assistance in the form of state subsidies to lower out-of-pocket costs for Covered California enrollees	Provide state-funded assistance for dependent coverage through Covered California for families who cannot afford the employee share of premiums for dependent coverage
Problem Statement	The majority of the remaining uninsured are undocumented adults and many are low-income; extending Medi-Cal to this population could cover up to 1.2 million undocumented adults.	Around 27,000 seniors and persons with disabilities with incomes under 138 percent FPL must pay a monthly amount for medical care, similar to a health insurance deductible, to be eligible for Medi-Cal.	While federal ACA subsidies lower the cost of obtaining coverage through Covered California, the subsidies may fall short of making coverage affordable for many Californians.	Californians may experience hardship accessing care due to costs at the point of service in the form of deductibles and copayments, and as a result, delay or forego necessary health care services.	For individuals with employer coverage, the ACA definition of affordability excludes employee premiums for dependents, affecting 30,000 uninsured Californians.
2018 Proposals	SB 974 (Lara) extends eligibility for full-scope Medi-Cal benefits to low-income adults 65 and over regardless of immigration status. (As amended May 25, 2018) Failed passage on the Assembly Appropriations Suspense file. AB 2965 (Arambula) extends eligibility for full-scope Medi-Cal benefits to individuals ages 19-25, who are otherwise eligible but for their immigration status. Failed passage on the Senate Appropriations Suspense file. In 2018, the Legislature considered, but did not include, budget proposals that expand Medi-Cal to undocumented adults.	AB 2430 (Arambula) expands Medi-Cal eligibility for seniors and persons with disabilities so that individuals would be eligible with incomes up to 138 percent FPL. The Legislature is also considering budget proposals that adjust the program eligibility to 138 percent FPL. Failed passage on the Senate Appropriations Suspense file. The Legislature also considered, but did not include, budget proposals that adjust the program eligibility to 138 percent FPL.	AB 2459 (Friedman) establishes a state premium tax credit for individuals with incomes between 400 and 600 percent FPL who purchase coverage through Covered California. Failed passage on the Senate Appropriations Suspense file. AB 2565 (Chiu) requires Covered California to offer enhanced premium assistance to consumers with incomes between 138 and 400 percent FPL. Failed passage on the Senate Appropriations Suspense file. SB 1255 (Hernandez) requires Covered California to administer state premium tax credits or cost-sharing reductions. Failed passage on the Assembly Appropriations Suspense file	SB 1255 (Hernandez) requires Covered California to administer state financial assistance (defined in the bill as premium tax credits or reductions in cost-sharing). Failed passage on the Assembly Appropriations Suspense file. AB 3148 (Arambula) requires Covered California to offer additional cost sharing assistance to individuals with incomes between 200 and 400 percent FPL who are eligible for federal premium tax credits. Failed passage on the Assembly Appropriations Suspense file. The Legislature considered, but did not adopt, budget augmentations that included $150 million General Fund in 2018-19 and $300 million ongoing for state premium assistance in Covered California similar to this bill and legislation for this proposal and Affordability proposal #1.	None

NOTES

1. Legislative Analyst's Office (LAO), "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage to Undocumented Adults," May 10, 2018.
2. The 75 percent uninsured rate includes undocumented adults reporting public coverage because they are assumed to have restricted scope Medi-Cal and are considered uninsured. Steven P. Wallace, Jacqueline Torres, Tabashir Sadegh-Nobari, Nadereh Pourat, and E. Richard Brown, "Undocumented Immigrants and Health Reform," UCLA Center for Health Policy Research Final Report to The Commonwealth Fund, August 2012.
3. Only medical care that is strictly of an emergency nature, such as treatment in an emergency room, or treatment in a critical care unit or intensive care unit, meets this requirement. The California Department of Health Care Services Manual of Criteria defines emergency medical condition as a condition, if not treated urgently, would (1) place the patient's health in serious jeopardy; (2) result in serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.
4. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) imposed federal eligibility limits on some lawfully present immigrants for various federally sponsored health programs, including Medicaid. Lawfully present immigrants who gained legal status after August 22, 1996 must wait five years before becoming eligible for full-scope, federally-funded Medicaid coverage. Certain immigrant groups are exempt from the five-year bar, including refugees, asylees, Cuban/Haitian entrants, trafficking victims, and families of veterans.
5. See Welfare and Institutions Code §14007.5.
6. California Department of Health Care Services, "Medi-Cal Statistical Brief – Medi-Cal's Non-Citizen Population," Research and Analytic Studies Division, October 2015.
7. California Welfare and Institutions Code Sections 24003, 14007.65, 14007.7, 14148, 14148.5, and 15832. California Health and Safety Code Section 104162.
8. LAO, "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage."
9. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2016. SB 4 (Lara), Chapter 709, Statutes of 2015, refined the program enacted in the budget.
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11. LAO, "Estimating the Costs of Expanding Full-Scope Medi-Cal Coverage."
12. Assembly Appropriations Committee analysis of AB 2965 (Arambula), as amended March 23, 2018, posted online May 24, 2018. See information about the 2013 Health Realignment provided by the California Association of Public Hospitals and Health Systems.
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20. Assembly Appropriations Committee analysis of AB 2430, as introduced February 14, 2018, posted online May 21, 2018.
21. Assembly Appropriations Committee analysis of AB 2430.
22. 42 U.S. Code §§ 1396a(a)(10)(A)(ii)(X); 1396a(m).
23. Assembly Health Committee analysis of AB 763, as introduced February 25, 2015, posted online April 3, 2015.
24. AB 2877 (Thomson, Chapter 93, Statutes of 2000.)
25. Assembly Appropriations Committee analysis of AB 763.
26. Molly O'Malley Watts, Elizabeth Cornachione, and Marybeth Masumeci, "Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015," Kaiser Family Foundation, March 2016.
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29. UCLA Center for Health Policy Research, AskCHIS 2016, "Difficulty of finding affordable plan through Covered California."
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About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad- based stakeholder engagement.

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RESEARCH BRIEF

2019 HEALTH PLAN CHOICE AND PREMIUMS IN HEALTHCARE.GOV STATES

October 26, 2018

Note: Average premiums in this brief may differ from data released by the Centers for Medicare & Medicaid Services (CMS) on October 11, 2018.[1] These discrepancies are a result of two methodological differences: 1) average premiums presented in this brief are weighted by county-level plan selections as of the end of the Open Enrollment period (using PY18 plan selections to calculate PY19 average premiums) while the October 11, 2018 released data for PY 18 and PY 19 were both weighted by county-level plan selections as of May 31, 2018; and 2) average premiums presented in this brief include the portion of the premium attributable to coverage in addition to essential health benefits, while the October 11, 2018 released average premium data were only the portion of the premium attributable to essential health benefits.

This brief presents information on qualified health plans (QHPs) available in states that rely on the HealthCare.gov eligibility and enrollment platform (HealthCare.gov states), including estimates for issuer participation, consumer options, average premiums, and subsidies in the upcoming open enrollment period (OEP), and trends since the first OEP. National estimates and summary tables are presented in each section of the text. State-specific estimates are in the Appendix. Unless otherwise specified, all estimates reflect all states using the HealthCare.gov platform for each given year.

[1] https://www.cms.gov/newsroom/press-releases/premiums-federally-facilitated-exchanges-drop-2019

Key Findings – HealthCare.gov States

Issuer Participation: Issuer participation in the Exchanges in HealthCare.gov states increased with 155 total state level issuers in plan year 2019 (PY19), up from 132 in PY18. Five states in PY19 will have only one issuer: Alaska, Delaware, Mississippi, Nebraska, and Wyoming; down from eight states in PY18: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming.[2]

Consumer Options: 20% of current enrollees will have only one issuer to choose from, down from 29% in PY18. The average number of qualified health plans (QHPs) available to enrollees is 26 for PY19, up from 25 in PY18. Alaska and Mississippi enrollees will have the fewest QHPs in PY19 (an average of 5 QHPs per county), while Florida will have the highest (an average of 49 QHPs per county).

Average Premiums: The average monthly premium for the second-lowest cost silver plan (SLCSP), also called the benchmark plan, for a 27-year-old decreased by 2% from PY18 ($412) to PY19 ($405). However, the average premium for the benchmark plan in PY19 will be 85% higher than in PY14.

Subsidy Utilization and Costs: The average monthly APTC ($544) amount will decrease by an estimated 3% from PY18 ($558), however the average APTC amount for PY19 is 110% higher than the average APTC for PY14 ($259). In PY14 through PY18, more than 80% of enrollees were in plans for which APTCs were paid.

Lowest-Cost Plan Available: The percentage of current enrollees with access to a plan for $200 or less decreased from 38% for PY15 to 6% for PY18, and will decrease to 5% for PY19. If enrollees were to stay within their current metal level, 2% will have access to coverage with premiums of $200 or less for PY19.

[2] Data released on October 11, 2018 counted AZ and KY as single issuer states for 2018 as there was no overlap in county coverage; every county was single issuer.

I. Issuer Participation

Table 1 provides estimates of issuer participation across HealthCare.gov states for plan year 2014 (PY14) through PY19. For comparison purposes, estimates of total state issuers are provided for states that have used the HealthCare.gov eligibility and enrollment platform in at least one plan year, as well as for states that have used the HealthCare.gov platform during all plan years. The estimates treat states equally in averages and percentage distributions (i.e. they are unweighted). The bullets below compare differences between the upcoming plan year, PY19, and the prior plan year, PY18, in the first section, and highlight trends across all plan years in the second section. See Tables 1A and 1B in the Appendix for state and county specific estimates.

Differences between PY19 and PY18:

- Issuer participation in the Exchanges increased, with 155 total state level issuers in PY19, up from 132 in PY18.
- The average number of state level issuers is four for PY19, up from three in PY18.
- Five HealthCare.gov states (13%) will have only one issuer in PY19: Alaska, Delaware, Mississippi, Nebraska, and Wyoming; down from eight (21%) in PY18: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming.

Trends across Plan Years:

- The total number of state level issuers for the 35 HealthCare.gov states during all plan years increased from PY14 (187) to PY15 (217) and PY16 (217) and declined in PY17 (152) and PY18 (121). PY19 (144) will be the first increase in state level issuer participation since PY15.
- The average number of state level issuers was five in PY14, increased to six in PY15 and PY16, decreased to four in PY17 and 3 in PY18, and will increase to 4 in PY19.
- The percentage of states with six or more issuers was 31% in PY14, compared to only 20% of states in PY19.

Table 1
Total and Average Number of Issuers Participating in HealthCare.gov States, PY14 – PY19

	PY14	PY15	PY16	PY17	PY18	PY19
All States Using HealthCare.gov for the Listed Plan Year						
Number of States Included in Estimates	*36*	*37*	*38*	*39*	*39*	*39*
Total Number of Issuers in State	**191**	**231**	**232**	**167**	**132**	**155**
Average Number of Issuers in State	**5**	**6**	**6**	**4**	**3**	**4**
Percentage of States with 1 Issuer	6%	3%	3%	13%	21%	13%
Percentage of States with 2-5 Issuers	64%	57%	61%	67%	62%	69%
Percentage of States with 6+ Issuers	31%	41%	37%	21%	18%	18%
Only States Using HealthCare.gov for All Six Plan Years						
Number of States Included in Estimates	*35*	*35*	*35*	*35*	*35*	*35*
Total Number of State Issuers	**187**	**217**	**217**	**152**	**121**	**144**
Average Number of State Issuers	**5**	**6**	**6**	**4**	**3**	**4**
Percentage of States with 1 Issuer	6%	3%	3%	14%	23%	14%
Percentage of States with 2-5 Issuers	63%	57%	60%	66%	57%	66%
Percentage of States with 6+ Issuers	31%	40%	37%	20%	20%	20%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Numbers may not sum exactly due to rounding. Two estimates are included for HealthCare.gov states, one with all states included in a given plan year and the other including only the 35 states using HealthCare.gov across all plan years. Issuers were identified using their unique five-digit Health Insurance Oversight System (HIOS) issuer IDs within a state. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering qualified health plans through the Exchanges in two states would appear to be two separate issuers. Data do not include stand-alone dental plans, child-only plans, or small business health options program (SHOP) plans. See the "Methods and Limitations" section for additional details. Discrepancies with data released October 11, 2018 are due to differences in plan data sets used for 2016.

II. Consumer Options

Table 2 provides estimates of issuer and plan options for enrollees for plan year 2014 (PY14) through PY19 for all HealthCare.gov states. The bullets below compare differences between the upcoming plan year, PY19, and the prior plan year, PY18, in the first section, and highlight trends across all plan years in the second section. See Table 2A in the Appendix for state and county specific estimates.

Differences between PY19 and PY18:

- For PY19, 20% of current enrollees will have one issuer to choose from, down from 29% in PY18; while more than half (57%) will have three or more, compared to 44% in PY18.

- The average number of qualified health plans (QHPs) available to enrollees is 26 for PY19, up from 25 in PY18.

Trends across Plan Years:

- The percentage of current enrollees with only one issuer to choose from increased from PY17 (20%) to PY18 (29%), but will decrease for PY19 (20%).

- The average number of QHPs available to enrollees had decreased every year since PY15 (55), with 46 in PY16, 30 in PY17, and 25 in PY18, but will increase in PY19 (26).

Table 2
Average Number of Issuer and Health Plan Options for Enrollees in HealthCare.gov States, PY14 – PY19

	PY14	PY15	PY16	PY17	PY18	PY19
Issuer Options	**4**	**5**	**5**	**3**	**3**	**3**
Percentage with 1 Issuer	7%	3%	2%	20%	29%	20%
Percentage with 2 Issuers	18%	10%	12%	23%	26%	23%
Percentage with 3+ Issuers	75%	87%	86%	56%	44%	57%
Plan Options	**54**	**58**	**48**	**32**	**26**	**27**
Catastrophic Plans	3	3	3	1	1	1
Qualified Health Plans	**51**	**55**	**46**	**30**	**25**	**26**
Bronze Plans	15	17	14	10	7	8
Silver Plans	18	22	19	14	12	12
Gold Plans	14	13	10	5	4	5
Platinum Plans	4	4	2	2	1	1

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Percentages may not sum exactly due to rounding. County averages and percentages were weighted by the number of plan selections in each county for the same plan year, except PY19 for which PY18 plan selections were used. QHPs do not include catastrophic plans. Issuers were identified using their unique five-digit Health Insurance Oversight System (HIOS) issuer IDs within a state. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering QHPs through the Exchanges in two states would appear to be two separate issuers. Data do not include stand-alone dental plans, child-only plans, or small business health options program (SHOP) plans. See the "Methods and Limitations" section for additional details.

III. Average Premiums

Tables 3 and 4 provide estimates of the average monthly premium for the second-lowest cost silver plan (SLCSP), also called the benchmark plan, and the lowest-cost plan (LCP), available to a 27-year-old for Exchange plans covering enrollees in plan year 2014 (PY14) through PY19 across all HealthCare.gov states. The bullets below compare differences between the upcoming plan year, PY19, and the prior plan year, PY18, in the first section; and highlight trends across all plan years in the second section. See Tables 3A, 3B, 4A and 4B in the Appendix for state and county specific estimates.

Differences between PY19 and PY18:

- The average monthly premium for the benchmark plan will decrease by 2% in PY19 ($405) compared to PY18 ($412); however, there is considerable variation by state.
    - *Wyoming* will have the highest average premium for the benchmark plan in PY19 ($709), the same average premium as PY18.
    - *Indiana* will have the lowest average premium for the benchmark plan in PY19 ($280), a decrease of 2% from PY18 ($287).
    - *North Dakota* will have the highest percentage increase in the average premium for the benchmark plan in PY19 ($375), an increase of 21% from PY18 ($310).
    - *Tennessee* will have the greatest percentage decrease in the average premium for the benchmark plan in PY19 ($448), a decrease of 26% from PY18 ($608).
- The average monthly premium for the LCP will decrease by 1% in PY19 ($288) compared to PY18 ($291).

Trends across Plan Years:

- The average monthly premium for the benchmark plan in PY19 ($405) will be 85% higher than in PY14 ($218).
    - *Nebraska* will have the highest percentage increase in the average premium for the benchmark plan in PY19 ($686) relative to the first plan year, PY14 ($205), an increase of 235%.
    - *Indiana* will have the lowest percentage increase in the average premium for the benchmark plan in PY19 ($280) relative to the first plan year, PY14 ($270), an increase of 4%.
- The average monthly premium for the LCP in PY19 ($288) will be 75% higher than in PY14 ($164).

Table 3
Average Monthly Premium for the Second-Lowest Cost Silver Plan (SLCSP) Available for a 27-Year-Old in HealthCare.gov States, PY14 – PY19

	SLCSP Average Monthly Premium for a 27-Year-Old	Annual Percentage Change	Cumulative Percentage Change
PY14	**$218**	-	-
PY15	**$224**	3%	3%
PY16	**$242**	8%	11%
PY17	**$300**	24%	38%
PY18	**$412**	37%	89%
PY19	**$405**	-2%	85%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. The numbers in this table represent premiums before the application of advance premium tax credits. HealthCare.gov average premiums are weighted by the number of Exchange plan selections in each county. The PY14 through PY18 average premiums are weighted by current year plan selections and PY19 is weighted by PY18 plan selections. This analysis identifies the second-lowest cost silver plan in each county based on the portion of the premium that covers essential health benefits. Estimates include all states using the HealthCare.gov platform in the specified plan year. See the "Methods and Limitations" section for details.

Table 4
Average Monthly Premium for Lowest-Cost Plan (LCP) Available for a 27-Year-Old in HealthCare.gov States, PY14 – PY19

	LCP Average Monthly Premium for a 27-Year-Old	Annual Percentage Change	Cumulative Percentage Change
PY14	**$164**	-	-
PY15	**$173**	5%	5%
PY16	**$195**	13%	19%
PY17	**$248**	27%	51%
PY18	**$291**	17%	77%
PY19	**$288**	-1%	75%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. The numbers in this table represent premiums before the application of advance premium tax credits. HealthCare.gov average premiums are weighted by the number of Exchange plan selections in each county. The PY14 through PY18 average premiums are weighted by current year plan selections and PY19 is weighted by PY18 plan selections. This analysis identifies the lowest-cost plan in each county based on the portion of the premium that covers essential health benefits. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. Estimates include all states using the HealthCare.gov platform in the specified plan year. See the "Methods and Limitations" section for details.

IV. Subsidy Utilization and Costs

Table 5 provides estimates of the percentage of enrollees in Exchange plans to which advance premium tax credits (APTCs) were paid and had cost-sharing reductions (CSRs)[3] in plan year 2014 (PY14) through PY18 across all HealthCare.gov states. Table 6 contains estimates of APTCs in PY18 and PY19 for specific household compositions that may be eligible to receive APTCs. Table 7 presents the average monthly APTC for PY14 through PY18 and estimates the average monthly APTC for PY19 for enrollees who selected plans during the PY18 Open Enrollment Period (OEP) using plans available in PY19. For all plan years, Table 7 uses the maximum APTC enrollees can receive. An enrollee will receive less than the maximum APTC if he or she selects a plan with a premium less than the maximum APTC amount. The bullets below compare differences between the upcoming plan year, PY19, and the prior plan year, PY18, in the first section; and highlight trends across plan years in the second section. See Tables 5A and 6A in the Appendix for state and county specific estimates.

Differences between PY19 and PY18:

- The estimated average monthly APTC for current enrollees is $544 for PY19, a 3% decrease from PY18 ($558).

- A 27-year-old with a household income of $25,000 is estimated to receive an average monthly APTC of $265 for PY19, a 3% decrease from PY18 ($274) based on the average premium for the benchmark plan across all HealthCare.gov states.

- A family of four with a household income of $60,000 is estimated to receive an average monthly APTC of $1,155 for PY19, a 3% decrease from PY18 ($1,185) based on the average premium for the benchmark plan across all HealthCare.gov states.

Trends across Plan Years:

- The average monthly APTC for PY19 is ($544), an increase of 110% from PY14 ($259).

- The percentage of enrollees making plan selections with APTCs has remained relatively stable, staying between 84% and 87% between PY14 and PY18.

- The percentage of enrollees making plan selections with CSRs remained relatively stable, at approximately 60% between PY14 and PY17, but decreased to 54% for PY18.

[3] As of the last quarter of 2017, CSR payments are no longer paid to issuers; however, issuers are still required by law to offer plans with CSRs to eligible enrollees if they participate in an Exchange.

Table 5
Percentage of Plan Selections Receiving APTCs or CSRs in HealthCare.gov States, PY14 – PY18

	Percentage of Plan Selections with APTC	Percentage of Plan Selections with CSR
PY14	84%	60%
PY15	87%	60%
PY16	85%	59%
PY17	84%	60%
PY18	85%	54%

Source: Financial assistance information is from active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY18.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Estimates are based on plan selections made during the Open Enrollment Period (OEP) for each specified plan year. As of the last quarter of 2017, CSR payments are no longer paid to issuers; however, issuers are still required by law to offer plans with CSRs to eligible enrollees if they participate in the Exchanges. See the "Methods and Limitations" section for more details.

Table 6
Average Monthly Benchmark Premiums and Advance Premium Tax Credits (APTCs) Available in HealthCare.gov States, PY18 – PY19

	27 Year-Old with a Household Income of $25,000	Family of Four with a Household Income of $60,000
PY18 Benchmark Before APTC	$412	$1,582
PY18 APTC	$274	$1,185
PY19 Benchmark Before APTC	$405	$1,554
PY19 APTC	$265	$1,155
Percentage Change in APTC PY18 to PY19	-3%	-3%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform in PY18 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Averages for premiums are weighted by the county's number of Exchange PY18 plan selections. In this example, the family of four is one 40-year-old adult, one 38-year-old adult, and two children under the age of 15. All enrollees are assumed to not be tobacco users. For households eligible for premium tax credits, after-tax-credit benchmark premiums are capped at a given percentage of household income. The maximum percent of income paid toward the benchmark plan is adjusted annually to be a measure of the difference between premium growth and income growth. If the premium of the benchmark plan falls below the maximum applicable percentage of income amount for which a household is responsible, then the household does not receive a tax credit and pays for the full premium for the plan selected. After-tax benchmark premiums will differ slightly between PY18 and PY19 for identical family compositions and income amounts because of changes in the applicable percentages and the Federal Poverty Level Guidelines. Alaska and Hawaii's Federal poverty guidelines are higher than those for the continental United States; consequently, the after tax credit premium is lower for a given amount of income. Our calculations of premiums after tax credits assume that all members of the family of four making $60,000 would be eligible for premium tax credits. However, in states with higher Medicaid of Children's Health Insurance Program (CHIP) thresholds, the children would be eligible for Medicaid/CHIP and not eligible for premium tax credits. Starting for PY18, new regulation modified the age rating methodology for individuals age 20 and younger; the 2018 family of four premiums reported in this report take into account the new age rating methodology; the 2018 average family of four premium estimates in last year's report released on October 30, 2017 do not take this change into account. Starting for PY19, new regulation modified the methodology of determining the APTC amount attributable to children under 19 on an individual or family policy, in which the premium of a stand-alone dental plan is added to the premium of any plan not offering pediatric dental benefits for purposes of determining the benchmark plan and resultant APTC amount. The data presented in this table do not take this change into account. See the "Methods and Limitations" section for more details.

Table 7

Average Monthly Advance Premium Tax Credit (APTC) in HealthCare.gov States, PY14 – PY19

	Average Monthly APTC	Annual Growth	Cumulative Growth
PY14	**$259**	-	-
PY15	**$263**	2%	2%
PY16	**$289**	10%	12%
PY17	**$382**	32%	47%
PY18	**$558**	46%	115%
PY19	**$544**	-3%	110%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. For PY14 through PY18, the estimates for average advance premium tax credit (APTC) are calculated using enrollees who made a plan selection during each plan year's Open Enrollment Period (OEP). For PY19, the average APTC is an estimate of the APTC for enrollees who made a plan selection during the PY18 OEP using plans available in PY19 and the same methodology employed in previous years. The PY19 estimates hold all PY18 enrollee characteristics unchanged and premiums are based on the same age and family composition as in PY18. For PY19, only enrollees who could be linked to complete plan and premium data for PY19 and PY18 are included. Tobacco users are excluded from all plan years. For all plan years, the estimates presented in this table use the maximum APTC enrollees can receive. An enrollee will receive less than the maximum APTC if he or she selects a plan with a premium less than the maximum APTC amount. See the "Methods and Limitations" section for more details.

V. Lowest-Cost Plan Available

Tables 8 and 9 provide estimates of the lowest-cost plan (LCP) monthly premium available to enrollees for plan year 2015 (PY15) through PY19 across all HealthCare.gov states participating in a given plan year. The estimates take enrollees who made a plan selection in the prior Open Enrollment Period (OEP) and calculate the average premium for the LCP based on the plans available to these enrollees in the specified plan year, e.g., the LCP available to PY14 enrollees in the PY15 OEP. The bullets below compare differences between the upcoming plan year, PY19, and the prior plan year, PY18, in the first section; and highlight trends across all plan years in the second section. See Tables 7A, 7B, 8A, and 8B in the Appendix for state and county specific estimates.

Differences between PY19 and PY18:

- The percentage of enrollees with access to a plan for $200 per month or less decreased from 6% for PY18 to 5% to PY19.
- If PY18 enrollees were to stay within their current metal level 2% will have access to coverage with premiums of less than $200 for PY19.
- The percentage of enrollees with access to a plan for which they are responsible for paying less than $75 of the premium decreased by 1 percentage point from PY18 (80%) to PY19 (79%).

Trends across Plan Years:

- The percentage of enrollees with access to a plan for $200 per month or less decreased from 38% for PY15 to 5% to PY19.
- The percentage of enrollees with access to coverage within their metal level with premiums of less than $200 decreased from 21% in PY15 to 2% in PY19.
- The percentage of enrollees with access to a plan for which they are responsible for paying less than $75 of the premium increased by 7 percentage points from PY15 (72%) to PY19 (79%).

Table 8

Percentage of Enrollees by the Monthly Premium of the Lowest-Cost Plan (LCP) Available in the Subsequent Open Enrollment Period in HealthCare.gov States, PY15 – PY19

	Percentage of Enrollees by the Monthly Premium of the LCP Available			
	$200 or less	**$201 - $300**	**$301 - $400**	**$401 or more**
From Any Metal Level				
PY15	38%	28%	17%	17%
PY16	29%	31%	16%	24%
PY17	16%	28%	17%	39%
PY18	6%	25%	21%	48%
PY19	5%	23%	23%	49%
Within Enrollees' Previously Chosen Metal Level				
PY15	21%	31%	18%	30%
PY16	18%	31%	18%	33%
PY17	11%	24%	18%	47%
PY18	2%	12%	20%	66%
PY19	2%	13%	20%	65%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Percentages across premium categories may not sum due to rounding. For each plan year, premiums were calculated using enrollees who made a plan selection during the previous year's Open Enrollment Period (OEP). The estimates hold all enrollee characteristic s unchanged and premiums are based on the same age and family composition as in the previous year. For each plan year, only enrollees who could be linked to complete plan and premium data for the current and previous plan year are included, and tobacco users are excluded. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. Estimates include all states that had plan selections on the HealthCare.gov platform in the prior OEP and include 36 states for PY15, 37 states for PY16, 38 states for PY17, 39 states for PY18 and PY19. See the "Methods and Limitations" section for more details.

Table 9

Percentage of Enrollees by the Portion of the Monthly Premium Paid by the Enrollee for the Lowest-Cost Plan (LCP) Available in the Subsequent Open Enrollment Period (OEP) in HealthCare.gov States, PY14 – PY19

	Percentage of Enrollees by the Portion of the Monthly Premium Paid by the Enrollee for the LCP Available			
	$75 or less	**$76 - $150**	**$151 - $200**	**$201 or more**
From Any Metal Level				
PY15	72%	13%	6%	8%
PY16	72%	13%	6%	9%
PY17	71%	13%	5%	12%
PY18	80%	6%	3%	11%
PY19	79%	6%	3%	12%
Within Enrollees' Previously Chosen Metal Level				
PY15	56%	20%	8%	16%
PY16	57%	20%	7%	15%
PY17	58%	18%	6%	17%
PY18	60%	18%	6%	17%
PY19	62%	15%	5%	17%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Percentages across premium categories may not sum due to rounding. For each plan year, premiums after subsidy were calculated using enrollees who made a plan selection during the previous year's Open Enrollment Period (OEP). This analysis holds all enrollee characteristics unchanged and calculates premiums and tax credits based on the same age, family composition, and household income as in the previous year. For each plan year, this analysis includes only enrollees who could be linked to complete plan and premium data for the current and previous plan year, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. Estimates include all states that had plan selections on the HealthCare.gov platform in the prior OEP and include 36 states for PY15, 37 states for PY16, 38 states for PY17, 39 states for PY18 and PY19. See the "Methods and Limitations" section for more details.

VI. Methods and Limitations

Data

County level data on issuers, plans, and premiums were obtained from the Federally-Facilitated Exchange (FFE) Qualified Health Plan (QHP) landscape files for plan year 2014 (PY14) through PY19; these files are publicly available on the HealthCare.gov website.[4] We used the individual and family health plan files, which do not include stand-alone dental, child-only, and Small Business Health Options Program (SHOP) plans. The landscape files are updated throughout the year to reflect changes in issuer participation and represent snapshots of issuers and plans on a specific date. We used the dated versions of the landscape files consistent with the most recently published ASPE Research Briefs on health plan choice and premiums in the health insurance Exchanges.[5,6,7,8] There were between 36 and 39 states included in the landscape files for PY14 through PY19 as some states did not begin using the HealthCare.gov platform until after PY14, and one state stopped using the platform after PY14.[9] Except where noted, we used all available states in each landscape file to calculate national estimates.[10]

Individual level enrollment data were obtained from the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS). The enrollment data represent active QHP selections at a point in time, similar to the landscape files. We used the dated versions of MIDAS consistent with the most recently published ASPE Research Briefs on health plan choice and premiums in the health insurance Exchanges.[11] Throughout this brief, we use the term "enrollees" to refer to individuals with active plan selections in the MIDAS data;

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[4] The FFM QHP landscape files can be downloaded at: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/.

[5] The 2018 ASPE Research Brief can be downloaded at: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2018-federal-health-insurance-exchange.

[6] The 2017 ASPE Research Brief can be downloaded at: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace.

[7] The 2016 ASPE Research Brief can be downloaded at: https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

[8] The landscape file dated versions used for each plan year in this brief were: PY14 (January 2014); PY15 (August 2015); PY16 (July 29, 2016); PY17 (October 14, 2016); PY18 (October 23, 2017); PY19 (October 10, 2018).

[9] In total, there are 35 states included in the landscape files for all PYs (Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming), one state in only PY14 (Idaho), two states in PY15-PY2018 (Nevada and Oregon), one state in PY16-PY18 (Hawaii), one state in PY17-PY19 (Kentucky), and ten states plus the District of Columbia without data in any landscape file PY (California, Colorado, Connecticut, District of Columbia, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington). In total, each plan year landscape file contained the following number of states: 36 in PY14, 37 in PY15, 38 in PY16, and 39 in PY17 through PY19; with a total of 40 states included in at least one plan year landscape file.

[10] This year the Appendix tables only include estimates for the first available plan year (PY14 in most tables and PY15 in tables examining current enrollees going into the next open enrollment), the previous plan year (PY18), and the upcoming plan year (PY19). The methodology for PY15, PY16, and PY17 estimates has not changed from last year's brief; to compare PY19 estimates in the Appendix to these plan years refer back to last year's brief available at: https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf

[11] The MIDAS enrollment file dated versions included in this brief are: 2014 (April 2014); 2015 (February 22, 2015); 2016 (February 2, 2016); 2017 (January 31, 2017); 2018 (December 23, 2017).

the term does not refer to "effectuated enrollees" – individuals who selected plans and paid the premium. As a result, estimates in this brief may differ from those calculated using effectuated enrollment.

Plan data not available in the landscape files or MIDAS were obtained from the CMS Health Insurance Marketplace Public Use Files (Marketplace PUFs).[12] The Benefits and Cost Sharing PUFs were used to identify the percentage of premiums covering essential health benefits (EHBs) in PY14 and PY15, as they were absent from the landscape files for these years.

Issuers Participations and Plan Options

To examine issuers and plans, we estimated the average number of issuers, health plans, and plan metal types available across states and counties in HealthCare.gov states. We also calculated the total number of issuers across all and within each state, as well as for selected counties. Finally, we estimated differences in issuer participation and plan choice for the upcoming plan year and previous plan years. Weighted and unweighted averages and percentage distributions were calculated. Averages were weighted using county level plan selections in the MIDAS data for the same year as each plan year landscape file used, except for PY19, which was weighted using PY18 plan selections. Issuers were identified using their unique five-digit Health Insurance Oversight System (HIOS) issuer IDs. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering plans through the Exchanges in two states would appear to be two separate issuers.

Average Premiums

To examine average premiums, we determined the second-lowest cost silver plan (SLCSP), also called the benchmark plan, for each county in each of the landscape files. Plans in the Exchanges are required to offer a comprehensive package of items and services, known as essential health benefits (EHBs). Exchange plans can also offer benefits beyond EHBs and each plan reports the percentage of premium related to EHB. Most plans have an EHB percentage of 100%; however, plans that cover benefits beyond EHB have EHB percentages smaller than 100%, reflecting the fact that a portion of the premium pays for benefits beyond EHB. Benchmark plans are determined by ranking silver plans available to a consumer by the amount of premium related to EHB only.

To estimate the benchmark plan available to consumers, we ranked each silver plan in a county by the EHB premium amount and identified the SLCSP available in that county. In some counties with three or more silver plans, the EHB premium amount for the two lowest-cost silver plans is exactly the same. From PY14-PY17, when this occurred, the silver plan with the next highest premium relative to the tied lowest-cost silver plans was the benchmark. For PY18 and PY19, when this occurs, the premium for the tied lowest-cost silver plans was used as the benchmark plan. This operational change resulted from a clarification in how to calculate

[12] The Marketplace PUFs are available at: https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html

advance premium tax credits (APTCs) released by Internal Revenue Service (IRS).[13] Additionally, when a county only has a single silver plan it is used as the benchmark. In this brief, the terms "SLCSP" and "benchmark plan" are used interchangeably to refer to the second-lowest cost silver plan in a county, which may not be the actual benchmark plan for all individual consumers in a county.

We calculated the average premium and the annual and cumulative percentage change in these for the SLCSP and the lowest-cost plan (LCP) available to a 27-year-old for Exchange plans covering enrollees in plan year 2014 (PY14) through PY19 across all HealthCare.gov states.

In addition to reweighting PY18 estimates using county level open enrollment plan selections from 2018 rather than 2017, the premium estimates for a Family of Four with Household Income of $60,000 in PY18 differ from last year's report released on October 30, 2017 due to a change in the age bands for children in states using the federal default standard curve. The change included moving from the single age band of 0.635 used in PY17 and prior plan years to seven bands with higher premium ratios. The new bands are effective in PY18 and PY19 and following years for each age group: ages 0-14 = 0.765; age 15 = 0.833; age 16 = 0.859; age 17 = 0.885; age 18 = 0.913; age 19 = 0.941; age 20 = 0.970. In last year's brief the estimates for a Family of Four with Household Income of $60,000 were applicable to the family of four being composed of two adults, one age 40 and one age 38, and two children under age 21. For this year's brief we used the age band for ages 0-14 (0.765) in these estimates and therefore the two children are assumed to be under age 15.

Subsidy Utilization and Cost

To examine subsidies, we calculated the percentage of MIDAS plan selections receiving financial assistance for APTCs and with cost-sharing reductions (CSRs) in PY14 through PY18. Additionally, we calculated the average benchmark plan premium and APTC for PY18 and PY19 under two scenarios for household compositions eligible for APTC: 1) a 27-year-old with household income of $25,000, and 2) a family of four with a household income of $60,000. Estimates of average before and after APTC average premium, average APTC amount, and the percentage change in the average APTC amount were calculated. Finally, we estimated the average APTC and growth in APTC for PY14 through PY19. For PY14-PY18, we estimated the average maximum APTC using plan selections made during each plan year's Open Enrollment Period (OEP). For PY19, we estimated the average APTC for enrollees who selected plans during the PY18 OEP using the benchmark plan available in their county in PY19. See *Lowest-Cost Premiums Available* below for details of how enrollees in PY18 were linked to PY19. Note, here we use the maximum APTC enrollees can receive. An enrollee will receive less than the maximum APTC if he or she selects a plan with a premium less than the maximum APTC amount.

APTCs were calculated using the maximum applicable amount determined annually by the IRS and based on household income. The maximum applicable amount is the amount of premium an APTC eligible consumer in the Exchanges is expected to pay toward their benchmark premium.

[13] IRS Questions and Answers on Premium Tax Credits are available at: https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit

Individuals eligible to enroll in the Exchanges with household incomes between 100%-400% of the federal poverty level (FPL) are APTC eligible unless they are disqualified based on other factors. The amount of APTC a consumer qualifies for was calculated by subtracting the maximum applicable amount from their benchmark plan premium. However, APTC can only be applied to the portion of a plan's premium that covers EHB. For example, if a consumer has a $200 APTC and selects a plan that costs $200 before APTC and has an EHB amount of 95%, the tax credit will cover $190 of the plan premium and the consumer will be responsible for covering the remaining $10. We included this factor in our APTC calculations. EHB premium amounts were used in determining the benchmark plan and APTCs, however, comparisons of benchmark premiums in this brief use the full premium amount, not just the EHB amount.

Lowest-Cost Plan Available

To examine the LCP premiums available to enrollees, we estimated the percentage of current enrollees, defined as individuals who made plan selections in the prior OEP, e.g. the premiums for the LCP (identified in PY19 landscape files) available to PY18 enrollees (from PY18 MIDAS plan selections) in PY19, who could obtain coverage for several premium dollar amount markers. We calculated estimates within and regardless of current enrollees' current metal level for PY15 through PY19.

Beginning in PY18, there is a new metal level of coverage, expanded bronze, which has an actuarial value between 56 and 65 percent. For the purposes of this brief, this plan type is included in the standard bronze category. Estimates across all states and for each state are provided. Enrollee characteristics, including age, family composition, and household income were held constant when estimating premiums. We included only enrollees who could be linked to complete plan and premium data in their current enrollment year and the prior plan year. Therefore, each plan year's estimates exclude any states that had no plan selections on the HealthCare.gov platform in the prior OEP. The estimates include 36 states for PY15, 37 states for PY16, 38 states for PY17, 39 states for PY18 and 39 states for PY19. We excluded tobacco users as their premium rates may be higher than standard, non-tobacco rates. For PY14 and PY15, we also excluded enrollees in Virginia plans covering treatment of morbid obesity. Catastrophic plans, which are not available to all consumers, were also excluded.

Appendix: State and County Tables

Table 1A

Total and Number of State Issuers in HealthCare.gov States, PY14, PY18, and PY19

State	PY14	PY18	PY19	Change		Issuers Entry/Exit	
				PY18-PY19	PY14-PY19	Entry PY19	Exit PY19
All States Using HealthCare.gov for the Listed Plan Year	**191**	**132**	**155**	**23**	**-36**	**23**	**0**
Only States Using HealthCare.gov for All Six Plan Years	**187**	**121**	**144**	**23**	**-43**	**23**	**0**
AK	2	1	1	0	-1	0	0
AL	2	2	2	0	0	0	0
AR	3	4	4	0	1	0	0
AZ	10	2	5	3	-5	3	0
DE	3	1	1	0	-2	0	0
FL	11	6	7	1	-4	1	0
GA	5	4	4	0	-1	0	0
HI	N/A	2	2	0	N/A	0	0
IA	4	1	3	2	-1	2	0
ID	4	N/A	N/A	N/A	N/A	N/A	N/A
IL	8	4	5	1	-3	1	0
IN	4	2	2	0	-2	0	0
KS	4	3	3	0	-1	0	0
KY	N/A	2	2	0	N/A	0	0
LA	5	3	3	0	-2	0	0
ME	2	2	3	1	1	1	0
MI	12	8	9	1	-3	1	0
MO	4	3	4	1	0	1	0
MS	2	1	1	0	-1	0	0
MT	3	3	3	0	0	0	0
NC	2	2	3	1	1	1	0
ND	3	2	3	1	0	1	0
NE	4	1	1	0	-3	0	0
NH	1	3	3	0	2	0	0
NJ	4	4	4	0	0	0	0
NM	4	4	4	0	0	0	0
NV	N/A	2	2	0	N/A	0	0
OH	12	8	10	2	-2	2	0
OK	6	1	2	1	-4	1	0
OR	N/A	5	5	0	N/A	0	0
PA	14	9	11	2	-3	2	0
SC	4	1	2	1	-2	1	0

SD	3	2	2	0	-1	0	0
TN	4	3	5	2	1	2	0
TX	12	8	8	0	-4	0	0
UT	6	2	3	1	-3	1	0
VA	8	7	8	1	0	1	0
WI	13	11	12	1	-1	1	0
WV	1	2	2	0	1	0	0
WY	2	1	1	0	-1	0	0

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Numbers may not sum exactly due to rounding. Two estimates are included for HealthCare.gov states, one with all states included in a given plan year and the other including only the 35 states using HealthCare.gov across all plan years. Issuers were identified using their unique five-digit Health Insurance Oversight System (HIOS) issuer IDs within a state. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering qualified health plans through the Exchange in two states would appear to be two separate issuers. Data do not include stand-alone dental plans, child-only plans, or small business health options program (SHOP) plans. See the "Methods and Limitations" section for additional details.

Table 1B
Number of Issuers in Selected Counties in HealthCare.gov States, PY14, PY18, and PY19

State	County	City in County	Number of Issuers			Change	
			PY14	PY18	PY19	PY18-PY19	PY14-PY19
AL	Jefferson	Birmingham	2	2	2	0	0
AK	Anchorage	Anchorage	2	1	1	0	-1
AK	Juneau	Juneau	2	1	1	0	-1
AZ	Maricopa	Phoenix	10	1	4	3	-6
AZ	Pima	Tucson	10	1	3	2	-7
AR	Pulaski	Little Rock	3	4	4	0	1
DE	New Castle	Wilmington	3	1	1	0	-2
FL	Broward	Ft. Lauderdale	8	4	4	0	-4
FL	Duval	Jacksonville	4	4	4	0	0
FL	Hillsborough	Tampa	6	4	4	0	-2
FL	Miami-Dade	Miami	9	4	4	0	-5
FL	Orange	Orlando	5	3	4	1	-1
FL	Palm Beach	West Palm Beach	8	4	4	0	-4
GA	Fulton	Atlanta	4	2	3	1	-1
HI	Honolulu	Honolulu	N/A	2	2	0	N/A
IL	Cook	Chicago	6	3	3	0	-3
IN	Marion	Indianapolis	2	2	2	0	0
IA	Linn	Cedar Rapids	2	1	2	1	0
KS	Sedgwick	Wichita	3	2	2	0	-1
KS	Wyandotte	Kansas City	2	2	2	0	0
KY	Fayette	Lexington	N/A	1	2	1	N/A
KY	Jefferson	Louisville	N/A	1	2	1	N/A
LA	Orleans	New Orleans	4	3	3	0	-1
ME	Cumberland	Portland	2	2	3	1	1
MI	Wayne	Detroit	11	7	8	1	-3
MS	Jackson	Jackson	1	1	1	0	0
MO	Saint Louis	St. Louis	2	2	2	0	0
MT	Gallatin	Bozeman	3	3	3	0	0
NE	Douglas	Omaha	4	1	1	0	-3
NV	Clark	Las Vegas	N/A	2	2	0	N/A
NH	Hillsborough	Manchester	1	3	3	0	2
NJ	Essex	Newark	4	4	4	0	0
NM	Bernalillo	Albuquerque	4	4	4	0	0
NC	Guilford	Greensboro	2	1	1	0	-1
NC	Mecklenburg	Charlotte	2	1	1	0	-1
NC	Wake	Raleigh-Durham	2	2	3	1	1

ND	Cass	Fargo	3	2	3	1	0
OH	Cuyahoga	Cleveland	7	5	5	0	-2
OH	Franklin	Columbus	4	3	4	1	0
OH	Hamilton	Cincinnati	7	4	5	1	-2
OH	Montgomery	Dayton	6	3	4	1	-2
OK	Oklahoma	Oklahoma City	5	1	2	1	-3
OK	Tulsa	Tulsa	5	1	2	1	-3
OR	Multnomah	Portland	N/A	5	5	0	N/A
PA	Allegheny	Pittsburgh	5	2	2	0	-3
PA	Philadelphia	Philadelphia	4	2	3	1	-1
SC	Richland	Columbia	4	1	1	0	-3
SD	Lincoln	Sioux Falls	3	2	2	0	-1
SD	Minnehaha	Sioux Falls	3	2	2	0	-1
TN	Davidson	Nashville	4	2	3	1	-1
TN	Shelby	Memphis	4	1	4	3	0
TX	Bexar	San Antonio	5	3	3	0	-2
TX	Comal	San Antonio	4	3	3	0	-1
TX	Dallas	Dallas	4	3	3	0	-1
TX	El Paso	El Paso	3	3	4	1	1
TX	Harris	Houston	6	4	4	0	-2
TX	Hidalgo	McAllen	3	3	3	0	0
TX	Medina	San Antonio	2	2	2	0	0
TX	Travis	Austin	7	4	4	0	-3
UT	Salt Lake	Salt Lake City	6	2	3	1	-3
VA	Henrico	Richmond	4	1	2	1	-2
WV	Cabell	Huntington	1	2	2	0	1
WV	Wayne	Huntington	1	2	2	0	1
WI	Milwaukee	Milwaukee	4	3	4	1	0
WY	Laramie	Cheyenne	2	1	1	0	-1

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Numbers may not sum exactly due to rounding. Two estimates are included for HealthCare.gov states, one with all states included in a given plan year and the other including only the 35 states using HealthCare.gov across all plan years. Issuers were identified using their unique five-digit Health Insurance Oversight System (HIOS) issuer IDs within a state. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering qualified health plans through the Exchange in two states would appear to be two separate issuers. Data do not include stand-alone dental plans, child-only plans, or small business health options program (SHOP) plans. See the "Methods and Limitations" section for additional details.

Table 2A

Average Number of Qualified Health Plans (QHPs) per County and per Issuer in County by HealthCare.gov State, PY14, PY18, and PY19

State	QHPs per County (Weighted Average)					QHPs per Issuer in County (Weighted Average)				
				Change					Change	
	PY14	PY18	PY19	PY18-PY19	PY14-PY19	PY14	PY18	PY19	PY18-PY19	PY14-PY19
All States Using HealthCare.gov for the Listed Plan Year	**51**	**25**	**26**	**1**	**-25**	**12**	**10**	**9**	**0**	**-3**
AK	34	5	5	0	-29	17	5	5	0	-12
AL	7	7	7	0	0	6	6	6	0	0
AR	29	25	23	-2	-5	11	7	6	0	-5
AZ	105	5	18	13	-87	11	5	6	1	-6
DE	19	6	7	1	-12	6	6	7	1	1
FL	112	54	49	-5	-63	19	15	13	-2	-6
GA	32	16	24	8	-8	11	10	10	0	-1
HI	N/A	21	22	1	N/A	N/A	11	11	1	N/A
IA	29	5	11	6	-18	14	5	6	1	-8
ID	30	N/A	N/A	N/A	N/A	8	N/A	N/A	N/A	N/A
IL	54	21	19	-2	-35	11	9	8	-1	-3
IN	25	25	20	-5	-5	10	15	11	-4	1
KS	28	11	11	0	-17	11	5	5	0	-6
KY	N/A	11	12	1	N/A	N/A	11	8	-3	N/A
LA	39	21	24	3	-16	11	7	8	1	-3
ME	17	15	25	10	8	9	8	8	1	0
MI	41	37	39	3	-1	5	6	6	0	1
MO	19	10	14	4	-5	9	7	8	1	-1
MS	16	5	5	0	-11	11	5	5	0	-6
MT	26	16	18	2	-8	9	5	6	1	-3
NC	22	9	11	2	-11	14	8	9	2	-5
ND	24	8	21	12	-3	8	6	7	1	-1
NE	31	7	9	1	-22	9	7	9	1	0
NH	10	14	15	1	5	10	5	5	0	-5
NJ	26	19	19	1	-7	7	5	5	0	-1
NM	38	15	19	4	-19	10	4	5	1	-5
NV	N/A	12	12	0	N/A	N/A	6	6	0	N/A
OH	40	32	33	1	-7	8	10	9	-1	1
OK	47	6	12	6	-36	12	6	6	0	-6
OR	N/A	21	25	5	N/A	N/A	5	6	1	N/A
PA	35	14	16	3	-19	7	7	6	-1	-1
SC	26	23	24	1	-2	7	23	22	-1	15
SD	32	17	16	-1	-16	11	8	8	-1	-3

TN	59	6	14	8	-45	22	4	5	1	-16
TX	40	24	23	0	-17	10	8	8	0	-2
UT	76	23	33	10	-42	14	12	11	0	-3
VA	29	12	14	1	-15	8	6	6	-1	-2
WI	66	31	28	-3	-39	17	11	9	-2	-8
WV	12	15	13	-2	1	12	9	8	-1	-4
WY	16	10	10	0	-6	8	10	10	0	2

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Numbers may not sum exactly due to rounding. Numbers may not sum exactly due to rounding. Averages were weighted using MIDAS plan selections in the county for the same plan year as the plan landscape file, except PY19 for which PY18 plan selections were used. Issuers were identified using their unique five-digit Health Insurance Oversight System (HIOS) issuer IDs within a state. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS ID is specific to the state in which it operates, such that a company offering qualified health plans through the Exchange in two states would appear to be two separate issuers. Data do not include stand-alone dental plans, child-only plans, or small business health options program (SHOP) plans. See the "Methods and Limitations" section for additional details.

Table 3A

Average Monthly Premium for the Second-Lowest Cost Silver Plan (SLCSP) for a 27-Year-Old in HealthCare.gov States, PY14, PY18, and PY19

State	SLCSP Average Monthly Premium for a 27-Year-Old				
	PY14	PY18	PY19	Percent Change	
				PY18–PY19	PY14–PY19
All States Using HealthCare.gov for the Listed Plan Year	**$218**	**$412**	**$405**	**-2%**	**85%**
AK	$349	$596	$577	-3%	65%
AL	$210	$458	$448	-2%	113%
AR	$241	$298	$311	4%	29%
AZ	$164	$427	$384	-10%	134%
DE	$237	$484	$561	16%	137%
FL	$218	$383	$390	2%	79%
GA	$236	$397	$398	0%	69%
HI	N/A	$378	$416	10%	N/A
IA	$207	$585	$624	7%	201%
ID	$199	N/A	N/A	N/A	N/A
IL	$186	$401	$390	-3%	110%
IN	$270	$287	$280	-2%	4%
KS	$196	$425	$453	7%	131%
KY	N/A	$355	$378	7%	N/A
LA	$252	$390	$369	-5%	46%
ME	$266	$482	$445	-8%	67%
MI	$207	$313	$313	0%	51%
MO	$235	$432	$413	-5%	75%
MS	$313	$445	$427	-4%	36%
MT	$208	$430	$460	7%	122%
NC	$244	$514	$506	-2%	107%
ND	$233	$310	$375	21%	61%
NE	$205	$629	$686	9%	235%
NH	$237	$389	$330	-15%	39%
NJ	$265	$339	$289	-15%	9%
NM	$183	$340	$300	-12%	64%
NV	N/A	$353	$337	-4%	N/A
OH	$216	$313	$313	0%	45%
OK	$175	$540	$571	6%	227%
OR	N/A	$342	$365	7%	N/A
PA	$198	$472	$398	-16%	101%
SC	$222	$427	$454	6%	104%
SD	$234	$428	$456	6%	94%

TN	$161	$608	$448	-26%	178%
TX	$204	$358	$364	2%	79%
UT	$206	$523	$512	-2%	148%
VA	$223	$440	$455	3%	104%
WI	$246	$467	$441	-6%	79%
WV	$230	$457	$499	9%	116%
WY	$344	$709	$709	0%	106%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. The numbers in this table represent premiums before the application of advance premium tax credits. HealthCare.gov average premiums are weighted by the number of Exchange plan selections in each county. The PY14 through PY18 estimates are weight by current year plan selections and PY19 are weighted by PY18 plan selections. This analysis identifies the second-lowest cost silver plan in each county based on the portion of the premium that covers essential health benefits. Estimates include all states using the HealthCare.gov platform in the specified plan year. See the "Methods and Limitations" section for details.

Table 3B
Monthly Premium for the Second-Lowest Cost Silver Plan (SLCSP) for a 27-Year-Old in Selected Counties in HealthCare.gov States, PY14, PY18, and PY19

State	County	City in County	SLCSP Monthly Premium for a 27-Year-Old				
			PY14	PY18	PY19	Percent Change	
						PY18–PY19	PY14–PY19
AL	Jefferson	Birmingham	$211	$447	$431	-4%	104%
AK	Anchorage	Anchorage	$355	$582	$563	-3%	58%
AK	Juneau	Juneau	$334	$596	$577	-3%	73%
AZ	Maricopa	Phoenix	$161	$421	$350	-17%	117%
AZ	Pima	Tucson	$138	$297	$279	-6%	102%
AR	Pulaski	Little Rock	$251	$280	$312	1%	24%
DE	New Castle	Wilmington	$237	$484	$561	16%	137%
FL	Broward	Ft. Lauderdale	$199	$349	$363	4%	82%
FL	Duval	Jacksonville	$210	$376	$385	2%	83%
FL	Hillsborough	Tampa	$199	$360	$390	8%	96%
FL	Miami-Dade	Miami	$221	$363	$367	1%	66%
FL	Orange	Orlando	$225	$385	$388	1%	72%
FL	Palm Beach	West Palm Beach	$220	$349	$370	6%	68%
GA	Fulton	Atlanta	$205	$345	$361	4%	76%
HI	Honolulu	Honolulu	N/A	$378	$416	10%	N/A
IL	Cook	Chicago	$174	$337	$315	-7%	81%
IN	Marion	Indianapolis	$290	$301	$309	3%	7%
IA	Linn	Cedar Rapids	$209	$576	$594	3%	184%
KS	Sedgwick	Wichita	$184	$397	$434	9%	136%
KS	Wyandotte	Kansas City	$213	$468	$479	2%	125%
KY	Fayette	Lexington	N/A	$323	331	2%	N/A
KY	Jefferson	Louisville	N/A	$327	304	-7%	N/A
LA	Orleans	New Orleans	$257	$335	$315	-6%	22%
ME	Cumberland	Portland	$242	$421	$397	-6%	64%
MI	Wayne	Detroit	$184	$272	$273	0%	49%
MS	Jackson	Jackson	$332	$486	$500	3%	51%
MO	Saint Louis	St. Louis	$216	$381	$345	-9%	60%
MT	Gallatin	Bozeman	$206	$448	$484	8%	136%
NE	Douglas	Omaha	$222	$617	$673	9%	203%
NV	Clark	Las Vegas	N/A	$315	$302	-4%	N/A
NH	Hillsborough	Manchester	$237	$389	$330	-15%	39%
NJ	Essex	Newark	$264	$337	$285	-15%	8%
NM	Bernalillo	Albuquerque	$159	$329	$280	-15%	76%
NC	Guilford	Greensboro	$228	$519	$561	8%	146%

NC	Mecklenburg	Charlotte	$251	$547	$440	-20%	75%
NC	Wake	Raleigh-Durham	$222	$456	$385	-16%	74%
ND	Cass	Fargo	$222	$244	$325	33%	46%
OH	Cuyahoga	Cleveland	$204	$262	$268	2%	32%
OH	Franklin	Columbus	$207	$331	$316	-5%	52%
OH	Hamilton	Cincinnati	$196	$290	$283	-3%	45%
OH	Montgomery	Dayton	$212	$310	$283	-9%	33%
OK	Oklahoma	Oklahoma City	$165	$562	$563	0%	241%
OK	Tulsa	Tulsa	$183	$520	$520	0%	185%
OR	Multnomah	Portland	N/A	$311	$340	9%	N/A
PA	Allegheny	Pittsburgh	$139	$293	$273	-7%	96%
PA	Philadelphia	Philadelphia	$246	$521	$381	-27%	55%
SC	Richland	Columbia	$220	$461	$495	7%	125%
SD	Lincoln	Sioux Falls	$217	$327	$367	-1%	69%
SD	Minnehaha	Sioux Falls	$217	$327	$367	-1%	69%
TN	Davidson	Nashville	$154	$480	$399	-17%	158%
TN	Shelby	Memphis	$159	$671	$414	-38%	161%
TX	Bexar	San Antonio	$196	$305	$329	8%	67%
TX	Comal	San Antonio	$202	$305	$329	8%	62%
TX	Dallas	Dallas	$223	$341	$343	1%	54%
TX	El Paso	El Paso	$174	$321	$311	-3%	79%
TX	Harris	Houston	$201	$327	$322	-2%	60%
TX	Hidalgo	McAllen	$155	$270	$328	22%	112%
TX	Medina	San Antonio	$202	$360	$368	2%	82%
TX	Travis	Austin	$205	$334	$359	7%	75%
UT	Salt Lake	Salt Lake City	$197	$486	$481	-1%	145%
VA	Henrico	Richmond	$208	$395	$409	3%	97%
WV	Cabell	Huntington	$220	$392	$435	11%	98%
WV	Wayne	Huntington	$220	$392	$435	11%	98%
WI	Milwaukee	Milwaukee	$258	$466	$461	-1%	79%
WY	Laramie	Cheyenne	$324	$653	$653	0%	102%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. The premiums in this table represent premiums before the application of tax credits. This brief identifies the second-lowest cost silver plan based on the portion of the premium that covers essential health benefits. See the "Methods and Limitations" section for details.

Table 4A

Average Monthly Premium for the Lowest-Cost Plan (LCP) for a 27-Year-Old in HealthCare.gov States, PY14, PY18, and PY19

State	LCP Average Monthly Premium for a 27-Year-Old				
	PY14	PY18	PY19	Percent Change	
				PY18-PY19	PY14-PY19
All States Using HealthCare.gov for the Listed Plan Year	**$164**	**$291**	**$288**	**-1%**	**75%**
AK	$254	$443	$387	-13%	53%
AL	$163	$290	$293	1%	80%
AR	$181	$243	$262	8%	45%
AZ	$140	$326	$293	-10%	110%
DE	$203	$388	$368	-5%	82%
FL	$164	$256	$282	10%	72%
GA	$177	$335	$290	-14%	63%
HI	N/A	$275	$296	8%	N/A
IA	$147	$475	$382	-20%	159%
ID	$152	N/A	N/A	N/A	N/A
IL	$133	$284	$300	6%	125%
IN	$208	$251	$259	3%	24%
KS	$130	$305	$327	7%	151%
KY	N/A	$255	$267	5%	N/A
LA	$177	$301	$279	-7%	57%
ME	$216	$310	$307	-1%	42%
MI	$149	$204	$208	2%	40%
MO	$160	$316	$323	2%	101%
MS	$230	$380	$373	-2%	62%
MT	$165	$285	$311	9%	88%
NC	$188	$380	$341	-10%	81%
ND	$186	$246	$253	3%	36%
NE	$159	$466	$427	-8%	169%
NH	$186	$321	$248	-23%	34%
NJ	$230	$269	$233	-13%	1%
NM	$141	$222	$205	-8%	46%
NV	N/A	$269	$269	0%	N/A
OH	$175	$235	$243	3%	39%
OK	$114	$324	$296	-9%	159%
OR	N/A	$248	$265	7%	N/A
PA	$159	$299	$293	-2%	84%
SC	$174	$299	$306	2%	76%
SD	$196	$328	$337	3%	72%

TN	$119	$337	$288	-14%	143%
TX	$140	$254	$256	1%	83%
UT	$155	$285	$273	-4%	76%
VA	$157	$326	$336	3%	114%
WI	$195	$342	$307	-10%	58%
WV	$184	$385	$420	9%	128%
WY	$288	$476	$473	-1%	64%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. The numbers in this table represent premiums before the application of advance premium tax credits. HealthCare.gov average premiums are weighted by the number of Exchange plan selections in each county. The PY14 through PY18 average premiums are weighted by current year plan selections and PY19 are weighted by PY18 plan selections. This analysis identifies the lowest-cost plan in each county based on the portion of the premium that covers essential health benefits. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. Estimates include all states using the HealthCare.gov platform in the specified plan year. See the "Methods and Limitations" section for details.

Table 4B

Monthly Premium for the Lowest-Cost Plan (LCP) Monthly Premium for a 27-Year-Old in Selected Counties in HealthCare.gov States, PY14, PY18, and PY19

State	County	City in County	LCP Monthly Premium for a 27-Year-Old				
			PY14	PY18	PY19	Percent Change	
						PY18–PY19	PY14–PY19
AL	Jefferson	Birmingham	$170	$305	$268	-12%	57%
AK	Anchorage	Anchorage	$254	$432	$377	-13%	49%
AK	Juneau	Juneau	$254	$442	$388	-12%	53%
AZ	Maricopa	Phoenix	$139	$332	$273	-18%	96%
AZ	Pima	Tucson	$119	$235	$218	-7%	83%
AR	Pulaski	Little Rock	$190	$253	$262	4%	38%
DE	New Castle	Wilmington	$203	$388	$368	-5%	82%
FL	Broward	Ft. Lauderdale	$128	$234	$270	15%	111%
FL	Duval	Jacksonville	$137	$267	$282	6%	106%
FL	Hillsborough	Tampa	$167	$265	$289	9%	73%
FL	Miami-Dade	Miami	$163	$243	$273	12%	67%
FL	Orange	Orlando	$182	$258	$278	8%	53%
FL	Palm Beach	West Palm Beach	$147	$250	$275	10%	87%
GA	Fulton	Atlanta	$166	$305	$259	-15%	56%
HI	Honolulu	Honolulu	N/A	$275	$296	8%	N/A
IL	Cook	Chicago	$125	$250	$269	8%	116%
IN	Marion	Indianapolis	$233	$265	$287	8%	29%
IA	Linn	Cedar Rapids	$132	$467	$352	-25%	166%
KS	Sedgwick	Wichita	$121	$282	$307	9%	153%
KS	Wyandotte	Kansas City	$127	$339	$355	5%	179%
KY	Fayette	Lexington	N/A	$228	$245	7%	N/A
KY	Jefferson	Louisville	N/A	$231	$225	-3%	N/A
LA	Orleans	New Orleans	$170	$298	$275	-7%	62%
ME	Cumberland	Portland	$192	$276	$275	-1%	43%
MI	Wayne	Detroit	$138	$179	$184	3%	34%
MS	Jackson	Jackson	$277	$415	$437	5%	58%
MO	Saint Louis	St. Louis	$147	$231	$266	15%	81%
MT	Gallatin	Bozeman	$163	$296	$329	11%	102%
NE	Douglas	Omaha	$162	$436	$388	-11%	140%
NV	Clark	Las Vegas	N/A	$239	$239	0%	N/A
NH	Hillsborough	Manchester	$186	$321	$248	-23%	34%
NJ	Essex	Newark	$230	$264	$228	-13%	0%
NM	Bernalillo	Albuquerque	$126	$212	$197	-7%	56%
NC	Guilford	Greensboro	$167	$388	$406	5%	143%

NC	Mecklenburg	Charlotte	$183	$403	$296	-27%	61%
NC	Wake	Raleigh-Durham	$161	$347	$265	-23%	65%
ND	Cass	Fargo	$175	$208	$232	11%	32%
OH	Cuyahoga	Cleveland	$152	$200	$216	8%	42%
OH	Franklin	Columbus	$196	$237	$231	-3%	18%
OH	Hamilton	Cincinnati	$178	$224	$249	11%	40%
OH	Montgomery	Dayton	$192	$226	$242	7%	26%
OK	Oklahoma	Oklahoma City	$105	$309	$274	-11%	160%
OK	Tulsa	Tulsa	$123	$324	$307	-5%	149%
OR	Multnomah	Portland	N/A	$222	$243	9%	N/A
PA	Allegheny	Pittsburgh	$119	$199	$209	5%	75%
PA	Philadelphia	Philadelphia	$195	$329	$303	-8%	56%
SC	Richland	Columbia	$166	$323	$332	3%	101%
SD	Lincoln	Sioux Falls	$196	$284	$271	-5%	38%
SD	Minnehaha	Sioux Falls	$196	$284	$271	-5%	38%
TN	Davidson	Nashville	$114	$288	$281	-3%	147%
TN	Shelby	Memphis	$117	$358	$315	-12%	170%
TX	Bexar	San Antonio	$138	$210	$229	9%	65%
TX	Comal	San Antonio	$138	$210	$229	9%	65%
TX	Dallas	Dallas	$153	$228	$242	6%	59%
TX	El Paso	El Paso	$119	$219	$214	-2%	80%
TX	Harris	Houston	$138	$221	$235	6%	71%
TX	Hidalgo	McAllen	$109	$232	$241	4%	121%
TX	Medina	San Antonio	$138	$321	$271	-16%	96%
TX	Travis	Austin	$144	$230	$257	12%	78%
UT	Salt Lake	Salt Lake City	$143	$266	$255	-4%	78%
VA	Henrico	Richmond	$139	$269	$311	16%	123%
WV	Cabell	Huntington	$176	$336	$389	16%	121%
WV	Wayne	Huntington	$176	$336	$389	16%	121%
WI	Milwaukee	Milwaukee	$200	$356	$305	-14%	53%
WY	Laramie	Cheyenne	$271	$438	$435	-1%	61%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. The premiums in this table represent premiums before the application of tax credits. This brief identifies the second-lowest cost silver plan based on the portion of the premium that covers essential health benefits. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section for details.

Table 5A

Percentage of Enrollees Receiving Subsidies in HealthCare.gov States, PY14, PY18, and PY19

State	Percentage of Plan Selections with APTC			Percentage of Plan Selections with CSR		
	PY14	PY17	PY18	PY14	PY17	PY18
All States Using HealthCare.gov for the Listed Plan Year	**84%**	**84%**	**85%**	**60%**	**60%**	**54%**
AK	86%	88%	88%	56%	41%	39%
AL	83%	90%	89%	66%	73%	70%
AR	88%	84%	85%	58%	56%	55%
AZ	75%	79%	82%	51%	51%	49%
DE	80%	81%	82%	46%	45%	45%
FL	90%	90%	91%	69%	72%	64%
GA	85%	87%	85%	64%	69%	65%
HI	N/A	80%	79%	N/A	58%	44%
IA	82%	86%	85%	49%	52%	41%
ID	89%	N/A	N/A	66%	N/A	N/A
IL	75%	79%	82%	45%	47%	42%
IN	87%	73%	67%	55%	47%	42%
KS	77%	84%	83%	52%	55%	44%
KY	N/A	78%	75%	N/A	51%	42%
LA	87%	86%	85%	59%	55%	49%
ME	88%	86%	85%	57%	53%	46%
MI	85%	81%	82%	63%	49%	42%
MO	84%	86%	83%	57%	56%	56%
MS	93%	89%	92%	73%	76%	82%
MT	84%	84%	84%	50%	42%	33%
NC	90%	90%	90%	65%	65%	61%
ND	82%	84%	83%	36%	46%	45%
NE	85%	91%	92%	53%	55%	46%
NH	76%	63%	71%	45%	36%	39%
NJ	82%	78%	77%	52%	51%	48%
NM	77%	71%	78%	50%	46%	32%
NV	N/A	83%	82%	N/A	55%	48%
OH	83%	75%	74%	48%	45%	37%
OK	77%	89%	90%	59%	61%	65%
OR	N/A	73%	74%	N/A	39%	35%
PA	79%	80%	85%	61%	55%	43%
SC	86%	88%	89%	64%	70%	58%
SD	88%	90%	91%	62%	58%	51%
TN	77%	85%	84%	62%	57%	57%
TX	82%	83%	85%	59%	61%	57%

UT	84%	86%	88%	56%	60%	53%
VA	80%	82%	81%	55%	59%	56%
WI	89%	81%	84%	60%	51%	43%
WV	84%	84%	86%	55%	50%	47%
WY	91%	89%	91%	54%	54%	32%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Estimates based on plan selections made during the Open Enrollment Period for each specified plan year. See the "Methods and Limitations" section for details. As of October 2017, CSR payments are no longer paid to issuers; however, issuers are still required by law to offer plans with CSRs to eligible enrollees if they participate in the Exchange. See the "Methods and Limitations" section for details.

Table 6A

Average Monthly Benchmark Premiums and Advance Premium Tax Credits (APTCs) Available in HealthCare.gov States, PY18 and PY19

State	27 Year-old with a Household Income of $25,000					Family of Four with Household Income of $60,000				
	PY18		PY19		APTC % Change PY18 – PY19	PY18		PY19		APTC % Change PY18 – PY19
	Benchmark Before APTC	APTC	Benchmark Before APTC	APTC		Benchmark Before APTC	APTC	Benchmark Before APTC	APTC	
All States Using HealthCare.gov for the Listed Plan Year	**$412**	**$274**	**$405**	**$265**	**-3%**	**$1,582**	**$1,185**	**$1,554**	**$1,155**	-3%
AK	$596	$496	$577	$476	-4%	$2,307	$1,997	$2,232	$1,924	-4%
AL	$458	$321	$448	$308	-4%	$1,658	$1,265	$1,621	$1,223	-3%
AR	$298	$161	$311	$170	6%	$1,154	$762	$1,204	$803	5%
AZ	$427	$289	$384	$244	-15%	$1,653	$1,256	$1,487	$1,089	-13%
DE	$484	$346	$561	$421	22%	$1,874	$1,476	$2,172	$1,774	20%
FL	$383	$246	$390	$250	2%	$1,481	$1,088	$1,510	$1,111	2%
GA	$397	$258	$398	$258	0%	$1,538	$1,138	$1,540	$1,142	0%
HI	$378	$246	$416	$289	17%	$1,462	$1,051	$1,609	$1,223	16%
IA	$585	$448	$624	$484	8%	$2,264	$1,872	$2,412	$2,014	8%
IL	$401	$263	$390	$249	-5%	$1,550	$1,156	$1,507	$1,107	-4%
IN	$287	$141	$280	$138	-2%	$1,109	$685	$1,084	$678	-1%
KS	$425	$288	$453	$313	9%	$1,645	$1,253	$1,754	$1,356	8%
KY	$355	$206	$378	$234	13%	$1,372	$936	$1,463	$1,048	12%
LA	$390	$253	$369	$229	-9%	$1,509	$1,116	$1,429	$1,031	-8%
ME	$482	$344	$445	$305	-11%	$1,863	$1,468	$1,722	$1,324	-10%
MI	$313	$176	$313	$173	-1%	$1,210	$818	$1,212	$814	0%
MO	$432	$295	$413	$270	-8%	$1,671	$1,279	$1,596	$1,187	-7%
MS	$445	$289	$427	$287	-1%	$1,613	$1,149	$1,544	$1,146	0%
MT	$430	$293	$460	$320	9%	$1,665	$1,273	$1,779	$1,381	9%
NC	$514	$376	$506	$366	-3%	$1,987	$1,594	$1,957	$1,559	-2%
ND	$310	$173	$375	$233	35%	$1,200	$808	$1,450	$1,047	30%

NE	$629	$492	$686	$546	11%	$2,433	$2,041	$2,655	$2,257	11%
NH	$389	$252	$330	$190	-25%	$1,506	$1,113	$1,276	$878	-21%
NJ	$339	$201	$289	$149	-26%	$1,311	$917	$1,119	$720	-22%
NM	$340	$203	$300	$159	-22%	$1,316	$923	$1,160	$758	-18%
NV	$353	$215	$337	$197	-9%	$1,365	$972	$1,304	$906	-7%
OH	$313	$167	$313	$173	3%	$1,209	$785	$1,211	$811	3%
OK	$540	$403	$571	$431	7%	$2,090	$1,697	$2,210	$1,812	7%
OR	$342	$201	$365	$223	11%	$1,239	$833	$1,320	$915	10%
PA	$472	$334	$398	$257	-23%	$1,825	$1,431	$1,538	$1,139	-20%
SC	$427	$289	$454	$314	8%	$1,653	$1,257	$1,755	$1,357	8%
SD	$428	$291	$456	$316	8%	$1,657	$1,265	$1,762	$1,364	8%
TN	$608	$470	$448	$308	-35%	$2,353	$1,958	$1,732	$1,334	-32%
TX	$358	$221	$364	$223	1%	$1,387	$993	$1,408	$1,007	1%
UT	$523	$380	$512	$368	-3%	$1,689	$1,280	$1,655	$1,242	-3%
VA	$440	$302	$455	$315	4%	$1,701	$1,305	$1,760	$1,362	4%
WI	$467	$328	$441	$301	-8%	$1,808	$1,409	$1,705	$1,307	-7%
WV	$457	$311	$499	$348	12%	$1,767	$1,342	$1,928	$1,488	11%
WY	$709	$572	$709	$569	-1%	$2,744	$2,351	$2,741	$2,343	0%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY18 and PY19.

Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year 2014. Averages for premiums are weighted by the county's number of Exchange PY18 plan selections. In this example, the family of four is one 40-year-old adult, one 38-year-old adult, and two children under the age of 15. All enrollees are assumed to not be tobacco users. For households eligible for premium tax credits, after-tax-credit benchmark premiums are capped at a given percentage of household income. The maximum percent of income paid toward the benchmark plan is adjusted annually to be a measure of the difference between premium growth and income growth. If the premium of the benchmark plan falls below the maximum applicable percentage of income amount for which a household is responsible, then the household does not receive a tax credit and pays for the full premium for the plan selected. After-tax benchmark premiums will differ slightly between PY18 and PY19 for identical family compositions and income amounts because of changes in the applicable percentages and the Federal Poverty Level (FPL) Guidelines. Alaska and Hawaii's Federal poverty guidelines are higher than those for the continental United States; consequently, the after tax credit premium is lower for a given amount of income. Our calculations of premiums after tax credits assume that all members of the family of four making $60,000 would be eligible for premium tax credits. However, in states with higher Medicaid of Children's Health Insurance Program (CHIP) thresholds, the children would be eligible for Medicaid/CHIP and not eligible for premium tax credits. Starting for PY19, new regulation modified the methodology of determining the APTC amount attributable to children under 19 on an individual or family policy, in which the premium of a stand-alone dental plan is added to the premium of any plan not offering pediatric dental benefits for purposes of determining the benchmark plan and resultant APTC amount. The data presented in this table do not take this change into account. See the "Methods and Limitations" section for details.

Table 7A

Percentage of Enrollees by the Monthly Premium of the Lowest-Cost Plan (LCP) Available in the Subsequent Open Enrollment Period (OEP) in HealthCare.gov States, PY15, PY18, and PY19

State	Percentage of Enrollees by the Monthly Premium of the LCP Available											
	PY15				PY18				PY19			
	$200 or less	$201 - $300	$301 - $400	$401 or more	$200 or less	$201 - $300	$301 - $400	$401 or more	$200 or less	$201 - $300	$301 - $400	$401 or more
All States Using HealthCare.gov for the Listed Plan Year	**38%**	**28%**	**17%**	**17%**	**6%**	**25%**	**21%**	**48%**	**5%**	**23%**	**23%**	**49%**
AK	12%	0%	37%	51%	0%	0%	16%	84%	0%	12%	15%	73%
AL	36%	30%	15%	19%	8%	14%	31%	46%	8%	13%	32%	48%
AR	23%	33%	15%	28%	9%	33%	15%	44%	8%	24%	22%	46%
AZ	63%	17%	18%	2%	2%	22%	23%	53%	11%	19%	20%	50%
DE	25%	33%	16%	27%	0%	12%	15%	74%	0%	12%	18%	71%
FL	29%	33%	16%	21%	5%	32%	21%	41%	3%	23%	27%	48%
GA	39%	31%	14%	16%	0%	18%	26%	55%	4%	23%	26%	47%
HI	N/A	N/A	N/A	N/A	0%	22%	30%	49%	0%	16%	31%	53%
IA	46%	23%	18%	13%	0%	0%	6%	94%	0%	4%	17%	79%
ID	50%	20%	5%	25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IL	50%	21%	22%	6%	4%	27%	21%	48%	2%	20%	26%	52%
IN	18%	36%	13%	32%	11%	27%	18%	43%	8%	26%	20%	46%
KS	55%	17%	20%	7%	0%	23%	29%	48%	0%	16%	29%	55%
KY	N/A	N/A	N/A	N/A	11%	32%	15%	42%	7%	28%	18%	46%
LA	32%	31%	15%	22%	0%	19%	31%	49%	2%	24%	26%	48%
ME	21%	27%	16%	37%	0%	21%	23%	55%	0%	22%	23%	55%
MI	45%	22%	19%	14%	24%	30%	14%	32%	23%	29%	13%	34%
MO	37%	26%	15%	21%	6%	25%	14%	55%	3%	18%	24%	55%
MS	27%	34%	16%	23%	0%	10%	15%	76%	0%	9%	17%	75%
MT	41%	21%	16%	22%	3%	21%	28%	48%	1%	14%	32%	54%
NC	22%	38%	14%	26%	0%	9%	19%	72%	2%	15%	23%	61%

ND	36%	29%	11%	25%	26%	28%	15%	31%	23%	29%	16%	33%
NE	44%	24%	13%	19%	0%	2%	17%	80%	0%	7%	19%	74%
NH	44%	20%	23%	13%	0%	12%	29%	59%	7%	30%	14%	48%
NJ	10%	36%	16%	37%	5%	25%	24%	46%	8%	36%	14%	41%
NM	55%	26%	17%	2%	9%	33%	13%	44%	15%	30%	12%	42%
NV	N/A	N/A	N/A	N/A	10%	31%	16%	43%	10%	31%	16%	42%
OH	39%	22%	17%	22%	15%	31%	12%	42%	12%	30%	13%	45%
OK	61%	22%	16%	1%	0%	18%	30%	52%	4%	23%	27%	47%
OR	N/A	N/A	N/A	N/A	11%	30%	17%	42%	10%	26%	19%	45%
PA	39%	27%	20%	13%	4%	16%	24%	57%	2%	19%	23%	56%
SC	40%	27%	17%	17%	0%	21%	29%	50%	0%	19%	28%	53%
SD	33%	30%	13%	24%	0%	22%	28%	50%	4%	16%	27%	53%
TN	58%	23%	18%	1%	0%	13%	24%	63%	1%	22%	28%	50%
TX	48%	26%	15%	11%	9%	35%	19%	37%	7%	34%	20%	40%
UT	68%	15%	17%	0%	30%	31%	16%	23%	32%	32%	14%	22%
VA	45%	26%	16%	13%	1%	21%	25%	53%	0%	15%	29%	56%
WI	19%	32%	16%	33%	2%	13%	20%	66%	2%	17%	21%	59%
WV	14%	29%	15%	41%	0%	6%	14%	80%	0%	2%	9%	88%
WY	14%	8%	31%	48%	0%	0%	15%	85%	0%	0%	15%	85%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year. Percentages across premium categories may not sum due to rounding. For each plan year, premiums were calculated using enrollees who made a plan selection during the previous year's Open Enrollment Period (OEP). The estimates hold all enrollee characteristics unchanged and premiums are based on the same age and family composition as in the previous year. For each plan year, only enrollees who could be linked to complete plan and premium data for the current and previous plan year are included, and tobacco users are excluded. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section for more details.

Table 7B

Percentage of Enrollees by the Monthly Premium of the Lowest-Cost Plan (LCP) Available Within Metal Level in the Subsequent Open Enrollment Period (OEP) in HealthCare.gov States, PY15, PY18, and PY19

State	Percentage of Enrollees by the Monthly Premium of the LCP Available Within Metal Level											
	PY15				PY18				PY19			
	$200 or less	$201 - $300	$301 - $400	$401 or more	$200 or less	$201 - $300	$301 - $400	$401 or more	$200 or less	$201 - $300	$301 - $400	$401 or more
All States Using HealthCare.gov for the Listed Plan Year	**21%**	**31%**	**18%**	**30%**	**2%**	**12%**	**20%**	**66%**	**2%**	**13%**	**20%**	**65%**
AK	4%	6%	19%	71%	0%	0%	9%	91%	0%	8%	8%	84%
AL	16%	39%	15%	31%	1%	9%	7%	83%	1%	8%	11%	81%
AR	12%	33%	16%	39%	3%	25%	23%	49%	2%	22%	24%	51%
AZ	51%	21%	18%	10%	2%	14%	19%	65%	4%	15%	21%	61%
DE	15%	25%	20%	41%	0%	3%	13%	84%	0%	2%	11%	87%
FL	15%	33%	19%	33%	1%	10%	22%	67%	1%	10%	21%	68%
GA	18%	36%	18%	27%	0%	9%	24%	67%	1%	10%	23%	66%
HI	N/A	N/A	N/A	N/A	0%	8%	20%	72%	0%	7%	16%	77%
IA	31%	29%	15%	25%	0%	0%	3%	97%	0%	2%	8%	90%
ID	40%	25%	5%	30%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IL	32%	28%	17%	22%	1%	11%	25%	63%	1%	13%	24%	62%
IN	13%	25%	20%	41%	6%	25%	21%	48%	6%	24%	21%	49%
KS	38%	26%	16%	20%	0%	10%	19%	70%	0%	7%	18%	74%
KY	N/A	N/A	N/A	N/A	3%	20%	22%	55%	3%	18%	19%	59%
LA	12%	32%	20%	36%	0%	9%	27%	64%	1%	13%	25%	61%
ME	13%	23%	17%	47%	0%	9%	13%	78%	0%	12%	16%	72%
MI	25%	31%	15%	29%	10%	26%	19%	44%	11%	23%	20%	46%
MO	21%	33%	15%	32%	2%	12%	17%	68%	1%	11%	21%	67%
MS	10%	35%	18%	37%	0%	9%	12%	79%	0%	9%	16%	75%
MT	24%	30%	16%	30%	2%	11%	18%	69%	1%	10%	21%	69%
NC	12%	29%	21%	37%	0%	2%	11%	87%	1%	5%	13%	80%

ND	27%	24%	16%	33%	11%	30%	18%	41%	6%	23%	23%	48%
NE	25%	34%	13%	27%	0%	1%	7%	92%	0%	4%	10%	86%
NH	24%	28%	20%	28%	0%	8%	20%	73%	3%	20%	21%	55%
NJ	8%	22%	22%	47%	1%	12%	29%	58%	2%	26%	22%	50%
NM	40%	25%	21%	14%	3%	16%	22%	60%	6%	21%	19%	54%
NV	N/A	N/A	N/A	N/A	3%	23%	23%	51%	4%	25%	22%	49%
OH	22%	29%	15%	33%	8%	23%	19%	50%	7%	23%	19%	52%
OK	43%	26%	15%	16%	0%	8%	20%	72%	1%	10%	17%	71%
OR	N/A	N/A	N/A	N/A	9%	15%	22%	54%	4%	17%	20%	59%
PA	20%	35%	17%	28%	0%	8%	16%	76%	1%	8%	16%	75%
SC	18%	35%	16%	31%	0%	5%	14%	81%	0%	6%	14%	80%
SD	18%	35%	14%	33%	0%	10%	22%	68%	2%	8%	20%	70%
TN	31%	30%	17%	23%	0%	5%	11%	85%	0%	9%	17%	74%
TX	28%	34%	16%	22%	2%	19%	26%	53%	3%	18%	25%	55%
UT	48%	28%	12%	12%	8%	22%	12%	57%	14%	24%	12%	50%
VA	22%	35%	17%	27%	0%	10%	19%	71%	0%	6%	19%	75%
WI	12%	29%	17%	43%	0%	5%	13%	82%	1%	10%	17%	73%
WV	9%	23%	18%	51%	0%	3%	10%	88%	0%	1%	7%	92%
WY	5%	11%	22%	62%	0%	0%	4%	96%	0%	0%	4%	96%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year. Percentages across premium categories may not sum due to rounding. For each plan year, premiums were calculated using enrollees who made a plan selection during the previous year's Open Enrollment Period. The estimates hold all enrollee characteristics unchanged and premiums are based on the same age and family composition as in the previous year. For each plan year, only enrollees who could be linked to complete plan and premium data for the current and previous plan year are included, and tobacco users are excluded. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section for more details.

Table 8A

Percentage of Enrollees by the Portion of the Monthly Premium Paid by the Enrollee for the Lowest-Cost Plan (LCP) Available in the Subsequent Open Enrollment Period (OEP) in HealthCare.gov States, PY15, PY18, and PY19

State	Percentage of Enrollees by the Portion of the Monthly Premium Paid by the Enrollee for the LCP Available											
	PY15				PY18				PY19			
	$75 or less	$76 - $150	$151 - $200	$201 or more	$75 or less	$76 - $150	$151 - $200	$201 or more	$75 or less	$76 - $150	$151 - $200	$201 or more
All States Using HealthCare.gov for the Listed Plan Year	**72%**	**13%**	**6%**	**8%**	**80%**	**6%**	**3%**	**11%**	**79%**	**6%**	**3%**	**12%**
AK	78%	6%	4%	12%	68%	13%	4%	15%	82%	6%	2%	11%
AL	72%	11%	8%	9%	92%	2%	1%	5%	91%	3%	2%	5%
AR	70%	15%	5%	10%	67%	16%	5%	13%	62%	17%	6%	14%
AZ	59%	26%	7%	8%	65%	12%	4%	20%	70%	10%	5%	15%
DE	61%	19%	6%	15%	66%	13%	3%	18%	83%	2%	1%	14%
FL	81%	9%	4%	7%	90%	2%	1%	6%	89%	3%	1%	7%
GA	76%	11%	6%	7%	78%	9%	2%	11%	82%	5%	2%	10%
HI	N/A	N/A	N/A	N/A	69%	9%	3%	18%	71%	7%	3%	19%
IA	61%	22%	8%	8%	100%	0%	0%	0%	87%	2%	0%	11%
ID	70%	25%	5%	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IL	57%	22%	12%	9%	73%	7%	3%	16%	66%	11%	5%	18%
IN	71%	14%	4%	11%	40%	22%	11%	27%	32%	21%	11%	36%
KS	63%	19%	10%	8%	81%	6%	1%	12%	75%	7%	2%	15%
KY	N/A	N/A	N/A	N/A	68%	9%	6%	17%	67%	8%	5%	20%
LA	80%	8%	5%	7%	74%	10%	3%	13%	73%	10%	4%	13%
ME	71%	14%	5%	10%	87%	2%	0%	10%	80%	5%	2%	13%
MI	74%	13%	7%	6%	80%	7%	4%	9%	77%	9%	4%	10%
MO	74%	11%	7%	8%	80%	6%	3%	11%	70%	9%	4%	16%
MS	85%	7%	3%	5%	82%	7%	2%	9%	77%	11%	4%	8%
MT	57%	20%	12%	10%	79%	6%	2%	12%	79%	6%	2%	13%
NC	81%	9%	3%	7%	87%	5%	1%	7%	91%	3%	1%	5%

ND	61%	21%	6%	12%	59%	21%	8%	12%	81%	7%	3%	8%
NE	72%	13%	7%	8%	88%	5%	1%	7%	93%	1%	0%	5%
NH	57%	18%	11%	14%	51%	13%	4%	32%	54%	12%	8%	26%
NJ	53%	21%	7%	20%	61%	13%	6%	19%	56%	14%	9%	21%
NM	59%	26%	8%	7%	72%	5%	5%	18%	69%	9%	5%	16%
NV	N/A	N/A	N/A	N/A	77%	9%	3%	11%	67%	12%	5%	15%
OH	64%	17%	9%	10%	62%	13%	7%	19%	56%	13%	8%	23%
OK	74%	16%	5%	6%	91%	1%	0%	8%	93%	1%	1%	5%
OR	N/A	N/A	N/A	N/A	60%	15%	5%	20%	60%	15%	5%	20%
PA	63%	17%	9%	11%	80%	4%	2%	15%	70%	10%	4%	16%
SC	78%	9%	6%	7%	88%	3%	1%	8%	90%	3%	1%	7%
SD	66%	18%	7%	9%	76%	13%	3%	8%	84%	8%	2%	6%
TN	74%	15%	5%	6%	88%	1%	0%	11%	79%	5%	2%	14%
TX	73%	12%	8%	7%	81%	5%	3%	11%	83%	5%	3%	10%
UT	71%	17%	8%	4%	89%	1%	3%	7%	90%	3%	2%	6%
VA	74%	10%	8%	8%	80%	5%	1%	14%	78%	4%	1%	16%
WI	71%	14%	5%	9%	77%	6%	2%	15%	76%	6%	3%	14%
WV	62%	17%	6%	15%	59%	16%	6%	19%	61%	15%	6%	19%
WY	68%	16%	5%	11%	90%	1%	0%	8%	90%	2%	1%	7%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year. Percentages across premium categories may not sum due to rounding. For each plan year, premiums after subsidy were calculated using enrollees who made a plan selection during the previous year's Open Enrollment Period. This analysis holds all enrollee characteristics unchanged and calculates premiums and tax credits based on the same age, family composition, and household income as in the previous year. For each plan year, this analysis includes only enrollees who could be linked to complete plan and premium data for the current and previous plan year, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section for more details.

Table 8B

Percentage of Enrollees by the Portion of the Monthly Premium Paid by the Enrollee for the Lowest-Cost Plan (LCP) Available Within Metal Level in the Subsequent Open Enrollment Period (OEP) in HealthCare.gov States, PY15, PY18, and PY19

State	Percentage of Enrollees by the Portion of the Monthly Premium Paid by the Enrollee for the LCP Available Within Metal											
	PY15				PY18				PY19			
	$75 or less	$76 - $150	$151 - $200	$201 or more	$75 or less	$76 - $150	$151 - $200	$201 or more	$75 or less	$76 - $150	$151 - $200	$201 or more
All States Using HealthCare.gov for the Listed Plan Year	**56%**	**20%**	**8%**	**16%**	**60%**	**18%**	**6%**	**17%**	**63%**	**15%**	**5%**	**17%**
AK	64%	12%	5%	19%	48%	21%	8%	23%	54%	20%	8%	18%
AL	55%	19%	8%	18%	72%	13%	5%	11%	71%	12%	5%	13%
AR	44%	28%	9%	19%	49%	26%	8%	17%	45%	26%	9%	20%
AZ	47%	25%	9%	19%	43%	23%	8%	26%	47%	22%	8%	23%
DE	32%	27%	10%	31%	39%	24%	8%	28%	47%	20%	8%	25%
FL	67%	15%	6%	13%	72%	14%	3%	10%	79%	10%	3%	9%
GA	59%	17%	7%	17%	66%	17%	4%	13%	67%	13%	4%	15%
HI	N/A	N/A	N/A	N/A	40%	21%	9%	30%	49%	17%	6%	28%
IA	43%	29%	12%	17%	38%	28%	10%	24%	76%	7%	2%	14%
ID	65%	20%	5%	10%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IL	40%	28%	12%	20%	49%	20%	7%	24%	50%	19%	7%	24%
IN	53%	22%	7%	17%	27%	28%	12%	33%	25%	24%	11%	40%
KS	51%	22%	10%	17%	54%	21%	6%	18%	63%	15%	5%	18%
KY	N/A	N/A	N/A	N/A	34%	28%	10%	28%	45%	19%	8%	28%
LA	63%	15%	7%	14%	57%	19%	6%	18%	57%	18%	6%	19%
ME	52%	21%	8%	19%	59%	18%	6%	17%	60%	16%	5%	19%
MI	55%	22%	8%	15%	56%	20%	7%	16%	53%	21%	8%	18%
MO	59%	18%	8%	15%	66%	14%	5%	15%	58%	16%	6%	20%
MS	66%	17%	6%	12%	79%	9%	2%	9%	85%	6%	2%	7%
MT	45%	24%	11%	21%	58%	17%	6%	18%	65%	14%	5%	17%
NC	63%	18%	6%	13%	60%	19%	7%	13%	73%	13%	4%	10%

ND	32%	31%	12%	25%	32%	32%	12%	25%	49%	24%	8%	19%
NE	57%	22%	8%	14%	65%	17%	6%	12%	83%	8%	2%	7%
NH	43%	20%	11%	26%	34%	20%	7%	39%	38%	18%	10%	34%
NJ	35%	24%	10%	31%	36%	24%	9%	31%	36%	23%	10%	31%
NM	38%	33%	13%	16%	41%	22%	9%	29%	44%	22%	10%	25%
NV	N/A	N/A	N/A	N/A	54%	23%	6%	17%	52%	22%	7%	19%
OH	42%	27%	10%	21%	37%	27%	9%	27%	38%	22%	9%	30%
OK	60%	20%	8%	13%	84%	6%	2%	9%	90%	3%	1%	6%
OR	N/A	N/A	N/A	N/A	34%	24%	11%	31%	35%	23%	9%	33%
PA	47%	21%	9%	23%	55%	16%	6%	23%	37%	22%	10%	32%
SC	62%	18%	7%	14%	51%	25%	7%	17%	64%	18%	5%	13%
SD	48%	24%	8%	19%	50%	26%	9%	15%	61%	20%	6%	12%
TN	56%	20%	8%	16%	80%	5%	1%	13%	56%	16%	6%	23%
TX	59%	20%	8%	14%	63%	17%	5%	16%	72%	11%	4%	13%
UT	53%	27%	8%	12%	67%	16%	5%	12%	73%	14%	4%	9%
VA	56%	19%	8%	17%	60%	18%	4%	18%	64%	13%	4%	20%
WI	56%	20%	8%	17%	56%	16%	6%	21%	60%	14%	6%	20%
WV	41%	23%	9%	26%	34%	26%	10%	31%	39%	25%	9%	27%
WY	47%	24%	9%	21%	51%	23%	8%	18%	72%	13%	4%	11%

Source: Plan information is from the plan landscape files and active plan selections in the Centers for Medicare and Medicaid (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the HealthCare.gov platform between PY14 and PY19.
Note: PY stands for plan year and is followed by the last two digits of the year of Exchange plan coverage, e.g. PY14 = plan year. Percentages across premium categories may not sum due to rounding. For each plan year, premiums after subsidy were calculated using enrollees who made a plan selection during the previous year's Open Enrollment Period. This analysis holds all enrollee characteristics unchanged and calculates premiums and tax credits based on the same age, family composition, and household income as in the previous year. For each plan year, this analysis includes only enrollees who could be linked to complete plan and premium data for the current and previous plan year, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section for more details.

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ACA Reduces Racial/Ethnic Disparities in Health Coverage Rates in California

Findings from the 2017 California Health Interview Survey

OCTOBER 31, 2018

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SHARE

Under the Affordable Care Act (ACA) millions of Californians have gained health coverage. With new data from the 2017 California Health Interview Survey (CHIS), this issue brief examines trends in coverage rates among nonelderly (under age 65) Californians from 2013, the year prior to full ACA implementation, through 2017.

Of particular note is how the ACA has narrowed disparities in coverage rates between different racial and ethnic groups. In 2017 there continued to be no statistically significant difference in the nonelderly uninsured rate between white, African-American, and Asian/Pacific Islander Californians — a major shift since 2013. However, Latinos continued to experience a higher uninsured rate than other groups.

Other key findings include:

- The 2017 uninsured rate in California, at 8.5%, remained stable — and nearly 50% lower than it was in 2013, before the ACA was fully implemented.
- In 2017 enrollment in Medi-Cal declined compared to 2016, but this was offset by an increase in private coverage.
- Coverage gains under the ACA were maintained in most regions of the state, but variation across regions continued.
- Coverage gains under the ACA were maintained for low- and moderate-income Californians.

While federal uncertainty over the future of the ACA permeated throughout 2017, the timing of both Covered California open enrollment and the fielding of the CHIS survey mean that 2018 CHIS data may better capture any effects these events had on coverage and enrollment.

Below are data visualizations for a few key findings. See the full issue brief, ***ACA Reduces Racial/Ethnic Disparities in Health Coverage*** (PDF) </wp-content/uploads/2018/10/acareducesdisparities.pdf>, available for download under Related Materials, for the complete data and analysis.

A note on methodology: In keeping with previous CHIS analyses, all Californians reporting Medi-Cal coverage are considered covered by Medi-Cal. This includes undocumented adults who are not eligible for full-scope Medi-Cal but may have used restricted-scope Medi-Cal. Restricted-scope Medi-Cal is not comprehensive coverage, covering only emergency and pregnancy-related services. When

asked by survey researchers about health coverage, some undocumented immigrants who have used restricted-scope Medi-Cal may respond that they have Medi-Cal coverage. If undocumented immigrants reporting Medi-Cal were considered uninsured, the number of Californians who are uninsured would be higher, as would the number of uninsured among some demographic groups, such as Latinos. (Download the full issue brief to read more about the methodology.)

Related Materials

ACA Reduces Racial/Ethnic Disparities in Health Coverage (PDF) <https://www.chcf.org/wp-content/uploads/2018/10/acareducesdisparities.pdf>

Related Tags: CHCF Goal: Improving Access to Coverage and Care, **Health Data**, **Individual Market**, **Insurance Coverage** <https://www.chcf.org/topic/insurance-coverage/>, **Medicaid**, **Uninsured**

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How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums

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Issue Brief

In health insurance systems designed to protect people with pre-existing conditions and guarantee availability of coverage regardless of health status, countervailing measures are also needed to ensure people do not wait until they are sick to sign up for coverage (as doing so would drive up average costs for other enrollees). The Affordable Care Act (ACA) included a variety of "carrots" (e.g., premium tax credits and cost-sharing reductions) and "sticks" (e.g., the individual mandate penalty and limited enrollment opportunities) to encourage healthy as well as sick people to enroll in health insurance coverage.

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r still if not for several key policy and legislative changes.

till+if+not+for+several+key+policy+and+legislative+changes.+&url=https%3A%2F%2Fwww.kff.org%2Fcdd3526%2F)

Despite the enduring popularity (https:// kff.org/health-reform/poll-finding/kaiser-health-tracking-pol late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/) of the ACA's protections for people with pre-existing conditions, the individual mandate – which requires most people to maintain health insurance coverage or else pay a penalty – has consistently been viewed (https:// kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2017-the-role-of-health-care-in-the-republican-tax-plan/) negatively by a substantial share of the public. After broader attempts to repeal and replace the ACA stalled out in the summer of 2017, Congress reduced the individual mandate penalty to $0 effective in 2019 as part of tax reform legislatio passed last December.

Soon thereafter, the Trump administration also announced new rules that will allow more loosely regulated plans – short-term limited duration (STLD) plans and association health plans (AHPs) – to proliferate on the individual market in competition with ACA-compliant coverage. These more loosely regulated plans will serve as a more affordable option for some people who are not eligible for the ACA's premium tax credits. However, particularly in the case of short-term plans, this lower-cost coverage is generally unavailable to people with pre-existing conditions and the plans often exclude coverage (https://w kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/) for certain services. STLD plans do not meet the ACA's requirement to maintain coverage, but, because the penalty for going without coverage will soon be $0, the attractiveness of STLD coverage will grow for healthy people. These plans will attract disproportionately healthy individuals away from ACA-compliant coverage, thus having an upward effect on premiums in the ACA-compliant individual market.

With the effective repeal of the individual mandate penalty and the expansion of short term and association health plans, we set out to quantify how much of an upward effect these policy and legislative changes are having on 2019 premiums. Among insurers that publicly specify the effect of these legislative and policy changes in their filings to state insurance commissioners, we found that 2019 premiums will be an average of 6% higher, as a direct result of individual mandate repeal and expansion of more loosely regulated plans, than would otherwise be the case.

Adding the impact from the loss of cost-sharing reduction payments – which drove up silver premiums by an average of 10% according to the Congressional Budget Office – to the impact from individual mandate penalty repeal and expansion of more loosely regulated plans, this analysis suggests on-exchange benchmark silver premiums will be about 16% higher in 2019 than would otherwise be the case.

A separate analysis (https://w kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/?preview_id=258035) finds that 2019 premiums on the whole are staying relatively flat or dropping in many parts of the country, in large part because insurers are currently overpriced (https://w kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2018/). Nonetheless, this analysis finds that 2019 premiums would be dropping even more if the individual mandate penalty were still in full effect.

Analyzing Insurer Rate Filings

Each year, insurers submit rate filings to state regulators justifying their premium changes for the upcoming year. These filings include varying amounts of detail, depending on the state and insurer, and sections of the publicly available filings are often redacted. Insurers sometimes do not include much detail in the public filings, and do not always explicitly mention the effect policy changes will have on rates.

We reviewed all publicly available filings insurers across the United States submitted to state regulators detailing their justifications for rate changes in the ACA-compliant individual market, both on- and off-exchange. While many insurers identify the repeal of the individual mandate penalty and/or the expansion of STLD/AHP plans as factors that will have an upward effect on 2019 premiums, not all companies quantify the amount by which rates will increase specifically due to these changes, and others redact this information from their publicly available filings. Additionally, some companies group together the upward effect of the individual mandate penalty repeal with the expansion of short-term and association plans, while other companies report these effects separately or only publicly quantify the effects of one of these changes.

We exclude from this analysis states that have implemented their own individual mandates (Massachusetts, New Jersey, and Washington, DC) or, in the case of New York, prohibited insurers from loading an individual mandate surcharge into 2019 premiums.

Among insurers that publicly quantify a rate impact from legislative and regulatory changes – effective repeal of the individual mandate penalty and/or expansion of more loosely regulated plans – the upward effect on 2019 premiums ranges from 0% to 16%. Among these insurers, the average rate increase in 2019 due to the individual mandate penalty repeal and expansion of more loosely regulated plans is 6%. Most 2019 rate impacts due to these legislative and policy changes fall between 4% and 8% (the 25th and 75th percentiles).

Table 3 in the Appendix (https:// kff.org/report-section/) shows rate increases by state and insurer among companies that publicly quantified the amount by which premiums will increase due to these legislative and policy changes in either 2018 or 2019.

In many cases, these rate increases come on the heels of similar assumptions made going into 2018 that the individual mandate would be repealed or weakly enforced (as insurers had to finalize 2018 rates before a decision had been made in Congress to effectively repeal the individual mandate). In setting rates for 2018, some insurers assumed either repeal, reduced enforcement, or public perception of reduced enforcement of the individual mandate would lead to a sicker risk pool in 2018 and priced accordingly. In 2018, among insurers that publicly quantified an impact of uncertainty about the individual mandate, companies incorporated a premium increase of 0% to 25%. Among these insurers, the average rate increase due to individual mandate uncertainty in 2018 was 5% and most fell between 2% and 6% (the 25th and 75th percentiles).

A number of insurers factored in rate impacts due to individual mandate uncertainty in 2018 and individual mandate penalty repeal in 2019. In many of these cases, though, the 2019 load appears to supersede the 2018 load and the two are not cumulative. There may be some cases when the 2019 individual mandate load is in addition to the 2018 load, but we assume the values in 2019 and 2018 are never cumulative, which is the more conservative approach.

Table 1: Range of Premium Impacts from Individual Mandate Uncertainty/Repeal in 2018 and 2019

Year of filings	Min	5th Percentile	Average	75th Percentile	Max
2019	0%	4%	%	%	16%
2018	0%	%	%	%	25%

NOTE: In some cases, the effect due to the individual mandate also includes the expansion STLD/AHPs, reduced outreach, o other legislative uncertainty.

SOURCE: Kaiser Family Foundation analysis of insurer rate filings to state regulators, state insurance regulators, and ratereview.healthcare.gov.

The upward effect on 2019 premiums due to the effective repeal of the individual mandate and expansion of more loosely regulated plans is in addition to other significant rate increase due to the Trump administration's decision to halt cost-sharing reduction subsidy payments (https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/). This decision, the Congressional Budget Office (https:// cbo.gov/system/files?file=115th-congress-2017-2018/reports/53664-costsharingreduction.pdf) estimates, is responsible for a 10% increase in 2018 on-exchange silver premiums.[1] Altogether, on-exchange silver premium in 2019 are therefore approximately 16% higher than would otherwise be the case if federal CSR payments had continued (the loss of which contributed approximately 10% to silver exchange premiums), the individual mandate penalty were still enforced, and more loosely-regulated plans were not expanding (the latter changes contributed an additional 6% to 2019 rates).[2]

Many states allowed insurers to load the loss of CSR payments onto silver premiums and m ny insurers only added that cost to plans offered on the marketplace in 2018. Therefore, ir most states, the effect of the loss of CSR payments was considerably smaller for bronze and gold plans offered off-exchange than for silver plans offered on-exchange. Because premium tax credits on the exchanges are tied to the cost of silver premiums, the effect of the loss of CSR payments was cushioned for many enrollees on-exchange. The impact of the individual mandate penalty repeal and expansion of more loosely regulated plans, however, is concentrated primarily off-exchange, where enrollees do not receive a subsidy to offset increases.

Table 2: Premium Impacts from Legislative and Policy Changes to the ACA

Legislative or Policy Change	Average percent by which 2019 unsubsidized premiums are higher than would be the case without change
• Individual mandate penalty repeal • Expansion of AHP / STLD plans	6% (all premiums on/off exchange)
• Loss of CSR payments	10% (silver exchange premiums)*
Combined Impact: • Individual mandate penalty repeal • Loss of CSR payments • Expansion of AHP / STLD plans	16% (silver exchange premiums)*

SOURCE: Kaiser Family Foundation analysis of insurer rate filings to state regulators, state insurance regulators, and ratereview.healthcare.gov. Premium impact due to CSR loss is from Congressional Budget Office (CBO) estimate.

NOTES: Premium changes represent the change in premiums before accounting for the premium tax credit. How each premium impact relates to other impacts depends on how each insurer calculates rate impacts. We conservatively assume the rates are additive (6% + 10% = 16%), as opposed to multiplicative (1.06 x 1.1 = 1.166, or 16.6%). *The CBO estimate of the loss of CSR payments' effect was specifically for silver exchange premiums. However, some insurers also applied a CSR load onto other metal levels and/or off-exchange premiums.

Going into 2018, insurers on average likely increased rates more than was necessary. As of mid-2018, insurers in the individual market are doing quite well financially on average (https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-mid-2018/), so many are unable to justify another year of premium increases going into 2019. Therefore, despite repeal of the individual mandate penalty and expansion of more loosely regulated plans in 2019, premiums in much of the country are holding flat or decreasing (https://www.kff.org/private-insurance/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/?preview_id=258035) relative to 2018. In states that use healthcare.gov, unsubsidized benchmark premiums are dropping (https://cms.gov/sites/drupal/files/2018-10/10-11-18%20Average%20Monthly%20Premiums%20for%20SLCSP%20and%20LCP%202016-2019.pdf) an average of 1.5% next year, from $502 per month for a 40-year-old in 2018, to $495 in 2019.

Our analysis therefore suggests the average healthcare.gov benchmark silver premium for a 40-year-old would be approximately $427 per month (instead of $495) in 2019, if it were not for the repeal of the individual mandate penalty, expansion of short-term plans, and loss of

cost-sharing subsidy payments.[3]

Discussion

Exchange premiums will be moderating in 2019, as many insurers are currently profitable after overshooting with 2018 rates. Benchmark silver premiums in states that use Healthcare.gov will be an average of 1.5% lower in 2019 than they were in 2018, which will likely come as welcomed news to people who are ineligible for subsidies and paying full-price for coverage in the individual market in states where there is a decrease. However, a number of middle and upper-middle income individuals and families have already been priced out (https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/) of the market and a small decrease in premiums may not be enough to bring them back.

Among insurers that publicly specify the effect of these legislative and policy changes, we found that 2019 premiums will be an average of 6% higher, as a direct result of individual mandate penalty repeal and expansion of more loosely regulated plans, than would otherwise be the case. Combined with estimates from the Congressional Budget Office, our analysis suggests the elimination of the cost-sharing subsidy and individual mandate penalty, as well as expansion of more loosely regulated plans, has caused on-exchange silver premiums to be 16% higher than would otherwise be the case. Instead of 2019 benchmark silver premiums on healthcare.gov averaging $495 per month for a 40-year-old, as was recently reported by HHS, we estimate the premium would be approximately $427 in the absence of individual mandate penalty repeal, expansion of more loosely regulated plans, and the loss of cost-sharing subsidy payments.

From a consumer perspective, the rate impact from these policy and legislative changes has played out differently for subsidized on-exchange consumers than for unsubsidized off-exchange consumers. Heading into 2018, off-exchange consumers generally experienced the 5% rate impact from uncertainty around the individual mandate enforcement, but many were able to avoid the steeper premium increases due to the loss of cost-sharing subsidy payments as insurers in many states were able to load this cost onto only silver plans, and/or only exchange plans. In some cases, on-exchange consumers in 2018 may have ended up paying less because of the loss of CSR payments, because of larger subsidies due to silver loading.

Looking ahead to 2019, premiums in much of the country are holding flat or decreasing a bit, but unsubsidized off-exchange consumers on average will nonetheless pay an average of 6% more than they otherwise would have, if it were not for repeal of the individual mandate and expansion of more loosely regulated plans. On the exchange, meanwhile, subsidized customers will continue to pay sliding-scale premiums based largely on their incomes, and so the amount of premium they pay is mostly unaffected by the repeal of the individual mandate and expansion of short-term plans.

Methods

Data were collected from publicly available health insurer rate filing submitted to state regulators for ACA-compliant coverage offered on- and off-exchange. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that include a base rate and other factors that build up to an individual rate. For some states where approved filings were unavailable, we gathered data from preliminary information released by state insurance departments and healthcare.gov. We did not group subsidiaries by parent company as some subsidiaries within a given state made differing assumptions.

We exclude insurers where the individual mandate penalty was not specified in the public rate filings. We assigned these insurers a value of "NA," meaning the company (1) did not mention the individual mandate, STLD, or AHPs at all; (2) mentioned an impact but did not quantify the amount; or (3) quantified the rate impact but redacted the amount from public filings. In some cases, we assigned a value of "NA" when it was clear the insurer requested a rate impact but it was unclear whether the state allowed that load, or if the insurer built in the load elsewhere in their rate calculations. A value of "0%" means the insurer did publicly quantify the impact and specified that it was 0%.

We exclude from this analysis states that have implemented their own individual mandates (Massachusetts, New Jersey, and Washington, DC) or, in the case of New York, prohibited insurers from loading an individual mandate surcharge into 2019 premiums.

Appendix

Table 3: Impact of Individual Mandate Penalty Repeal and Other Legislative and Regulatory Changes on Premiums, by State and Insurer, 2018 and 2019

State	Insurer	Overall 2018-2019 Rate Change	2018 Rate Impact of Individual Mandate (IM) Uncertainty	2019 Rate Impact of IM Penalty Repeal (Impact of other legislative and regulatory changes, if noted)
AZ	BCB		4	0% (IM; STLD)
AZ	Bright Healt	A – 2019 entran	A – 2019 entrant	4% (IM; STLD/AHPs; "other legislative uncertainty")
AZ	Health Ne	-6	A	2%
AZ	Osca	A – 2019 entran	A – 2019 entrant	5-10% (IM; "other potential reforms")
CA	Anthem B	4		% (Primarily IM)
CA	Blue Shield C	0		%
CA	Chinese Community	%	A	2%
CA	Health Ne			%
CA	Kaise	9	0%	%
CA	L.A. Care	%	A	5%
CA	Molin	2	0	%
CA	Oscar	7%	%	%
CA	Sharp	0	A	5%
CA	Sutter	15	0	0%
CA	Valle	-1%		%
CA	Western Hlth Advntg		0%	%
CO	Bright Healt			6% (5% IM; <1% STLD)
CO	Cign		A	12% (IM; STLD/AHPs)
CO	Denver Healt	2	A	5%
CO	Friday Health Plans	%	0%	4%
CO	Kaise		A	~7% (6% IM; 1.3% STLD)
CO	Rocky Mountain H O	6		0%
CT	Anthem Blue Cros	-3	A	5% (IM; STLD/AHPs)
CT	ConnectiCar			1% (0.5% IM; 0.5% STLD)
CT	ConnectiCare Ben	4		1% (0.5% IM; 0.5% STLD)
CT	ConnectiCare Ins			1% (0.5% IM; 0.5% STLD)
FL	olina	-2%	%	%
IL	ealth Alliance	%	%	8% (2.5% IM; 5% STLD)

I	areSource Indiana	%	A	5%
MD	CareFirst Blue Choice	17%	%	%
MD	CareFirst CFMI	-11%	A	0%
MD	CareFirst GHMSI	11%	A	0%
MD	Kaiser	7%	A	9% (Primarily IM)
ME	Anthem	4%	%	5% (IM; "sustainability of the ACA marketplace")
ME	Community Hlth Opt.	%	3%	10% (5% IM; 5% STLD)
ME	Harvard Pilgrim	%	4%	4%
MI	Alliance	%	A	5% (IM; STLD)
MI	Blue Care Network	%	%	%
MI	BCBS	4%	%	%
MI	Meridian	%	A	2%
MI	Molina	%	0%	7%
MI	Total Health Care	%	A	5% (IM; "other market-wide changes")
MN	Group Health	7%	A	~9% (5-8% IM; 1.5-4% STLD/AHPs
MN	Medica	12%	A	3%
MN	PreferredOne	11%	A	0%
MN	UCare	10%	A	5%
MO	Medica	A – 2019 entrant	A – 2019 entrant	%
MT	Montana Health Coop.	0%	%	6%
MT	PacificSource	%	A	7%
NC	BCBS	4%	A	4%
NE	Medica	%	%	7% (IM; STLD/AHPs)
NM	Christus	4%	%	% (IM; reduced outreach)
NM	HCSC	%	A	6%
NM	Molina	6%	%	%
NV	Health Plan of Nevada	%	A	10%
NV	Sierra	2%	A	10%
OH	AultCare	%	A	~16% (13% IM; 2% STLD; 0.9% AHPs)
OH	CareSource	7%	A	5%
OH	Medical Health Ins. Co	%	A	4% (IM; STLD)
OH	Molina	%	%	%

OH	Paramount	%	NA	7% (IM; STLD/AHPs)
OR	BridgeSpan	5%	5%	% (IM; STLD/AHPs)
OR	Health Ne	10		% (IM; STLD/AHPs)
OR	Kaise			% (IM; STLD/AHPs)
OR	Mod			% (IM; STLD/AHPs)
OR	PacificSourc	10		5% (IM; STLD/AHPs)
OR	Providenc	10	5	% (IM; STLD/AHPs)
OR	Regence BCB	0	5	% (IM; STLD/AHPs)
PA	Cap. Adv. Assuranc	21		%
PA	Cap. Adv. Insurance	43%	%	%
PA	First Priority Health	1		%
PA	First Priority Life	7	6	%
PA	Geisinger Health Pla	0%	%	%
PA	Geisinger Quality Opt.			%
PA	Highmar			%
PA	Highmark Choice	%	%	%
PA	Highmark Select Res.	0%		%
PA	Highmark Health In	7	6	%
PA	Keystone, Central	7	%	%
PA	Keystone, Eas	-2	6	%
PA	PA Health & Wellnes	NA – 2019 entran	NA – 2019 entran	%
PA	QC	6	NA	6%
PA	UPMC Health Cov.	12%	%	%
PA	UPMC Health Opt.		%	%
RI	BCB	8	NA	0%
RI	Neighborhoo	%	NA	2%
SC	BlueChoic	7%	6	NA
SC	BCBS	Unknown	6	NA
SD	Aver	3	5%	5%
SD	Sanford	10	NA	3%
TN	BCBS	15%	7%	1%
TN	right Healt	NA – 2019 entran	NA – 2019 entrant	4% (IM; STLD/AHPs; “other legislative uncertainty”)
TN	elti	NA – 2019 entran	NA – 2019 entran	5%

T	igna	-13%	4% (IM; non-compliant)	A
TN	scar Insurance	7%	%	5-10%
TX	Christus	%	15% (IM; reduced outreach)	0%
TX	Molin	7		%
TX	Sender	6%	A	10%
TX	Vista360health	6	NA	2%
UT	Molina Healthcare	23	%	0%
VA	CareFirst BlueChoic	5		5% (IM; STLD/AHPs)
VA	Cign	1	A	12% (IM; STLD/AHPs)
VA	GHMS	45		5% (IM; STLD/AHPs)
VA	Kaiser	4%	A	8%
VA	Optima	-7	5	5% (IM; STLD/AHPs)
VA	Piedmont	2	%	~12% (11.4% primarily IM; 0.8% STLD/AHPs)
VT	BCB		NA	2%
VT	MV	7%	A	2%
WA	Asuris	6	5	A
WA	BridgeSpa	%	5%	A
WA	Coordinated Car	4		5% (IM; STLD/AHPs)
WA	Health Allianc	7		A
WA	Kaiser, NW	14%	%	A
WA	Kaiser, WA	19	4	%
WA	LifeWise	7%	6	A
WA	Molin	7	5%	A
WA	Premera BC	2	4	A
WA	Regence BCB	%	5%	A
WA	Regence BS	3	5	A
WI	Aspirus Aris	Unknown	NA	4%
WI	Group Healt	Unknown	3	7% (IM; STLD/AHPs)
WI	Molina	-18%	7%	1%
WI	Network Health Pla	Unknown	NA	10% (IM; AHPs)
WV	CareSource	3	A	5%
Averag			**5%**	**%**

NOTES: Rate impacts are rounded to the nearest percent. "IM" refers to the uncertainty about and/or repeal of the individua mandate penalty. "STLD" refers to Short Term Limited Duration plans. "AHPs" refer to Association Health Plans. "NA" means an insurer did not publicly quantify a rate impact, including instances where insurers did not mention the individual mandate, STLD, or AHPs at all; mentioned an impact of these factors but did not explicitly quantify the rate impact; or quantified the rate impact but redacted the amount from public filings. A value of "0%" means the insurer did publicly quantify the impact and specified that it was 0%. Excludes data for DC, Massachusetts, and New Jersey, which have state-enforced individual mandates, and New York, which prohibited insurers from raising rates due to the individual mandate penalty repeal.

SOURCE: Kaiser Family Foundation analysis of insurer rate filings to state regulators and ratereview.healthcare.gov

Endnotes

Issue Brief

1. The CBO expects this amount to increase to 20% by 2021. We conservatively assume the 2019 impact remains at 10%.

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2. How these premium increases (due to CSR payments halting, individual mandate penalty dropping to zero, and short-term plans expanding) interact with each other on each insurers' calculations. We conservatively assume they are additive (i.e., 6% plus 10%, resulting in 16%) rather than multiplicative (i.e., 6% increase on top of a 10% increase, whic would be 16.6% overall).

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3. Note that this dollar figure is an approximation as we are applying a simple average (16%) load to weighted average healthcare.gov premiums, and this load is based on information that is publicly available information in all states.

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Wynne Health Group

Memorandum *October 22, 2018*

CMS Revises Guidance on ACA Section 1332 Waivers; Changes Focus on Access to Rather than Take-Up of Comparable Coverage; Short-Term Plans, AHPs to Be Considered

Today, the Centers for Medicare and Medicaid Services (CMS) and Department of Treasury issued **guidance on section 1332 waivers available to states under the Affordable Care Act** (ACA), which the Administration now refers to as State Relief and Empowerment Waivers.

- **What it is.** The guidance updates a final rule issued by the Obama Administration in February 2012 on implementation of section 1332 waiver authority and supersedes guidance issued in December 2015.

- **Why it is important for you.** Today's guidance seeks to "lower barriers" for states to employ 1332 waivers and encourages waivers that provide non-ACA coverage alternatives, such as short-term plans and association health plans (AHPs). The guidance reinterprets statutory criteria, also known as "guardrails," regarding the 1332 waiver providing coverage to as many people and being as affordable and comprehensive as would be provided absent the waiver. Under the revised guidance, a standard would instead be that the waiver provides access to such coverage even if people select less comprehensive coverage, such as short-term plans. States would still have to show a comparable number of people would be covered, with short-term plans and AHPs now included in that estimate.

  The guidance allows states to use existing legislative authority, rather than passing new legislation, to pursue 1332 waivers in some cases. CMS says the guidance will make a broader array of 1332 waivers possible, noting that seven of the eight approved to-date have addressed reinsurance in the individual market, "barely touch[ing] the surface of what may be possible to achieve through a waiver." CMS says it is "preparing to release waiver concepts to help spur conversations and ideas with states" and alludes to the possibility of waivers in which states revise the structure of ACA premium subsidies.

- **Potential next steps**. The guidance is applicable upon today's publication for inspection at the Office of Federal Register. It applies to 1332 waivers submitted after today's publication as well as to those submitted but not yet approved (see p. 31). Applications already approved prior to publication do not require reconsideration. Comments on the guidance are due in 60 days **(Dec. 22, 2018.)**

Highlights of today's guidance follow:

- **Principles for Section 1332 Waivers** – CMS and Treasury lay out five principles for states' development of section 1332 waivers (see p. 7-8 of the public inspection copy). They say they will "consider favorably" applications that address some or all of the following principles:

- Provide increased access to affordable private market coverage, including AHPs and short-term plans "over public programs." The agencies say they will "look favorably on section 1332 applications under which states increase issuer participation in state insurance markets and promote competition";
- Encourage sustainable spending growth, such as through considering eliminating or reducing state-level regulation that "limits market choice and competition";
- Foster state innovation that meet consumers' needs;
- Support and empower those in need, noting that waiver policies should "support state residents in need in the purchase of private coverage with financial assistance that meets their specific financial situations;" and
- Promote consumer-driven healthcare, saying that "instead of offering a one-size-fits-all plan proposal, a section 1332 state plan should focus on providing people with the resources and information they need to afford and purchase the private insurance coverage that best meets their needs."

- **Reinterpretation of Statutory Guardrails on Comprehensiveness, Affordability, and Coverage** – In today's guidance, the agencies reinterpret the existing statutory language ("guardrails") requiring 1332 waivers to provide coverage that is at least as comprehensive and affordable and coverage to at least a comparable number of people as absent the waiver. Specifically:

  - ***Comprehensiveness and Affordability*** – In a departure from the 2015 guidance, the Departments say they will now focus on the "the *availability* of comprehensive and affordable coverage." The Departments "will not require projections demonstrating that this coverage will actually be purchased by a comparable number of state residents; in other words, these guardrails will be met if the state plan has made other coverage options available that state residents may prefer, so long as access to affordable, comprehensive coverage also is available." They note that this will "avoid the previous guidance's effect of deterring states from offering less comprehensive coverage when it could have been better suited to consumer needs and potentially more affordable to a broad range of its residents."

    On comprehensiveness, the Departments will examine the state-selected essential health benefits benchmark plan, any other state's benchmark plan chosen for purposes of the waiver plan, or any benchmark plan selected by the state that the state "could otherwise build that could potentially become their EHB benchmark plan." On affordability, the Departments will "take into account access to affordable, comprehensive coverage available to all state residents, regardless of the type of coverage they would have had access to in the absence of the waiver." They will also consider the "magnitude of such changes," noting "a waiver that makes coverage slightly more affordable for some people but much less affordable for a comparable number of people would be less likely to be granted than a waiver that makes coverage substantially more affordable for some people without making others substantially worse off." See p. 13-14, including guidance on required data.

    Furthermore, the Departments will consider the "aggregate effects of the waiver" instead of focusing on whether the waiver would make coverage less affordable to "any particular group of residents," the Departments explain. They elaborate that "while the analysis will continue to consider effects on all categories of residents, the revised guardrails will give

states more flexibility to decide that improvements in comprehensiveness and affordability for state residents as a whole offset any small detrimental effects for particular residents."

- ***Coverage*** **–** The Departments say that the coverage guardrail, while requiring that coverage be offered to at least a comparable number of residents as would be covered absent the waiver, "is silent on the type of coverage that is required." The Departments indicate that to increase state flexibility, they are permitting that states to "provide access to less comprehensive or less affordable coverage as an additional option for their residents to choose."

  Under the revised guidance, the Departments will require states to forecast for each year the waiver is proposed how many individuals will have health coverage and how that compares to the number absent the waiver. The waiver will comply with the coverage guardrail if the "state can demonstrate that a comparable number of state residents eligible for coverage under title I of PPACA will have health care coverage under the section 1332 state plan as would have had coverage absent the waiver." The Departments clarify that they will consider "all forms of private coverage in addition to public coverage" including AHPs and short-term plans.

  Furthermore, the Departments "may approve a waiver even where a state expects a temporary reduction in coverage but can demonstrate that the reduction is reasonable under the circumstances, and that the innovations will produce longer-term increases in the number of state residents who have coverage such that, in the aggregate, the coverage guardrail will be met or exceeded over the course of the waiver term."

- **Deficit Neutrality** **–** Beginning on p. 18, the Departments provide further guidance on the evaluation of deficit neutrality of 1332 waiver proposals to the federal government. They note that the "estimated effect on federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including but not limited to user fees), that would result from the proposed waiver," among other considerations. They note that they have "revised the 2015 guidance to clarify that the 10-year budget plan should describe the changes in projected federal spending and changes in federal revenues attributed to the waiver for each of the 10 years."

  Furthermore, the "10-year budget plan should assume the waiver would continue permanently, unless such an assumption would be inconsistent with the nature and intent of the state plan. However, the budget plan should not include federal spending or savings attributable to any period outside of the 10-year budget window."

- **Pass-Through Funding** **–** On p. 18-20, the Departments discuss pass-through funding available for successful waiver applications including their estimates of premium tax credits, small business tax credits, or cost-sharing reductions. They note the "pass-through amount does not include any savings other than the reduction in PPACA financial assistance," adding it "will be reduced by any other increase in spending or decrease in revenue if necessary to ensure deficit neutrality." The annual pass-through amount "may be updated at any time to reflect changes in state or federal law (including regulation and sub-regulatory guidance)." See p. 20-21 for a discussion of economic assumptions and methodological guidelines.

- **Operational Considerations for Healthcare.gov States** **–** CMS says that while it previously indicated that Healthcare.gov could not vary eligibility and enrollment parameters, "the federal platform [since] has undergone technical enhancements necessary for the FFE's operations that

will enable it to support increased variation and flexibility for states that may want to leverage components of the federal platform to implement new models through section 1332 waivers." It discusses the enhanced direct enrollment pathway as allowing access to eligibility determinations for use in state-based 1332 initiatives.

The Departments also raise the prospect of states waiving, through a 1332 waiver, the requirement to have an Exchange and instead transitioning their Exchange populations into a 1332-based program. They say "HHS is continuing to evaluate what types of flexibilities related to plan management, financial assistance, and consumer assistance are feasible, and seeks to engage with states to determine interest in potential models. See p. 23-24.

The Departments also discuss the IRS' ability to accommodate certain modifications, citing an example of a Medicaid non-expansion state that seeks to expand premium tax credit availability to those under 100 percent FPL. See p. 25. CMS also says states can change the structure of premium tax credits, though in that case, may consider "waiving the [subsidy] provision entirely and creating a subsidy program administered by the state as part of its section 1332 waiver plan."

- **Flexibility on Enactment of State Legislation** – On p. 27-28, the Departments clarify that "in certain circumstances, states may use existing legislation if it provides statutory authority to enforce [ACA] provisions and/or the state plan, combined with a duly-enacted state regulation or executive order" to meet the requirement to enact authorizing legislation to pursue 1332 waivers.

The Departments say the federal comment period on 1332 waivers will be at least 30 days, varying based on proposals' complexity. CMS has posted a release, fact sheet, and blog post.

ITUP
Insure the Uninsured Project

» Legislative Update

Final Results of the 2017-18 Legislative Session

REVIEW OF THE 2017-18 LEGISLATIVE SESSION

Governor Brown signed into law most of the health bills sent to him by the Legislature this year. This issue brief summarizes legislation by topic and actions taken by the Governor, Chaptered (signed) or Vetoed.

Preserving California's Progress Under the Affordable Care Act (ACA)

As discussed in a recent ITUP blog, the Legislature passed several bills aimed at safeguarding advances made under the ACA, including:

Assembly Bill (AB) 2499 (Arambula, Chapter 678, Statutes of 2018) – Clarifies the ACA requirement in California law that health plans spend a minimum percent of premium on health care benefits (medical loss ratio), 80 percent for individual coverage and 85 percent for large group, applies consistent with federal standards in effect as of January 1, 2017, ensuring that a change in the ACA at the federal level will not eliminate this requirement in state law. Makes related changes.

Senate Bill (SB) 910 (Hernandez, Chapter 687, Statutes of 2018) – Prohibits short-term, limited-duration health insurance.

SB 1108 (Hernandez, Chapter 692, Statutes of 2018) – Requires the Department of Health Care Services (DHCS) in future federal Medi-Cal waivers and pilots to advance the goal of providing comprehensive health care to low-income Californians and offer beneficiaries nonmedical benefits, such as employment or housing assistance, on a voluntary basis.

SB 1375 (Hernandez, Chapter 700, Statutes of 2018) – Makes changes to existing California market rules for small employer coverage, strengthening the limits on association health plans enacted in the early 1990s and ensuring that ACA rating and coverage rules apply even if individuals or employers join associations.

Creating Greater Transparency and State Oversight

Bills passed that focus on increased transparency and state oversight affecting health care quality and costs, including:

AB 315 (Wood, Dahle, and Nazarian, Chapter 905, Statutes of 2018) – Requires pharmacy benefit managers (PBMs) to register with the Department of Managed Health Care (DMHC) and to disclose specified information. Requires DMHC to convene a task force on PBM reporting to determine what information on pharmaceutical costs should be reported to the state.

AB 595 (Wood, Chapter 292, Statutes of 2018) – Strengthens DMHC authority over health plan mergers including authorizing DMHC to disapprove mergers that substantially reduce competition.

AB 2275 (Arambula) – Requires the Department of Health Care Services (DHCS) to establish a quality assessment and performance improvement program for Medi-Cal managed care plans.
VETOED Veto message states this bill would duplicate current efforts while adding significant costs to Medi-Cal.

AB 2427 (Wood) – Authorizes DHCS to terminate a for-profit Medi-Cal managed care plan contract if the Attorney General determines the health plan engaged in anticompetitive conduct, as specified, or if the plan has a pattern of not complying with medical loss ratio requirements.
VETOED Veto message states this bill is unnecessary because DHCS has sufficient authority to deal with inappropriate or illegal conduct by plans.

Protecting Consumers and Expanding Services

The Legislature passed consumers protection bills and bills to expand or improve existing programs.

AB 11 (McCarty and Bonta) – Requires the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to include developmental screening services for children zero to three.
VETOED Veto message states this service is not necessary because screening for developmental delays is already required in the EPSDT program based on the schedule recommended by the American Academy of Pediatrics.

AB 1526 (Kalra, Chapter 247, Statutes of 2019) – Revises consumer notice requirements and timelines related to collection activity on old debts, including medical debts.

AB 2233 (Kalra) – Requires DHCS to submit a federal waiver renewal for the Assisted Living Waiver (ALW) pilot program, including an increase in the number of participant slots from 3,700 to at least 18,500. The ALW program provides a community-based alternative for eligible seniors and persons with disabilities who can be safely transitioned into residential care facilities with added supportive services.
VETOED Veto message states the Assisted Living Waiver program was expanded in this year's budget and any further changes should be considered in next year's budget.

AB 2299 (Chu) – Requires DHCS to ensure that written health education and informing materials, translated by managed care plans into Medi-Cal threshold languages (non-English languages spoken at a high proportional rate in a region), are at or below the equivalent of a sixth-grade reading level.
VETOED Veto message states current law and contracts with plans are sufficient to ensure plans make important health care documents understandable for Medi-Cal beneficiaries.

AB 2941 (Berman, Chapter 196, Statutes of 2018) – Requires a health plan to provide an enrollee who has been displaced by a state of emergency, as specified, access to medically necessary health care services, potentially including, among other things, coverage for out-of-network services or relaxation of prior authorization and approvals for some services.

AB 3224 (Thurmond, Chapter 179, Statutes of 2018) – In response to recent federal rules that allow for privatization of eligibility for federal health and social services program eligibility, requires that only county employees, as specified, determine eligibility for Medi-Cal, CalWORKs, and CalFresh.

SB 707 (Cannella)– Establishes the Medi-Cal Dental Advisory Group with the goal of increasing dental utilization rates and improving oral health of the Medi-Cal population.
VETOED Veto message states the Governor's confidence that DHCS will engage with stakeholders in this matter, without the need for a public stakeholder process.

SB 1021 (Wiener, Chapter 787, Statutes of 2018) – Extends from 2020 to 2023 the sunset that requires health plans to limit cost sharing for a covered outpatient prescription drug at $250/$500 per 30-day supply, as specified, as well as other formulary requirements and related health plan requirements.

SB 1156 (Leyva) – Establishes requirements and consumer protections on entities making third-party premium payments for health plan enrollees, if the entity is a provider of services that receives direct or indirect financial benefit from the third-party payments.
VETOED Veto message states this bill goes too far by permitting health plans to refuse premium assistance payments and to choose which patients they will cover.

SB 1287 (Hernandez, Chapter 855, Statutes of 2018) – Broadens the Medi-Cal definition of "medically necessary" for individuals under 21 years of age by incorporating the existing federal standards related to EPSDT services.

SB 1423 (Hernandez, Chapter 568, Statutes of 2018) – Modifies the minimum qualifications for an interpreter translating for limited-English-proficient Medi-Cal recipients enrolled in managed care.

Strengthening the Safety Net

The Legislature passed bills affecting safety-net programs and providers.

AB 180 (Wood) – Requires DHCS to establish a stakeholder process and develop guidance on what constitutes an incentive payment that can be excluded from the federally qualified health center (FQHC) or rural health clinic (RHC) Medi-Cal payment reconciliation process.
VETOED Veto message states the Governor's confidence that DHCS will engage with stakeholders in this matter, without the need for a public stakeholder process.

AB 2204 (Gray, Chapter 279, Statutes of 2018) – Exempts an intermittent (satellite) clinic operated by a fully licensed community or free clinic from specified clinic licensing provisions, if the intermittent clinic is open for no more than 40 hours per week.

AB 2428 (Gonzalez Fletcher, Chapter 762, Statutes of 2018) – Allows a FQHC or RHC that adds a new physical location to its existing primary care license to elect the same Prospective Payment System (PPS) rate as the original site for all locations, if certain conditions are met.

AB 2576 (Aguiar-Curry, Chapter 716, Statutes of 2018) – During or immediately following a declared state of emergency, eases and standardizes the process for clinics and their providers to deliver health care when the physical clinic may not be accessible.

SB 1125 (Atkins) – If federal financial participation is available, permits FQHCs and RHCs to be reimbursed for a maximum of two visits at a single location in a single day per patient, when the patient has a medical visit and either a mental health or dental visit on the same day.
VETOED Veto message states this bill requires significant, ongoing general fund commitments; and therefore, this issue should be considered as part of the budget process.

Improving Mental Health and Substance Use Disorder Treatment

Lawmakers passed bills aimed at improving care for those with mental health conditions and/or Substance Use Disorders (SUD), including:

AB 2022 (Chu, Chapter 484, Statutes of 2018) – Requires a school to notify students and parents/guardians on how students can access available mental health services on campus or in the community at least twice during the school year.

AB 2193 (Maienschein, Chapter 755, Statutes of 2018) – Requires a health plan to develop a maternal mental health (MMH) program and requires licensed practitioners who provide prenatal or postpartum care to ensure a mother is offered screening or is appropriately screened for MMH conditions.

AB 2315 (Quirk-Silva, Chapter 759, Statutes of 2018) – Requires the California Department of Education, in consultation with DHCS and others, to develop guidelines on the use of telehealth technology to provide mental and behavioral health services to students on public school campuses.

AB 2384 (Arambula) – Requires health plans, except for Medi-Cal managed care plans, to include in drug formularies specified prescription drugs for the medication-assisted treatment of SUDs.
VETOED Veto message states the drugs in the bill are useful in treating opioid addiction, but the bill eliminates requirements that may be in the best interest of patients.

AB 2393 (Committee on Health, Chapter 77, Statutes of 2018) – Consistent with the federal requirement of parity for mental health services, prohibits a county mental health plan from charging fees for specialty mental health services for Medi-Cal recipients who do not have a share of cost or who have met their share of cost.

AB 2487 (McCarty, Chapter 301, Statutes of 2018) – Authorizes physicians to complete a one-time continuing education course on opiate-dependent patient treatment and management, as an alternative to the existing requirement for a course on pain management and the treatment of terminally ill and dying patients.

AB 2760 (Wood, Chapter 324, Statutes of 2018) – Requires a prescriber to offer naloxone hydrochloride or another drug federally approved for the complete or partial reversal of opioid depression for patients, when certain conditions are present, and to provide education on overdose prevention.

AB 2983 (Arambula, Chapter 831, Statutes of 2018) – Prohibits a general acute care hospital or acute psychiatric hospital from requiring a person who voluntarily seeks care to be in custody pursuant to a Welfare and Institutions Code Section 5150 involuntary hold as a condition of admittance. Under a 5150 hold, a person with a mental illness can be involuntarily detained for up to 72 hours in a psychiatric facility.

AB 3115 (Gipson) – Authorizes a local Emergency Medical Services (EMS) agency to develop a triage to alternate destination program, permitting EMS to transport patients directly to mental health facilities or sobering centers rather than only to general acute care hospitals.
VETOED Veto message states support for innovative local efforts; but the Governor believes this bill adds too many restrictions including on the types of facilities to which patients can be transported.

SB 992 (Hernandez, Chapter 784, Statutes of 2018) – Changes current law for licensed alcoholism or drug abuse recovery or treatment facilities to improve client treatment, including requiring the facilities to develop a plan on addressing resident relapses that includes discharge and continuing care planning, as specified.

SB 1019 (Beall) – Grants funds under the authority of the Mental Health Services Oversight and Accountability Commission (Commission) to local educational agency and mental health partnerships, as specified, to support prevention, early intervention, and direct services to children and youth.
VETOED Veto message states this bill would wrongly limit the Commission's authority to exercise its judgment in the distribution of these grants.

SB 1045 (Wiener, Chapter 845, Statutes of 2018) – Authorizes an alternative conservatorship procedure for Los Angeles, San Diego, and San Francisco Counties, at the county's option, for individuals who are chronically homeless and incapable of caring for their own health and well-being due to co-occurring serious mental illness and SUDs.

Expanding the Mental Health and SUD Workforce/Scope of Practice

AB 2861 (Salas, Chapter 500, Statutes of 2018) – After securing federal approval and in accordance with California's Medicaid state plan, requires DHCS to allow a licensed practitioner of the healing arts or a certified SUD counselor to receive Medi-Cal reimbursement for covered individual outpatient counseling services for SUDs provided through telehealth, as specified.

SB 399 (Portantino) – Expands the definition of a "qualified autism service professional" to include behavioral service providers who meet specified educational and professional or work experience qualifications, and also prohibits a health plan from denying or reducing medically necessary behavioral health treatment, as specified.
VETOED Veto message states the Governor is not inclined to revise the standards for autism providers when the standards were updated just last year.

SB 906 (Beall and Anderson) – Requires DHCS to establish a program for certifying peer support specialists in mental illness or SUD recovery services, or both. Requires DHCS to secure federal approval for peer support specialist services as a Medi-Cal benefit.

VETOED Veto message states this bill imposes a costly new program that would shut out some individuals already working as peer support specialists.

Transforming Care Delivery System in California

The Legislature included initiatives in the 2018-19 state budget, discussed in the next section, to explore system transformation and improvement. Along this same line, the Legislature passed the following bill:

AB 2472 (Wood, Chapter 677, Statutes of 2018)– Requires the newly-created Council on Health Care Delivery Systems to analyze the feasibility of a public option to increase competition and choice for health care consumers. For additional information about a public option in California, see ITUP's Issue Brief.

2018-19 State Budget: Expanding Coverage and Improving Affordability

At the end of June, the Governor signed the final 2018-19 state budget. As part of the budget process, the Legislature considered, but ultimately did not fund, various proposals to expand Medi-Cal coverage and provide state subsidies to help some Californians afford coverage. Many of these budget proposals paralleled bills pending at the time including:

- AB 2430 (Arambula) – Expands eligibility in the Medi-Cal Aged and Disabled Program by increasing income disregards so individuals up to 138 percent of the federal poverty level (FPL) would be eligible. *(As amended June 7, 2018)*
- AB 2459 (Friedman) – Establishes a state premium tax credit for individuals with incomes between 400 and 600 percent FPL who purchase coverage through Covered California. *(As amended August 6, 2018)*
- AB 2565 (Chiu) – Requires Covered California offer enhanced premium assistance to consumers, eligible for federal tax credits, with incomes between 138 and 400 percent FPL. *(As amended May 25, 2018)*
- AB 2965 (Arambula) – Extends eligibility for full-scope Medi-Cal benefits to individuals ages 19-25 who are otherwise eligible but for their immigration status. (*As amended May 25, 2018)*
- SB 974 (Lara) – Extends eligibility for full-scope Medi-Cal benefits to low-income adults 65 and over who are otherwise eligible but for their immigration status. (*As amended May 25, 2018)*
- SB 1255 (Hernandez) – Requires Covered California to administer state financial assistance (defined as premium tax credits or reductions in cost-sharing) to help low- and middle-income Californians afford coverage. *(As amended March 21, 2018)*

Without funding in the state budget to pay for expanded coverage or state subsidies, in mid-August, the Assembly and Senate Appropriations Committees held the related bills in committee, delivering the final blow to these proposals for the 2017-18 legislative session.

The final 2018-19 state budget includes funding for a new *Council on Health Care Delivery Systems* charged with developing options for a unified financing system to achieve universal coverage in the state. The final state budget also directs Covered California to develop at least three options for administering financial assistance for low- and middle-income Californians to help them access

affordable coverage. Based on the continued interest among California lawmakers to address the remaining uninsured and the initiatives funded in the 2018-19 state budget, the next Legislature and new Governor will likely consider similar proposals to expand coverage and improve affordability as outlined above.

For more information on 2017-18 legislative proposals likely to resurface in the upcoming year, see ITUP's Issue Brief, *California Strategies: Covering California's Remaining Uninsured and Improving Affordability*.

UCLA CENTER FOR HEALTH POLICY RESEARCH

Health Policy Brief

October 2018

Disparities in Health Care Access and Health Among Lesbians, Gay Men, and Bisexuals in California

Joelle Wolstein, Shana A. Charles, Susan H. Babey, and Allison L. Diamant

"More than one million California adults describe their sexual orientation as lesbian, gay, homosexual, or bisexual."

SUMMARY: This policy brief examines differences in health care access, health behaviors, and health outcomes by sexual orientation among California adults. Using data from the California Health Interview Survey, the study finds that although lesbian, gay, and bisexual women and men have similar or better rates of insurance coverage compared to straight women and men, they are more likely to experience delays in getting needed health care. Lesbians, bisexual women, and bisexual men have higher rates of smoking and binge drinking than straight women and men; however, gay men are less likely to consume sugary beverages and to be physically inactive. Lesbians and bisexuals had poorer health status and higher rates of disability than straight adults. Future research is needed to explain these disparities, as well as to identify health care and structural interventions that will improve access to care and health outcomes for this population.

Lesbian, gay, and bisexual populations have poorer health status and more barriers to accessing health care relative to straight women and men.[1,2] Recent legal changes, such as legalization of same-sex marriage, have improved insurance coverage,[3] but it is unclear whether this has translated into improved access to medical care for LGBTQ adults. In addition, research indicates that the prevalence of risk factors for chronic health conditions, such as unhealthy behaviors and stress, is higher among individuals who are members of sexual and gender minorities.[1,4,5] This puts LGBTQ adults at potentially higher risk for related medical conditions, among them obesity, hypertension, cancer, and substance dependence. In fact, previous research suggests that sexual and gender minority groups have a higher prevalence of some chronic medical conditions.[6]

This policy brief uses data from the California Health Interview Survey (CHIS) to examine disparities in health care access, health outcomes, and health behaviors by sexual orientation and gender. The main findings in this brief were obtained by combining data from 2011 to 2014. Combining data from these years allows presentation of findings stratified by gender, which is important because disparities vary across lesbian, gay, and bisexual female and male populations.[7] This brief does not include information about transgender adults, as transgender data were not collected in CHIS prior to 2015.[8]

The LGB Population in California

In 2014, 580,000 California adults (2.3 percent) described their sexual orientation as lesbian, gay, or homosexual, and an additional 550,000 (2.2 percent) described their sexual orientation as bisexual.[9] The proportion of lesbian and gay adults with incomes below the federal poverty level (11.7 percent) was lower than that among straight adults (16.3 percent), but a higher proportion of bisexual adults (26.3 percent) than

The California Endowment

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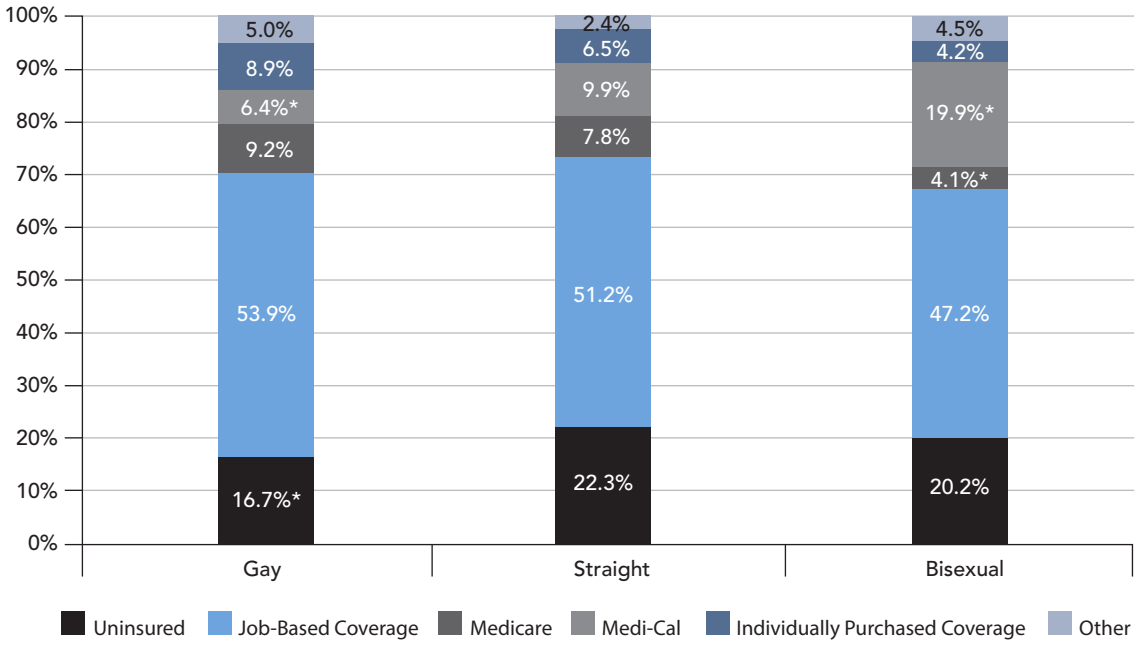
Exhibit 1

Current Health Insurance Status and Type by Sexual Orientation, Men, Ages 18-70, California, 2011-2014



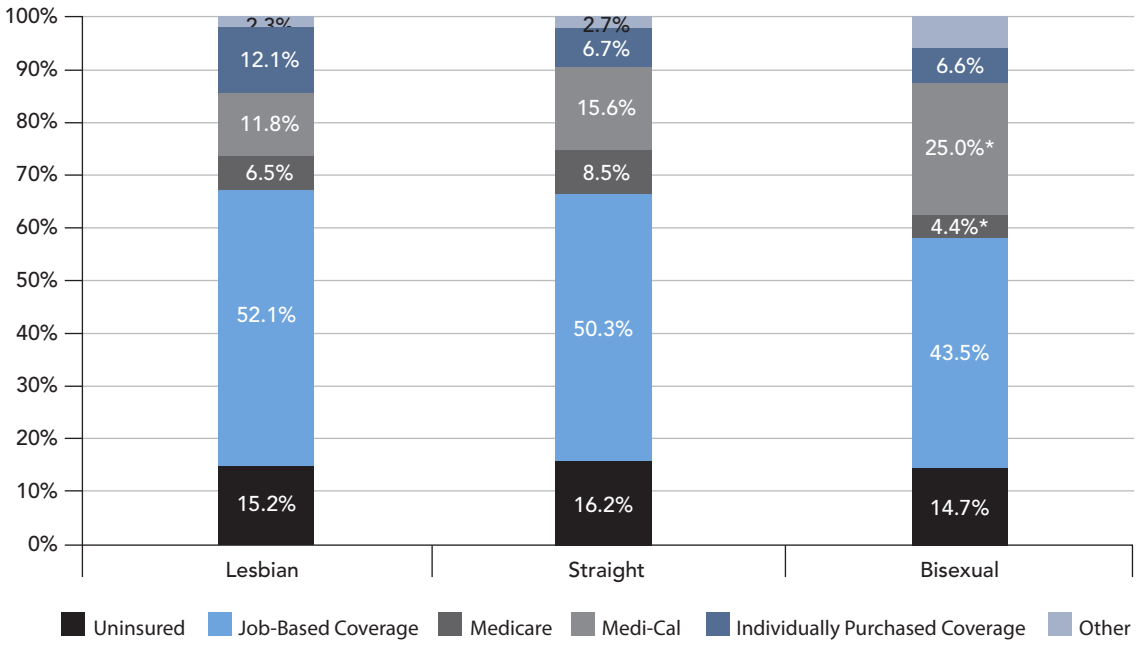
Source: 2011-2014 California Health Interview Survey

*Statistically different from "Straight" at the 95% CI level

straight adults had incomes below the poverty line. More than half of gay and lesbian adults (52 percent) had a college degree, a figure that was significantly higher than the proportions among straight adults (35 percent) and bisexual adults (32 percent).

Exhibit 2

Current Health Insurance Status and Type by Sexual Orientation, Women, Ages 18-70, California, 2011-2014

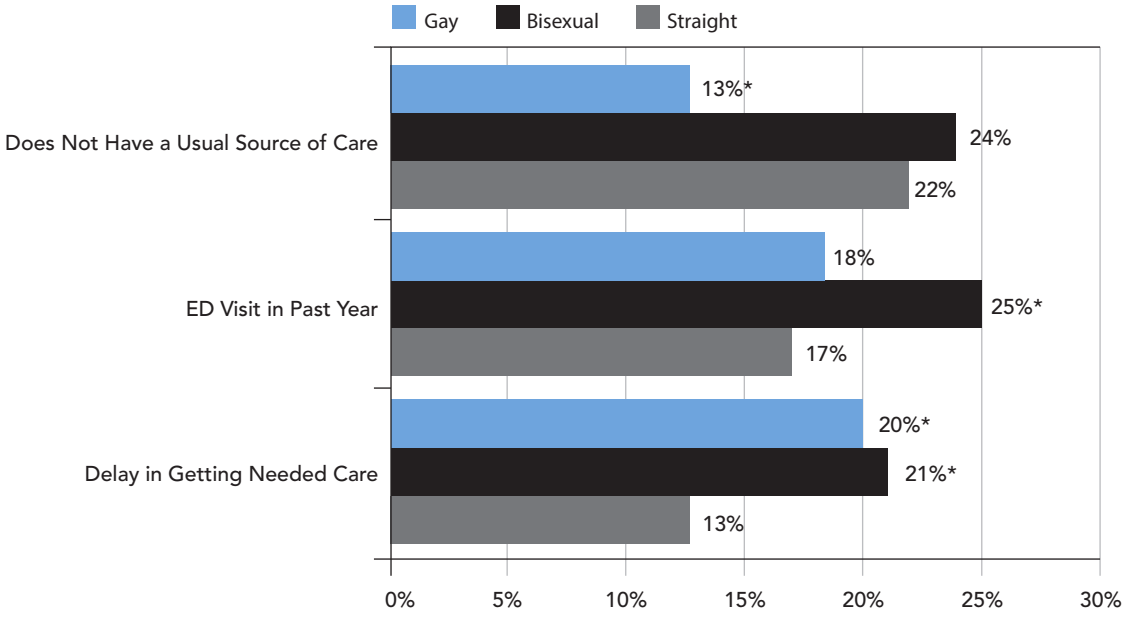


Source: 2011-2014 California Health Interview Survey

*Statistically different from "Straight" at the 95% CI level

No Usual Source of Care, Emergency Department (ED) Visit in the Past Year, and Delay in Needed Care by Sexual Orientation, Men, Ages 18-70, California, 2011-2014

Exhibit 3



Source: 2011-2014 California Health Interview Survey

*Statistically different from "Straight" at the 95% CI level

Gay Men Less Likely to Be Uninsured than Straight Men, but Gap Not Seen in Women's Coverage

Lack of insurance coverage is a significant barrier to receiving health care. Insurance coverage among men in California varied by sexual orientation, with gay men having a significantly lower rate of being uninsured (16.7 percent) than straight men (22.3 percent; Exhibit 1). Gay men had higher rates than straight men of nearly every type of health insurance coverage except Medi-Cal. About one in ten straight men was covered through Medi-Cal (9.9 percent), while only 6.4 percent of gay men had Medi-Cal coverage. Bisexual men had higher rates of Medi-Cal coverage (19.9 percent) than straight or gay men.

There were no statistically significant differences between straight women and lesbian or bisexual women in the rates of being uninsured (16.2 percent, 15.2 percent, and 14.7 percent, respectively; Exhibit 2). Within insurance types, however, there were some differences by sexual orientation. For instance, straight women had a slightly higher rate of Medi-Cal coverage (15.6 percent) compared to lesbians (11.8 percent). Mirroring this difference, lesbians had a slightly higher rate than straight women of individually purchased coverage (12.1 percent vs. 6.7 percent). In addition, bisexual women had a higher rate of Medi-Cal coverage than straight women (25.0 percent vs. 15.6 percent).

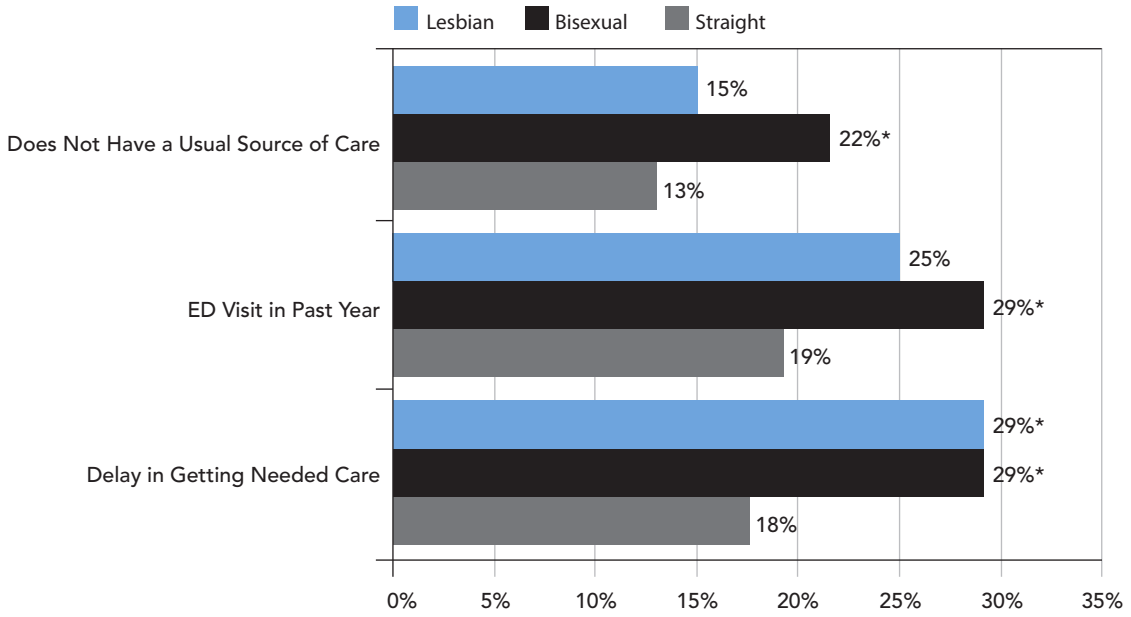
"Gay men are less likely to be uninsured than straight men."

Gay Men, Lesbians, and Bisexual Men and Women More Likely than Straight Men and Women to Delay Needed Health Care

With higher rates of health insurance coverage among gay men compared to straight men, and comparable rates among women, we would expect that health care utilization indicators would show similar or better access to care for lesbian, gay, and bisexual populations compared to straight populations. Gay men, in concordance with their higher rate of insurance, did report a lower rate of lacking a usual source of care compared to straight men (13 percent vs. 22 percent; Exhibit 3). There was no significant difference in usual source of care between bisexual and straight men. There was no significant difference in lacking a usual source of care between lesbians and straight women, but bisexual women reported a higher rate than

Exhibit 4

No Usual Source of Care, Emergency Department (ED) Visit in the Past Year, and Delay in Needed Care by Sexual Orientation, Women, Ages 18-70, California, 2011-2014



Source: 2011-2014 California Health Interview Survey

*Statistically different from "Straight" at the 95% CI level

"Gay men, lesbians, and bisexual adults are more likely than straight adults to delay needed health care."

straight women of lacking a usual source of care (22 percent vs. 13 percent; Exhibit 4).

Rates of visiting an Emergency Department (ED) – the most expensive option for health care, and often a last resort – did not differ between straight and lesbian or gay adults (Exhibits 3 and 4). However, among both men and women, bisexual adults reported higher rates of ED visits in the past year than straight adults (25 percent vs. 17 percent among men, and 29 percent vs. 19 percent among women).

Even with facilitators of care (i.e., similar or better rates of health insurance and having a usual source of care), delaying needed health care differed significantly by sexual orientation. One in five individuals among both gay men (20 percent) and bisexual men (21 percent) had delayed needed health care in the past year, compared to 13 percent of straight men (Exhibit 3). Among women, nearly one-third of both lesbians (29 percent) and bisexual women (29 percent) had delayed needed medical care in the past year, compared to 18 percent of straight women (Exhibit 4). Among LGB adults who reported delaying or not receiving needed medical care, the percentage reporting cost or lack of insurance as the reason for the delay did not statistically differ by sexual orientation (data not shown).

Unhealthy Behaviors Vary by Sexual Orientation and Differ Between Gay and Bisexual Men and Lesbians and Bisexual Women

Certain health behaviors—including smoking, excessive alcohol consumption, lack of physical activity, and consumption of unhealthy foods and beverages—increase the risk for chronic medical conditions. Considerable evidence links excessive alcohol use as well as tobacco use with multiple medical conditions, including cardiovascular disease and a variety of cancers. Consumption of sugary beverages and fast food is linked to obesity and obesity-related conditions, such as diabetes and hypertension.

Gay men were less likely to engage in certain unhealthy behaviors than straight men. Specifically, straight men were more than twice as likely as gay men to consume at least one sugary drink per day (22 percent vs. 10 percent), and they were also more likely than gay men to have not walked in the past week (20 percent vs. 11 percent; Exhibit 5). The prevalence of

Unhealthy Behaviors and Health Outcomes by Sexual Orientation and Gender, Adults Ages 18-70, California, 2011-2014 **Exhibit 5**

	Women			Men		
	Lesbian	Bisexual	Straight	Gay	Bisexual	Straight
Unhealthy Behaviors	%	%	%	%	%	%
Current smoker	23*	23*	10	17	20	17
Binge drinking in past year	43*	50*	27	36	52*	42
One or more sugary beverages per day	15	10	10	10*	23	22
Fast food two or more times per week	34	42*	34	43	52	46
No walking in past week	16	13	17	11*	18	20
Health Outcomes						
Asthma	23*	22*	15	22*	19*	12
Obesity	35*	26	24	21*	20*	27
Hypertension	21	19	23	21*	36*	24
Disability	29	42*	27	27	36*	25

Source: 2011-2014 California Health Interview Survey *Statistically different from "Straight" at the 95% CI level

these unhealthy behaviors among bisexual men was similar to that among straight men, but bisexual men were more likely than straight men to have engaged in binge drinking in the past year (52 percent vs. 42 percent). Smoking rates and fast food consumption did not vary significantly by sexual orientation among men.

Lesbian and bisexual women were more likely than straight women to engage in some unhealthy behaviors. Specifically, half of bisexual women and 43 percent of lesbians had engaged in binge drinking in the past year, compared to 27 percent of straight women (Exhibit 5). The prevalence of current smoking was more than twice as high among lesbian and bisexual women as among straight women (23 percent vs. 10 percent). Daily consumption of sugary drinks among women did not differ statistically by sexual orientation. Bisexual women were more likely to have eaten fast food at least twice per week (42 percent) than both lesbians (34 percent) and straight women (34 percent).

Gay Men Healthier and Bisexual Men Less Healthy than Straight Men; Lesbians and Bisexual Women Less Healthy than Straight Women

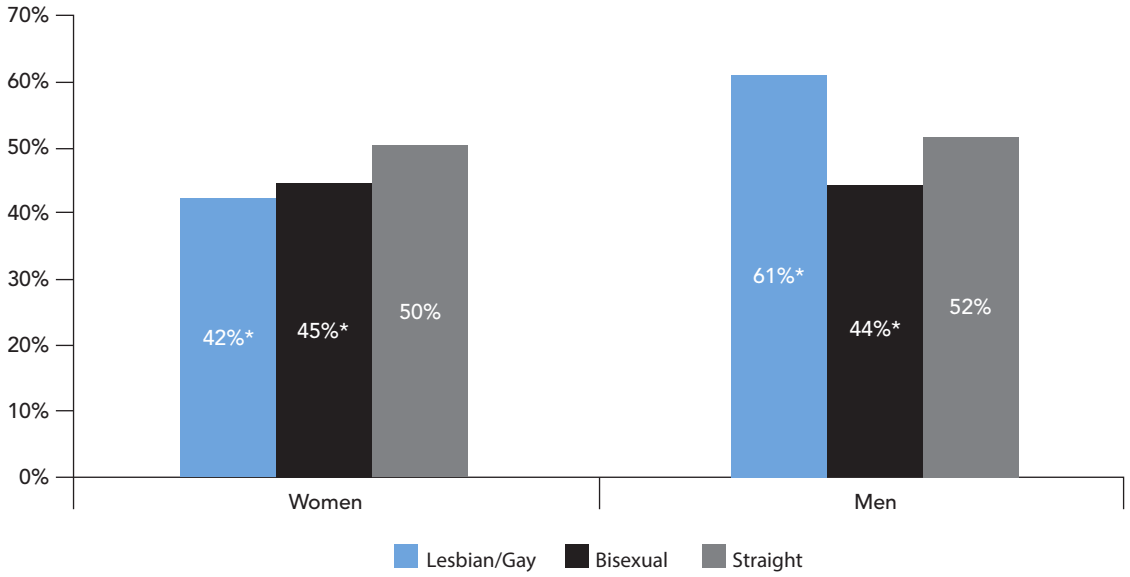
In terms of overall health status and health conditions, gay men tended to have better outcomes than straight men, whereas bisexual men tended to have worse outcomes. Among women, lesbians and bisexual women tended to have worse outcomes than straight women. This pattern in health outcomes is exemplified by the rates of self-reported "excellent" or "very good" health status (Exhibit 6). Half of straight women reported that their health was excellent or very good, compared to 42 percent of lesbians and 45 percent of bisexual women. Gay men were more likely to report excellent or very good health status than straight men (61 percent vs. 52 percent), while bisexual men were less likely than either gay or straight men to report this level of health status (44 percent).

"Gay men are mostly likely to say they are in excellent or very good health."

Gay men (21 percent) and bisexual men (20 percent) were less likely to be obese than straight men (27 percent) (Exhibit 5). Although obesity is a risk factor for diabetes, there was no significant variation in the prevalence of diabetes among men by sexual orientation (not shown). Despite lower obesity rates, bisexual men had the highest rate of hypertension (36 percent). However, gay men were less likely than straight men to have high blood pressure (21 percent vs. 24 percent). The prevalence of asthma was nearly twice as high among gay (22 percent) and bisexual (19 percent) men compared to straight men (12 percent). Asthma is a condition more strongly associated with socioeconomic status and environmental

Exhibit 6

Percent Reporting "Excellent" or "Very Good" Health Status by Sexual Orientation and Gender, Ages 18-70, California, 2011-2014



Source: 2011-2014 California Health Interview Survey

*Statistically different from "Straight" at the 95% CI level

"Bisexual adults have the highest rates of disability."

factors, including secondhand smoke, than with modifiable health behaviors, such as diet and physical activity. Bisexual men had a higher prevalence of disability (36 percent) than either straight or gay men (25 percent and 27 percent, respectively).

The prevalence of obesity was significantly higher among lesbians than straight women (35 percent vs. 24 percent), but was not statistically different between bisexual women and straight women (26 percent vs. 24 percent) (Exhibit 5). Despite differences in obesity rates by sexual orientation, the prevalence of hypertension did not differ by sexual orientation among women, nor did the prevalence of diabetes (not shown). Both lesbians (23 percent) and bisexual (22 percent) women were more likely to have asthma than straight women (15 percent). The rate of disability among bisexual women was 42 percent, which was significantly higher than the rate among both lesbians (29 percent) and straight women (27 percent).

Conclusions and Recommendations

Among California adults, there are a number of disparities by sexual orientation in terms of health care access, health behaviors, and health outcomes. The health disparities experienced by LGB adults differ among women and men. Although the differences by sexual orientation vary across specific outcomes, a general pattern emerges showing that lesbian and bisexual women tend to have worse health outcomes and behaviors than straight women. Among men, bisexual men tend to have worse health outcomes and behaviors than straight men, but gay men tend to have better health outcomes and behaviors than straight men. Bisexual and lesbian women are more likely than straight women to have asthma, to be current smokers, and to engage in binge drinking, and they are less likely to report excellent/very good health status. Among men, bisexual men are more likely than straight men to have hypertension and disability and to engage in binge drinking, and they are less likely to report excellent/very good health status. On the other hand, with the exception of asthma, gay men tend to have better health outcomes and health behaviors than straight men (i.e., with regard to sugary

beverage consumption, walking, obesity, hypertension, and general health status). Identification of poor health behaviors by health care providers, sensitive counseling of patients, and referral to available resources can all help with reducing the risk for chronic medical conditions among LGB adults.

Notable exceptions to the general patterns above are rates of insurance coverage and delay in getting needed medical care. Bisexual men and women have higher rates of Medi-Cal coverage than straight and gay or lesbian men and women. These higher rates of Medi-Cal coverage may reflect differences in income and disability rates.[10,11] Bisexual men and women have higher rates of poverty and disability than straight men and women. Among women, the percentage with no insurance coverage does not vary by sexual orientation. Among men, gay men are less likely to be uninsured, though bisexual men do not differ from straight men.

Despite similar or better rates of insurance coverage, lesbians, bisexual women, gay men, and bisexual men are more likely to delay needed health care than straight women and men. Many studies have found a strong link between gaining health insurance and gaining better access to care. Among LGB adults who reported delaying or not receiving needed medical care, the percent indicating that the reason for delaying was cost or lack of insurance did not statistically differ by sexual orientation. This suggests that other factors contribute to this disparity. These barriers to care can include prior negative experiences with health care providers and others in the health care setting, leading to a hesitation to seek even needed health care. Health care settings that do not indicate a welcoming environment for LGBTQ adults may also dissuade individuals from seeking needed medical care.

The following recommendations may help improve access to and receipt of care as well as reduce poor health outcomes among LGB populations:

- Improve the local health care environment so that LGBTQ adults feel welcome.
- Provide necessary training for health care staff and providers regarding culturally sensitive and clinically appropriate health care for LGBTQ adults.
- Ensure that health care providers (and trainees) understand the effects of social stressors, including homophobia and biphobia, on health behaviors (including the use of alcohol and tobacco).
- Ensure that health systems are collecting data on the sexual orientation of their patients, which allows population health studies to be performed to identify ongoing disparities in care and to promote solutions to overcome these disparities.

Data Source and Methods

The findings in this brief are based on data from the California Health Interview Survey (CHIS). For most analyses, we combined data from 2011 to 2014 to obtain stable estimates and allow for analyses to be stratified by gender. Each year, CHIS completes interviews with adults, adolescents, and parents of children in more than 20,000 households, drawn from every county in the state. Interviews are conducted in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Tagalog, and Korean. Adults between the ages of 18 and 70 are asked to identify their sexual orientation, using the following question: "Do you think of yourself as straight or heterosexual; as gay, lesbian or homosexual; or as bisexual?" Responses to this question are used to examine health and access to care by sexual orientation.

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This publication contains data from the California Health Interview Survey (CHIS), the nation's largest state health survey. Conducted by the UCLA Center for Health Policy Research, CHIS data give a detailed picture of the health and health care needs of California's large and diverse population.

CHIS is a collaboration of the UCLA Center for Health Policy Research, California Department of Public Health, California Department of Health Care Services, and the Public Health Institute. Learn more at: ***www.chis.ucla.edu***

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Wolstein J, Charles SA, Babey SH, Diamant AL. 2018. *Disparities in Health Care Access and Health Among Lesbians, Gay Men, and Bisexuals in California*. Los Angeles, Calif.: UCLA Center for Health Policy Research.

Endnotes

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October 2018 | Issue Brief

Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid

Samantha Artiga, Rachel Garfield, and Anthony Damico

Executive Summary

On October 10, 2018, the Trump administration released a proposed rule to change "public charge" policies that govern how the use of public benefits may affect individuals' ability to obtain legal permanent resident (LPR) status. The proposed rule would expand the programs that the federal government would consider in public charge determinations to include previously excluded health, nutrition, and housing programs, including Medicaid. It also identifies characteristics DHS could consider as negative factors that would increase the likelihood of someone becoming a public charge, including having income below 125% of the federal poverty level (FPL) ($25,975 for a family of three as of 2018). This analysis provides new estimates of the rule's potential impacts. Using 2014 Survey of Income and Program Participation data, it examines the (1) share of noncitizens who originally entered the U.S. without LPR status who have characteristics that DHS could potentially weigh negatively in a public charge determination and (2) number of individuals who would disenroll from Medicaid under different scenarios:

Nearly all (94%) noncitizens who originally entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination. Over four in ten (42%) have characteristics that DHS could consider a heavily weighted negative factor and over one-third (34%) have income below the new 125% FPL threshold. Under the proposed rule, individuals with lower income, a health condition, less education, and/or who use or are likely to use certain health, nutrition, and housing programs, including Medicaid, would face increased barriers to adjusting to LPR status because DHS could consider these characteristics as negative factors.

If the proposed rule leads to Medicaid disenrollment rates ranging from 15% to 35% among Medicaid and CHIP enrollees living in a household with a noncitizen, between 2.1 to 4.9 million Medicaid/CHIP enrollees would disenroll. These estimates reflect disenrollment among noncitizens without LPR status who would disenroll because participation in the program could negatively affect their chances of adjusting to LPR status as well as disenrollment among a broader group of enrollees in immigrant families, including their primarily U.S. born children, due to increased fear and confusion. The disenrollment rates draw on previous research on the chilling effect welfare reform had on enrollment in health coverage among immigrant families. Decreased participation in Medicaid would increase the uninsured rate among immigrant families, reducing access to care and contributing to worse health outcomes. Coverage losses also would result in lost revenues and increased uncompensated care for providers and have spillover effects within communities.

Introduction

On October 10, 2018, the Trump administration released a proposed rule to change "public charge" policies that govern how the use of public benefits may affect individuals' ability to enter the U.S. or adjust to legal permanent resident (LPR) status (i.e., obtain a "green card"). A previously published fact sheet describes key provisions of the proposed rule. Based on Kaiser Family Foundation analysis of 2014 Survey of Income and Program Participation (SIPP) data, this analysis provides new estimates of the:

- Share of noncitizens who originally entered the U.S. without LPR status who have characteristics that DHS could potentially weigh negatively in a public charge determination, and
- Number of individuals who could disenroll from Medicaid under different scenarios in response to the proposed rule.

Background

The proposed rule would broaden the programs that the federal government would consider in public charge determinations to include previously excluded health, nutrition, and housing programs. Under longstanding policy, if authorities determine that an individual is likely to become a public charge, they may deny that person's application for LPR status or entry into the U.S.[1] The proposed rule would define a public charge as an "alien who receives one or more public benefits" and would define public benefits to include cash assistance for income maintenance, government-funded institutionalized long-term care, and certain health, nutrition, and housing programs that were previously excluded from public charge determinations. These programs would include non-emergency Medicaid, the Medicare Part D Low-Income Subsidy Program, the Supplemental Nutrition Assistance Program (SNAP), and several housing support programs.

Officials consider the totality of a person's circumstances in a public charge determination. At a minimum, officials must take into account an individual's age; health; family status; assets, resources, and financial status; and education and skills. In the proposed rule and its preamble, DHS describes how it would consider each factor and identifies characteristics it would deem as positive factors that would reduce the likelihood of an individual becoming a public charge and negative factors that would increase the likelihood of becoming a public charge. The proposed rule would establish a new income standard of 125% of the federal poverty level (FPL) ($25,975 for a family of three as of 2018) for considering an individual's assets, resources, and financial status and would consider family income below that standard to be a negative factor.[2] The proposed rule also identifies certain heavily weighted negative or positive factors. One of these heavily weighted negative factors is current enrollment in or approval for enrollment in a public benefit or enrollment in a public benefit within the previous 36 months. In general, DHS would find an individual "inadmissible" and deny him or her adjustment to LPR status or entry into the U.S. if the person's negative factors outweigh his or her positive factors.

The proposed rule would directly affect noncitizens seeking to obtain LPR status.[3] DHS data show that 1.1 million individuals obtained LPR status in 2017, including about 550,000 living within the U.S.

who adjusted to LPR status and about 580,000 who entered the U.S. as a new arrival. [4] About 380,000 of the 550,000 individuals who adjusted to LPR status within the U.S. did so through a pathway that would likely be subject to a public charge determination.[5] Some groups, including refugees and asylees, are exempt from public charge determinations.

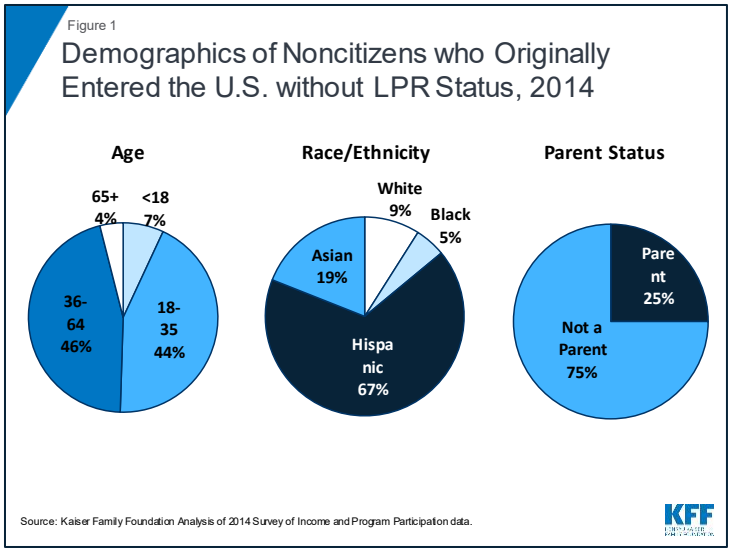
The proposed rule would likely lead to disenrollment from Medicaid and other programs among noncitizens who intend to seek LPR status as well as among a broader group of individuals in immigrant families, including their primarily U.S.-born children. Noncitizens without LPR status would likely disenroll from Medicaid and other programs because enrollment could negatively affect their chances of obtaining LPR status under the proposed rule. In addition, previous experience and recent research suggest that the proposed rule would have a "chilling effect" that would likely lead to disenrollment among a broader group of individuals in immigrant families even though the proposed rule would not directly affect them.[6] This research suggests that individuals may forgo enrollment in or disenroll themselves and their children from public programs because they do not understand the rule's details and would fear their or their children's enrollment could negatively affect their or their family members' immigration status. DHS recognizes evidence of a chilling effect and notes that previous studies examining the effect of welfare reform changes in 1996 showed enrollment reductions ranging from 21% to 54% from public programs due to this chilling effect.[7] However, in its estimates of program participation changes due to the proposed rule, DHS assumes only individuals directly affected by the rule (i.e., those applying to adjust status) drop coverage. It does not assume disenrollment among their family members or other noncitizen families, noting uncertainty related to estimating prospective disenrollment and that the proposed rule changes enrollment incentives versus eligibility policy.

Key Findings

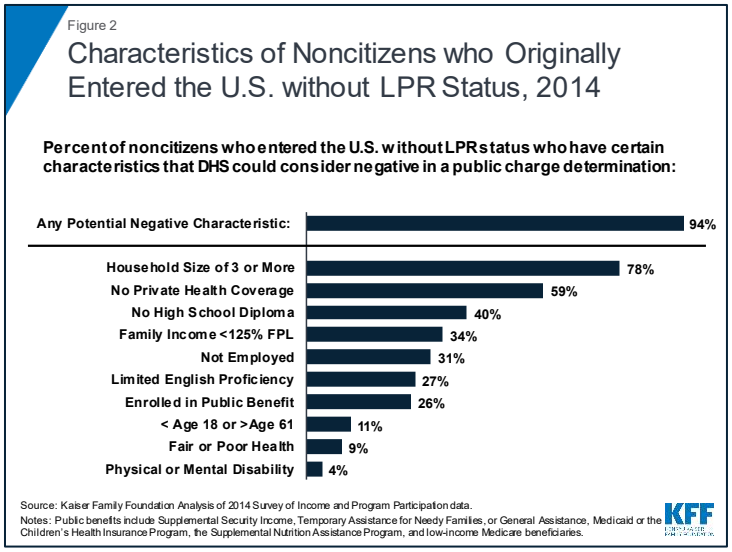
Characteristics of Noncitizens without LPR status

Using 2014 SIPP data, we show characteristics of noncitizens who originally entered the U.S. without LPR status that DHS could potentially consider in a public charge determination under the proposed rule. These estimates illustrate the share of noncitizens living in the U.S. who might face barriers to adjusting to LPR status under the proposed rule based on certain characteristics. Due to data limitations, they do not provide a precise count of the number of people within the U.S. who would be subject to public charge determinations. The estimates do not account for people who DHS could deny entry into the U.S. due to a public charge determination and do not account for all factors that DHS could consider in a public charge determination. As noted, officials would take into account the totality of an individual's circumstances, and no single factor would govern a determination. How DHS would operationalize its assessment of factors may differ from SIPP's measurement of characteristics. (See Appendix A: Methods for more detail.)

Noncitizens who entered the U.S. without LPR status include individuals across different ages, races/ethnicities, and family statuses. Although many were nonelderly Hispanic adults without a dependent child**,** 7% are a child, one in four is a parent (25%), and one-third (33%) is another race or ethnicity, including nearly one in five (19%) who is Asian (Figure 1).[8]



Nearly all (94%) noncitizens who entered the U.S. without LPR status have at least one characteristic that DHS could potentially weigh negatively in a public charge determination under the proposed rule. The most common characteristics that DHS could consider negative factors are a household size of three or more (78%), no private health coverage (59%), and no high school diploma (40%) (Figure 2 and Appendix B). In addition, over one-third (34%) have income below the 125% FPL[9] standard the proposed rule would establish. Just over one in four (26%) are enrolled in a public program that the rule identifies as a public benefit. This data may overestimate the share who are using a public program because the proposed rule would establish minimum thresholds for use of public benefits to be considered a negative factor that are not reflected in these measures. Moreover, some reported use of public benefits in the survey data may not be considered a public benefit under the proposed rule. For example, some individuals reporting Medicaid may be relying on emergency Medicaid, which would not be considered a public benefit under the proposed rule.



Over four in ten (42%) noncitizens who originally entered the U.S. without LPR status have characteristics that DHS could consider a heavily weighted negative factor. Potential heavily weighted negative factors examined in this analysis include current enrollment in a public benefit (26%), not being employed and not a full-time student (and aged 18 or older) (27%), and having a disability that limits the ability to work and lacking private health coverage (3%). The proposed rule identifies other heavily weighted negative factors that were not included in this analysis, including receipt of a public benefit within the previous 36 months and being found previously inadmissible or deportable on public charge grounds. Those with characteristics that DHS could potentially consider a heavily weighted negative factor are significantly more likely to be a parent (65% vs. 34%) and to be a woman (59% vs. 27%) compared to those without characteristics that DHS could consider a heavily weighted negative factor (data not shown).

Nearly nine in ten (89%) of all citizens (U.S. born and naturalized) also had one or more characteristics that DHS could potentially weigh negatively if they were subject to a public charge determination. Citizens were more likely than noncitizens who entered the U.S. without LPR status to have certain characteristics that DHS could consider negative, including being a child or older than age 61 and reporting fair or poor health and having a physical or mental disability that limits their ability to work (Appendix B).

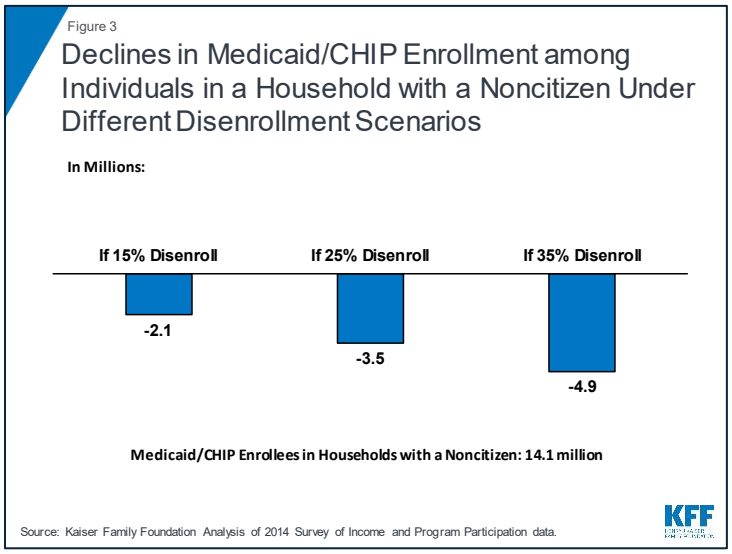
Impact on Medicaid Enrollment

We used SIPP data to illustrate the number of Medicaid and CHIP enrollees living in a family with at least one noncitizen who would disenroll under different potential disenrollment scenarios. As noted, previous experience and recent research suggests that the proposed rule may lead to broader disenrollment among individuals in families with immigrants beyond those the rule directly affects. We applied disenrollment rates of 15%, 25%, and 35%. Although it is difficult to predict the effect of the policy change, these disenrollment rates illustrate a range of potential impacts and draw on previous research on the chilling effect welfare reform had on enrollment in health coverage among immigrant families, and are consistent with earlier analysis of potential disenrollment among citizen children from Medicaid/CHIP.[10]

According to the SIPP data, there were over 14 million Medicaid/CHIP enrollees living in a household with at least one noncitizen, and half of these enrollees were citizen children. Although CHIP was not included as a public benefit in the proposed rule, DHS requested comment on its inclusion. Moreover, many individuals are not able to distinguish between their enrollment in Medicaid versus CHIP, and SIPP data do not provide separate Medicaid and CHIP coverage measures.

This analysis finds that, if the proposed rule leads to Medicaid disenrollment rates ranging from 15% to 35%, between 2.1 million and 4.9 million Medicaid/CHIP enrollees living in a family with at least one noncitizen would disenroll (Figure 3). These estimates reflect disenrollment among noncitizens without LPR status who would be directly affected by the rule[11] as well as disenrollment due to chilling effects among enrollees in immigrant families, including their primarily citizen children. The

estimates provide illustrative examples and, due to data limitations, may reflect both an undercount of noncitizens and an overestimate of noncitizens receiving Medicaid. (See Methods for more detail.)



These estimates of Medicaid disenrollment vary from DHS estimates because they take into account potential chilling effects among immigrant families and rely on different a different data source and methods. Using administrative and survey data, DHS estimated that about 142,000 individuals would disenroll from Medicaid per year and that this would lead to a $1.1 billion annual decrease in federal Medicaid expenditures. (See Appendix C for more detail on their approach.) Although DHS recognizes previous research showing that chilling effects led to enrollment reductions, it does not account for a chilling effect in its estimates. Instead, DHS assumes that all individuals directly affected by the public charge rule (i.e., those applying to adjust status) drop coverage but no disenrollment effects among their family members or among other noncitizen families.

Implications

Under the proposed rule, individuals with lower incomes, a health condition, less education, and/or who are enrolled or likely to enroll in certain health, nutrition, and housing programs would face increased barriers to obtaining LPR status. As such, the rule would have implications for future immigration opportunities for individuals and families, making it more difficult for low-income individuals and those with health conditions to obtain a green card. For example, a full-time worker in a family of three earning the minimum wage would not have sufficient annual income ($15,080) to meet the new income standard established in the rule, which would be $25,975 for a family of three. The increased barriers to obtaining a green card would disproportionately limit future opportunities for low-income families and individuals with health needs. It also could increase barriers to family reunification and potentially lead to family separation, for example, if DHS denies an individual a green card due to a public charge determination and that individual loses permission to remain in the U.S.

California Health Care Foundation

UCLA CENTER FOR HEALTH POLICY RESEARCH

October 2018

Issue Brief

ACA Reduces Racial/Ethnic Disparities in Health Coverage

Differences in the uninsured rate between white, African American, and Asian/Pacific Islander Californians have been eliminated; however, the coverage rate for Latinos still lags behind.

Under the Patient Protection and Affordable Care Act (ACA), millions of Californians have gained health coverage. These gains have come either through the expansion of Medicaid (called Medi-Cal in California) to low-income adults earning up to 138% of the federal poverty guideline (FPG), or through Covered California, the state's ACA health insurance marketplace, where people earning up to 400% FPG can purchase subsidized insurance coverage. The major coverage expansions of the ACA were implemented starting in 2014, and by 2016 the uninsured rate among nonelderly Californians had fallen from 15.5% to a historic low of 8.5%.

This brief examines health care coverage rates and sources of coverage among nonelderly (under age 65) Californians based on the 2017 California Health Interview Survey (CHIS). The authors focus on nonelderly Californians because those over 65 are nearly universally covered by Medicare. For ease of presentation, the nonelderly uninsured rate is referred to in the text as the "uninsured rate."

In 2017 multiple unsuccessful attempts by the Trump administration and Congress to repeal the ACA and enact policies that would have reduced the number of Californians with coverage created uncertainty for consumers about coverage options and requirements. California also took steps to mitigate the effects of certain federal actions. Federal actions and the uncertain environment may not have had a heavy influence on Californians' decisions regarding coverage for 2017, due in large part to timing. For example, 2017 open enrollment for Covered California ended on January 31, 2017, before ACA repeal attempts began in earnest and before many of the federal actions were announced. Covered California's 2018 open enrollment began in November 2017, near the end of CHIS data collection for 2017. 2018 CHIS data may better capture the effects of 2017 federal actions and uncertainties.

This brief focuses on changes from 2013 to 2017 to compare pre- and post-ACA implementation. It also flags important changes from 2016 to 2017. Only changes that are statistically significant

(see definition below) are highlighted. (The term "changed significantly" is used throughout the brief to mean a statistically significant change.)

Undocumented Adults: What Counts as Insurance?

In this brief, in keeping with previous CHIS analyses, all Californians reporting Medi-Cal coverage are considered covered by Medi-Cal. This includes undocumented adults who are not eligible for full-scope Medi-Cal but may have used restricted-scope Medi-Cal. Restricted-scope Medi-Cal is not comprehensive coverage, covering only emergency and pregnancy-related services. When asked by survey researchers about health coverage, some undocumented immigrants who have used restricted-scope Medi-Cal may respond that they have Medi-Cal coverage. If undocumented immigrants reporting Medi-Cal were considered uninsured, the number of Californians who are uninsured would be higher, as would the number of uninsured among some demographic groups, such as Latinos.

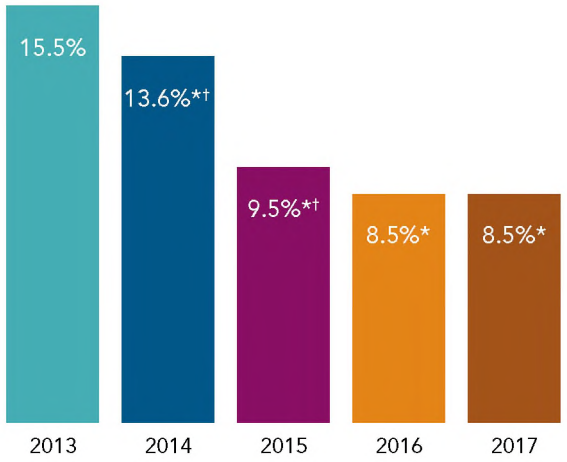
Statistical significance is a mathematical test that helps researchers assess whether differences are real or the result of random chance. In these survey findings, if a change is "statistically significant" the CHIS team is confident the change occurred due to a factor other than random chance.

Key Findings

Uninsured rate remained stable and nearly 50% lower than before ACA implementation.

In 2017 the uninsured rate among nonelderly Californians was 8.5%, just over half the 15.5% uninsured rate in 2013, before full implementation of ACA coverage provisions. Since 2016, with the ACA's main coverage provisions in place since 2014, California's nonelderly uninsured rate has been stable.

Figure 1. Uninsured Rate Among Californians Age 0–64, 2013–2017



*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$)
Source: California Health Interview Survey, 2017.

2016's historic narrowing of disparities in coverage between most racial/ethnic groups was maintained, although Latinos continued to experience a higher uninsured rate than others.

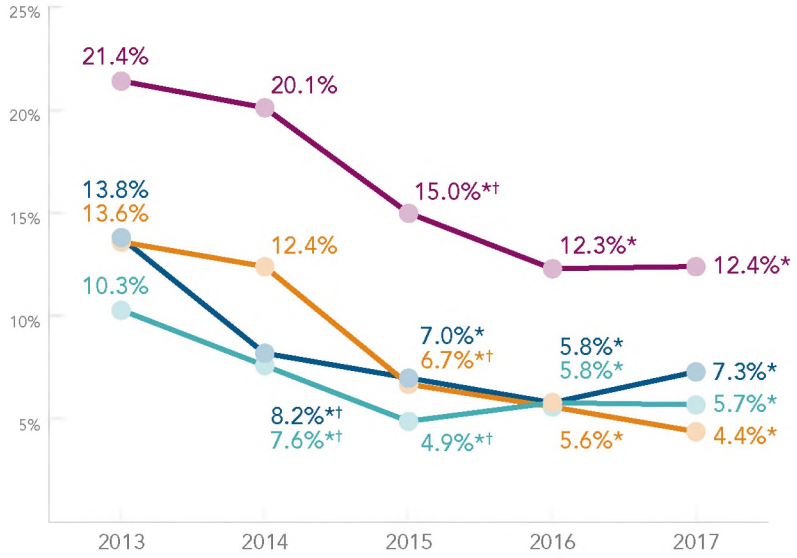
The ACA has significantly reduced the uninsured rate among all racial/ethnic groups in California and has produced historic declines in racial disparities in health coverage rates.

Between 2013 and 2017, the uninsured rate declined by more than 40% for each group, with slightly larger declines among African Americans and Asians/Pacific Islanders (see Figure 2, page 3). By 2016, there was no statistically significant difference between the uninsured rates for non-Latino whites (5.8%), African Americans (5.8%), and Asians/Pacific Islanders (5.6%) — the first time such equity in health coverage rates had been achieved between these racial/ethnic groups since CHIS began collecting data in 2001.

Although Latinos experienced a significant decline in their uninsured rate, dropping from 21.4% in 2013 to 12.4% in 2017, the coverage rate for Latinos continued to lag behind other racial/ethnic groups.

In 2017, there continued to be no statistically significant difference in the uninsured rate between non-Latino whites, African Americans, and Asian/Pacific Islanders. Between 2016 and 2017, uninsured rates remained statistically stable within each racial/ethnic group.

Figure 2. Uninsured Rate Among Californians Age 0–64, by Race/Ethnicity, 2013–2017



In 2017, there continued to be no statistically significant difference in the uninsured rate between non-Latino whites, African Americans, and Asian/Pacific Islanders.

Coverage gains maintained in most California regions, but variation across regions continued.

In 2017, every region of California had experienced a statistically significant decrease in its uninsured rate compared to 2013, with the exception of the Central Coast. (See Figure 3.) The San Joaquin Valley, which had the highest uninsured rate in 2013 (18.1%), experienced the largest decline, reaching a low of 7.6% in 2017. The Greater Bay Area had the lowest uninsured rate in 2013 (10.8%) and has experienced the smallest decline, reaching a low of 6.1% in 2016. By 2017, the Sacramento area had the lowest uninsured rate (5.7%) and the Central Coast had the highest (11.6%).

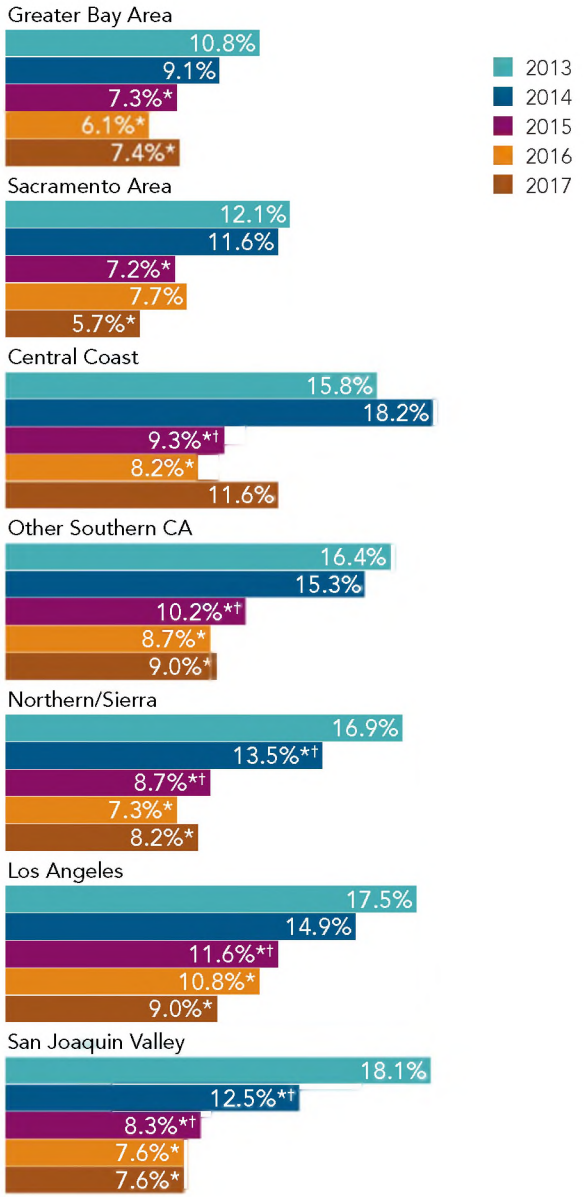
Most of the change in the uninsured rates within each region occurred between 2013 and 2015. Since then, rates have remained stable.

FIGURES 2 AND 3:
*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$).

Notes: While the uninsured rate among African Americans crept up slightly to 7.3% in 2017, it is not a statistically significant change. See Appendix for a list of counties within each region.

Source: California Health Interview Survey, 2017.

Figure 3. Uninsured Rate Among Californians Age 0–64, by Region, 2013–2017



Coverage gains maintained for low- and moderate-income Californians.

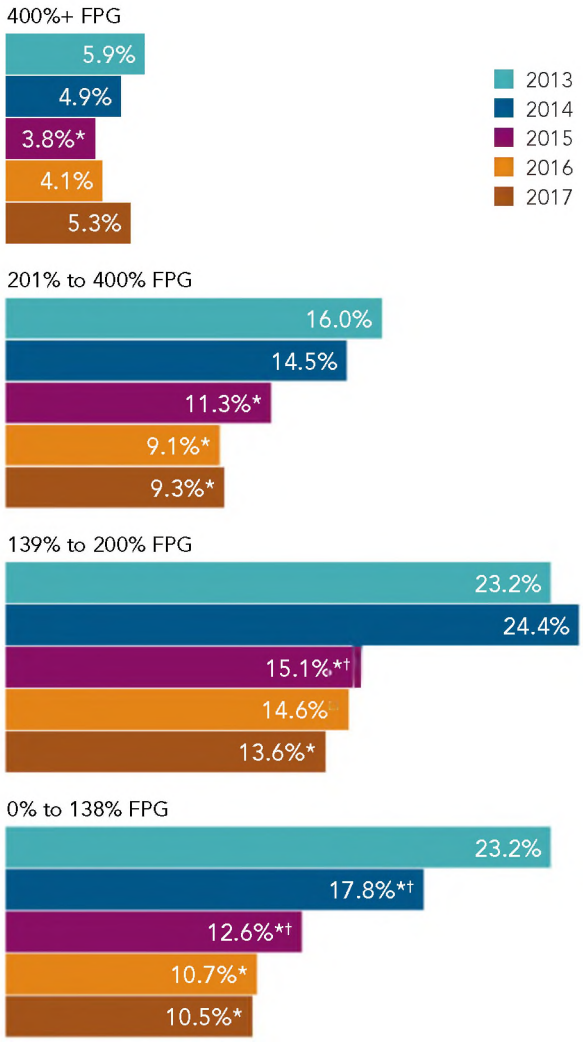
Under the ACA, low- and moderate-income families (earning up to 400% FPG) have seen the biggest decreases in their uninsured rates, reflecting the ACA's Medicaid expansion and subsidized private coverage for those earning up to and including 400% FPG. In fact, the biggest decline occurred among those earning 138% FPG or less, the income eligibility threshold for Medi-Cal, although large and significant declines also occurred among those earning 139% to 200% FPG and 201% to 400% FPG (see Figure 4).

Table 1. Federal Poverty Guidelines, 2017

	100%	138%	400%
Single Adult	$12,060	$16,643	$48,240
Family of Four	$24,600	$33,948	$98,400

The biggest decline in the uninsured rate has occurred among those earning 138% FPG or less, the income eligibility threshold for Medi-Cal.

Figure 4. Uninsured Rate Among Californians Age 0–64, by FPG, 2013–2017



*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$)

Note: See Table 1 for 2017 federal poverty guidelines (FPG) income values for single adults and families of four.

Source: California Health Interview Survey, 2017.

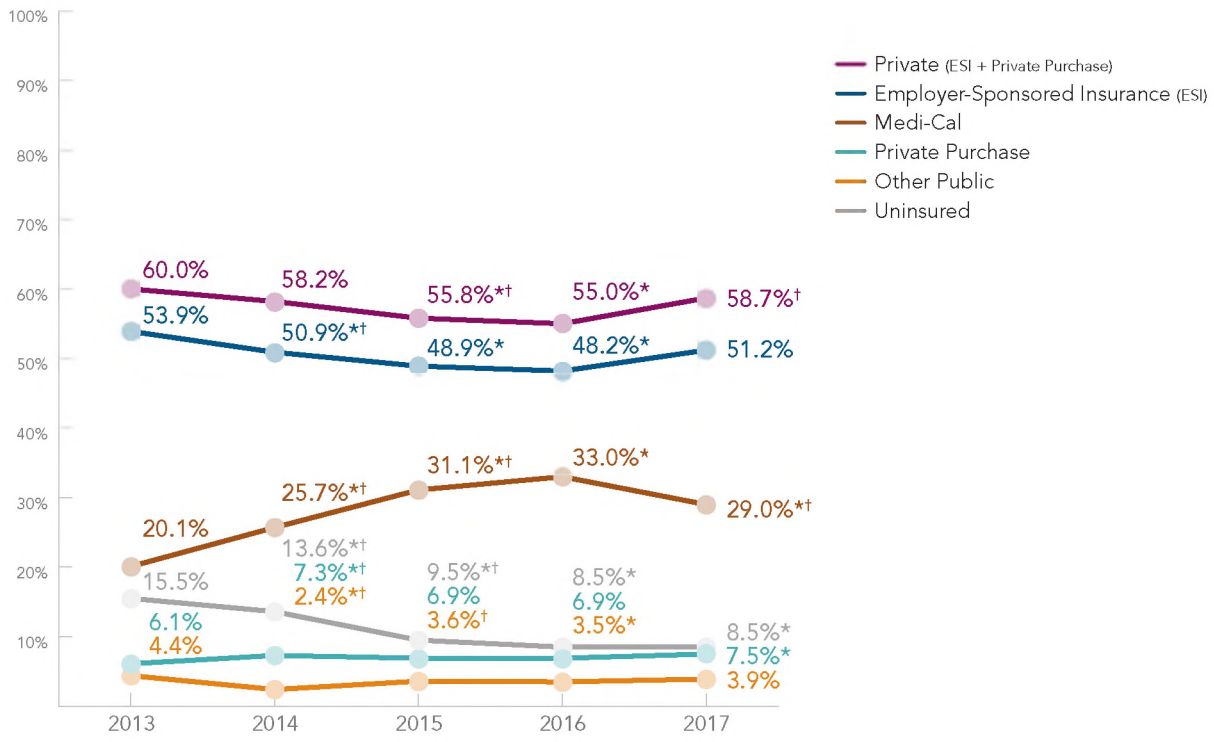
Medi-Cal enrollment decreased; private coverage rebounded.

Under the ACA, the percentage of Californians covered by Medi-Cal rose substantially, from 20.1% in 2013 to 33% in 2016 (see Figure 5, page 5). Although most Californians have continued to get their coverage through their jobs, the percentage with employer-sponsored insurance (ESI) declined between 2013 and 2016.

However, between 2016 and 2017, these trends started to shift. The percentage of Californians with coverage through Medi-Cal decreased significantly, from 33.0% to 29.0% (though it remained significantly higher than 2013). Meanwhile, the percentage of Californians with private insurance coverage (defined as including ESI and insurance purchased on the individual market, both on and off Covered California) rose significantly from 55.0% to 58.7%. This increase in private coverage offset decreases in Medi-Cal enrollment, resulting in a stable uninsured rate, and may reflect a growing economy and improvements in household income across the state.[1]

1. "Local Area Unemployment Statistics, 2008–2018," Bureau of Labor Statistics, data.bls.gov; "Real Median Household Income in California," Federal Reserve Bank of St. Louis, fred.stlouisfed.org.

Figure 5. Source of Health Insurance Coverage, Californians Age 0–64, 2013–2017



*Significantly different from 2013 ($p < 0.05$).
†Significantly different from previous year ($p < 0.05$).
Source: California Health Interview Survey, 2017.

Summing It All Up — and Looking Ahead

The story of health insurance coverage in 2017 is one of overall stability. The tremendous gains under the ACA largely persisted, including historic progress in narrowing racial/ethnic disparities in coverage. However, lagging progress among Latinos, persistent variation across regions, and many Californians still being uninsured point to the need for further work to ensure all Californians can get the coverage they need.

Continued monitoring of the uninsured rate will be particularly important going forward given the uncertainty created at the federal level around the ACA in 2017. In addition to the multiple ACA repeal attempts, many other federal policies in 2017, such as the elimination of cost-sharing reduction payments to insurers on the ACA health insurance marketplaces, were potentially destabilizing. The 2018 CHIS data may help show if the 2017 federal policy environment affected Californians' decisions around enrolling in, or purchasing, coverage.

Visit www.chcf.org for additional analyses focused on access metrics as well as future examinations of affordability drawing on CHIS and other data sources.

Methodology

In this fact sheet, health insurance coverage has been measured as coverage at a point in time (at time of survey response), rather than as coverage over the past year. Each respondent was coded into a single health insurance coverage type based on the following hierarchy: uninsured, Medicare, Medi-Cal, ESI, private direct purchase (which includes purchase on the individual market including on and off Covered California), and other public coverage. Those with Medicare were then reclassified into "other public coverage." For these reasons, the estimates included in this brief may not be comparable to estimates from other sources that report coverage over the past year or use a different health insurance hierarchy. See also "Undocumented Adults: What Counts as Insurance?" on page 2.

The measure of income included in this fact sheet is based on family income earned in the past month as a percentage of the FPG issued by the Department of Health and Human Services. The data also contain measures of income based on household income in the past calendar year as a percentage of the federal poverty thresholds issued by the Census Bureau. The family income as a percentage of the FPG measure was included because this measure is more consistent with the income and poverty line measures used to determine eligibility for federal programs, including Medicaid and health insurance exchange premium subsidies.

Data for this fact sheet were drawn from the newly released 2017 California Health Interview Survey (CHIS), in conjunction with data from the previously released 2011–16 CHIS annual data files. CHIS covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. CHIS is based on interviews conducted continuously throughout the year, with respondents in approximately 20,000 California households annually. For more information about CHIS, please visit CHIS online at www.chis.ucla.edu.

About the Author

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About the UCLA Center for Health Policy Research

The UCLA Center for Health Policy Research is one of the nation's leading health policy research centers.

The Center is the home of the California Health Interview Survey (CHIS) and is affiliated with the UCLA Fielding School of Public Health.

PB2018-10.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Appendix. California Counties within the CHIS Regions

CENTRAL COAST	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
GREATER BAY AREA	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
LOS ANGELES	Los Angeles
NORTHERN/SIERRA	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
SACRAMENTO AREA	El Dorado, Placer, Sacramento, Yolo
SAN JOAQUIN VALLEY	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
OTHER SOUTHERN CALIFORNIA	Imperial, Orange, San Bernardino, San Diego, Riverside

Reduced participation in Medicaid and other programs would negatively affect the health and financial stability of immigrant families and the growth and healthy development of their children, who are predominantly U.S.-born. Coverage losses would reduce access to care for families, contributing to worse health outcomes. Reduced participation in nutrition and other programs would likely compound these effects. In addition, the losses in coverage would lead to lost revenues and increased uncompensated care for providers and have broader spillover effects within communities. In the preamble to the proposed rule, DHS recognizes that disenrollment or foregone enrollment in public benefit programs could lead to worse health outcomes, especially for pregnant or breastfeeding women, infants, or children; reduced prescription adherence; increased emergency room use and emergent care due to delayed treatment; increased prevalence of diseases; increased uncompensated care; increased rates of poverty and housing instability; and reduced productivity and educational attainment.[12] Moreover, DHS indicates that the rule may decrease disposable income and increase poverty of certain families and children, including U.S. citizen children.[13] DHS also identifies potential impacts on communities, including decreased revenues to health care providers, pharmacies, grocery retailers, agricultural producers and landlords, as well as new direct and indirect costs for individuals and organizations serving immigrant families.[14]

This brief was prepared by Samantha Artiga and Rachel Garfield, with the Kaiser Family Foundation, and Anthony Damico, an independent consultant to the Kaiser Family Foundation.

Appendix A: Methods

The findings presented in this brief are based on Kaiser Family Foundation analysis of Wave #2 the 2014 Survey of Income and Program Participation (SIPP). SIPP enables us to directly measure individuals' immigration status at the time they entered the U.S. and health coverage and includes measures of health status. This approach differs from that used by DHS (described in detail in Appendix C), which was based on a combination of multiple administrative data sets and applied a number of broad assumptions. While SIPP has the advantage of directly measuring citizenship and immigration status, 2014 is the most recent year of data available. Because 2014 was a year of substantial transition for Medicaid due to the implementation of the Affordable Care Act, we also ran our analysis using the 2016 American Community Survey (ACS) to see if the time lag in data was affecting our results. The ACS analysis examined citizens versus non-citizens and led to very similar results.

We classified people as not having LPR status when originally entering the U.S. based on a SIPP question that asks, "What was [respondent's] immigration status when he/she first moved to the United States?" In addition to measuring people who might adjust to LPR status in the future, who would be subject to a public charge determination (unless they fall into an exempt category), this measure includes noncitizens who have adjusted to LPR status since arriving into the U.S. It also includes nonimmigrants and undocumented immigrants who do not have a current pathway to adjust to LPR status. Our testing of different citizenship measures led to overall similar patterns. The 2014 SIPP shows 20 million noncitizens, including 8.7 million of whom originally entered the country without LPR status. It also shows an additional 18.8 million citizens living in a household with a noncitizen (10.1 million of whom live in a household with a noncitizen who entered the country without LPR status). Due to underreporting of noncitizens and legal immigration status in the SIPP, these estimates may reflect an undercount of the total noncitizen population and especially the undocumented population. Given this potential undercount—and that the group of noncitizens without LPR status includes some individuals who have since adjusted to LPR status as well as nonimmigrants and undocumented immigrants who do not have a pathway to adjust to LPR status— our analysis of characteristics that DHS could consider negative in public charge determinations focuses on shares rather than absolute numbers of affected individuals.

For the estimates of the share of noncitizens without LPR status living within the U.S. who have characteristics that DHS could weigh negatively in a public charge determination under the proposed rule, we used SIPP to measure age, household size, poverty and work status, insurance status, enrollment in public programs, education, English proficiency, and health status and classified each factor as positive or negative based on the proposed rule's description of how DHS would consider the characteristic. DHS' implementation and operationalization of its assessment of factors may differ from SIPP's measurement of characteristics. In the preamble to the rule, DHS provided some data analysis of characteristics of the noncitizen population compared to citizens and discussed how certain characteristics correlate with enrollment in public benefit programs. They relied on older SIPP data (Wave 1 of the 2014 SIPP, which reflects 2013) and, in most cases, did not break out the non-LPR population in tables presented. Thus, their estimates are not directly comparable with ours.

In our analysis of household income, we use 125% of the Census poverty threshold, or $23,819 for a family of three in 2014. Census poverty thresholds are measured slightly differently than HHS poverty guidelines but lead to similar poverty levels for incomes of similar household size. In the proposed rule, DHS proposes a specific definition of a household to be used in the calculation of household income and notes that, while similar in concept to rules used by some government programs, their proposed definition varies in some ways. Thus, the final income cutoff for a particular family to meet the 125% of poverty rule as implemented may differ from our measurement or that used by other programs.

SIPP includes monthly measures of health insurance coverage. We coded individuals with at least one month of Medicaid or CHIP coverage during the 2014 calendar year as a Medicaid/CHIP recipients. Our analysis of 2014 SIPP finds 67.8 million total Medicaid/CHIP enrollees. This figure is low compared to current administrative estimates of 76 million, largely reflecting a well-documented "undercount" of Medicaid enrollment in survey data. Our analysis also finds that 14.1 million Medicaid/CHIP enrollees lived in a household with a noncitizen, 4.7 million of whom are noncitizen Medicaid enrollees. These data on Medicaid enrollees reflect both an undercount of noncitizens in the survey data (as noted above) as well as an overestimate of the share of noncitizens participating in Medicaid as it includes some who may be reporting emergency Medicaid or other state or local health assistance programs as Medicaid coverage.

For estimates of potential changes in coverage due to public charge policies, we present several scenarios using different disenrollment rates for Medicaid and CHIP. These disenrollment rates drew on previous research that showed decreased enrollment in Medicaid and CHIP among immigrant families after welfare reform.[15] For example, Kaushal and Kaestner found that after new eligibility restrictions were implemented for recent immigrants as part of welfare reform, there was 25% disenrollment among children of foreign-born parents from Medicaid even though the majority of these children were not affected by the eligibility changes and remained eligible.[16] Using this 25% disenrollment rate as a mid-range target, we assume a range of disenrollment rates from a low of 15% to a high of 35%. However, it remains uncertain what share of individuals may disenroll from Medicaid and CHIP in response to the proposed rule. Although the welfare reform experience is instructive of chilling effects among immigrant families broadly, it was associated with changes to program eligibility for immigrants. In contrast, this rule would change the potential consequences of participating in programs on an individual's immigration status.

Appendix B

Characteristics that DHS Could Consider in Public Charge Determinations by Citizenship Status, 2014					
	Potential Positive or Negative Factor?	Heavily Weighted?	Non-LPR Noncitizen	Total Noncitizens	Citizens
Age					
17 or younger	Negative		7%	9%	24%
18 to 61	Positive		89%	83%	57%
62 or older	Negative		5%	8%	19%
Family Size					
Less than Three People in Household	Positive		22%	21%	38%
Three or More People in Household	Negative		78%	79%	62%
Health Status					
No Physical or Mental Health Disability	Positive		96%	95%	87%
Physical or Mental Health Disability	Negative		4%	5%	13%
Excellent, Very Good, or Good Health	Positive		91%	91%	87%
Fair or Poor health	Negative		9%	9%	13%
Physical or Mental Health Disability and No Private Coverage	Negative	Y	3%	4%	7%
Family Income					
Less than 125% Federal Poverty Level (FPL)	Negative		34%	29%	18%
125% to less than 250% FPL	Positive		33%	32%	22%
250% FPL or more	Positive	Y	33%	38%	59%
Health Coverage					
Private Coverage	Positive		41%	45%	70%
No Private Coverage	Negative		59%	55%	30%
Public Benefits					
TANF or General Assistance	Negative	Y	4%	3%	4%
Medicaid/CHIP	Negative	Y	20%	23%	21%
SNAP	Negative	Y	10%	12%	14%
SSI	Negative	Y	1%	1%	3%
Low-Income Medicare beneficiary	Negative	Y	1%	2%	4%
Receiving Any Public Benefit	Negative	Y	26%	29%	27%
Not Receiving Any Public Benefit	Positive		74%	71%	73%
Employment					
Employed (and age 18+)	Positive		62%	59%	47%
Not employed (and age 18+)	Negative		31%	32%	29%
Not employed and not a full time student	Negative	Y	27%	29%	27%
Education					
Has high school diploma or higher (and age 18+)	Positive		53%	56%	68%
No high school diploma (and age 18+)	Negative		40%	35%	8%
English Proficiency					
Does Not Have Limited English Proficiency	Positive		73%	76%	99%
Limited English proficiency	Negative		27%	24%	1%
Any Negative Factor			**94%**	**94%**	**89%**
Any Heavily Weighted Negative Factor			**42%**	**47%**	**45%**

Notes: For each individual subject to a determination, DHS would take into account the totality of his her circumstances and would retain discretion on how to weigh specific circumstances and factors; no single factor would govern a determination. How DHS would implement and operationalize its assessment of factors under the rule may differ from how SIPP measures characteristics.
Source: Kaiser Family Foundation analysis of 2014 Survey of Income and Program Participation data.

Appendix C: Summary of DHS's Medicaid Estimates

Using administrative and survey data, DHS estimated that about 142,000 individuals would disenroll from Medicaid per year and that this would lead to a $1.1 billion annual decrease in federal Medicaid expenditures. As discussed below, DHS included a number of broad assumptions in its analysis. DHS does not account for a chilling effect in its estimates of disenrollment noting uncertainty related to estimating prospective disenrollment and that the proposed rule changes enrollment incentives versus eligibility policy. Instead, DHS assumes that all individuals directly affected by the public charge rule (i.e., those applying to adjust status) drop coverage but no disenrollment effects among their family members or among other noncitizen families. However, DHS recognizes that, "when eligibility rules change for public benefits programs there is evidence of a chilling effect that discourages immigrants from using public benefits programs for which they are still eligible." It also notes that previous studies examining the effect of welfare reform changes showed enrollment reductions ranging from 21% to 54% due to this chilling effect, it does not account for a chilling effect in its estimates of disenrollment.

Number of Medicaid Beneficiaries Impacted

Appendix C Table 1 shows how DHS estimates the number of Medicaid beneficiaries impacted by the proposed rule:

- DHS starts with an estimate of average annual Medicaid enrollment of 64,281,954. They report that they draw this figure from a 5-year average annual calculation based on the most recent 5 years of administrative data available. However, when calculated based on the cited data, we find average annual Medicaid enrollment of 72,215,654 from January 2014-July 2018, the most recent month available. Even if DHS is using an earlier period that includes 2013 data (which would result in an artificially low estimate, since 2013 is before the Affordable Care Act Medicaid expansion), the average annual enrollment number we calculate is 68,701,856.
- DHS then estimates the number of *households* that may be receiving Medicaid by multiplying its estimate of total Medicaid recipients by the average household size nationwide. This calculation assumes that household size is the same across households with and without Medicaid enrollees.
- DHS then estimates the number of households with a noncitizen who may be receiving Medicaid by multiplying its household estimate by the share of the total population that is noncitizen. This calculation assumes that households with a Medicaid enrollee have the same proportion of noncitizens as the general population.
- Finally, DHS multiples this estimated number of households with a noncitizen who may be receiving Medicaid by the average size of households that include noncitizens to estimate that 5,685,422 Medicaid enrollees live in a household with a noncitizen. This calculation assumes that households with a noncitizen receiving Medicaid are the same size as households with a noncitizen who is not receiving Medicaid. As described above, our analysis of SIPP revealed a much larger number of Medicaid enrollees reside in a household with a noncitizen.

Appendix C Table 1: DHS Methods to Estimate Number of Medicaid Enrollees Affected by the Proposed Rule			
Measure	**Data Point Used**	**Calculation**	**Calculation Method**
Medicaid Average Total Number of Recipients	64,281,954		Based on 5-year average from Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Data. Each annual total calculated by averaging the monthly enrollment population over each year.
Households that May be Receiving Medicaid	24,349,225	64,281,954/2.64	Divided the number of people receiving Medicaid by the Census estimated average household size of 2.64 for the total population.
Households with at least One Noncitizen who may be receiving Medicaid	1,697,141	24,349,225 x 6.97%	Multiplied the estimated number of households receiving Medicaid by the share of the total U.S. population that is a noncitizen (6.97%)
Medicaid Recipients Who are Members of Households Including Non-Citizens	5,685,422	1,697,141 x 3.35	Multiplied the estimated number of households with at least one noncitizen receiving Medicaid by the average household size for those who are foreign-born using the Census estimate (3.35)

Number of Medicaid Disenrollees

Appendix C Table 2 shows how DHS estimates the number of individuals that would disenroll from Medicaid under the proposed rule:

- DHS estimates the share of individuals that would disenroll from public programs by dividing the five-year annual average of the total number of people who adjusted to LPR status by the total noncitizen population, finding that 2.5% of noncitizens apply to adjust status each year.
- DHS applies this 2.5% disenrollment rate to its previously calculated estimate of Medicaid recipients who are members of households including noncitizens to estimate an annual enrollment decline of 142,136. This calculation assumes that everyone applying for adjustment of status within a year would disenroll. It does not account for any chilling effects that would lead to disenrollment among a broader group of individuals.

Appendix C Table 2: DHS Methods to Estimate Number of Medicaid Disenrollees			
Measure	**Data Point Used**	**Calculation**	**Calculation Method**
Anticipated share of Disenrollees	2.5%	544,246/22,214,947	Divided the number of immigrants that adjusted to LPR status annually by the total non-citizen population
Number of Medicaid Disenrollees	142,136	5,685,422 x 2.5%	Multiplied previous estimate of Medicaid recipients with a noncitizen in the household by the anticipated share of disenrollees (2.5%)

Reductions in Medicaid Expenditures

Appendix C Table 3 shows how DHS estimates reductions in Medicaid expenditures associated with Medicaid disenrollment under the proposed rule:

- Using administrative data, DHS estimates total annual Medicaid spending of $477 billion. They then divide this average annual spending amount by their earlier estimate of average total annual

enrollment to estimate average annual spending of $7,426 per enrollee. The Office of the Actuary (OACT) for the Centers for Medicare and Medicaid Services projects that average per enrollee Medicaid spending was approximately $7,200 in 2013, rising to $7,648 in 2017. These figures are a weighted average across all eligibility groups in Medicaid. There is wide variation in Medicaid spending per enrollee across eligibility groups, as DHS notes. Noncitizen Medicaid enrollees are more likely to be enrolled in low-cost enrollment groups such as adults without disabilities than the overall Medicaid population; thus, their average per enrollee spending is likely lower than the overall average for the Medicaid population.

- To estimate the reduction in Medicaid expenditures, DHS multiples their previous estimate of the anticipated annual enrollment decline (142,136) by their estimate of average per enrollee spending ($7,427). The estimate that DHS uses for average per enrollee spending is similar to that reported by (OACT) as well as other administrative data for total (federal and state) spending. Further, the total Medicaid payment amount used by DHS appears to include both federal and state spending. However, DHS indicates that their initial calculation just represents declines in federal expenditures and later inflates their overall estimated expenditure decreases across all programs by 50% to reflect estimated additional reductions in state expenditures to account for state matching funds.

Appendix C Table 3:
DHS Methods to Estimate Reductions in Medicaid Expenditures

Measure	Data Point Used	Calculation	Calculation Method
Average Annual Medicaid Payments	$477,395,691,240		5-year average based on Expenditure Reports from MBES/CBES
Average Annual Medicaid Payment per Person	$7,426.59	$477,395,691,240/ 64,281,954	Divided average annual Medicaid payments by previous estimate of average annual total number of Medicaid recipients
Anticipated Reduction in Medicaid Expenditures	$1.1 billion	142,136 x $7,426.59	Multiplied previous estimate of anticipated number of disenrollees by the average annual benefit per person

ENDNOTES

[1] Becoming a public charge may also be a basis for deportation in extremely limited circumstances. "Public Charge Fact Sheet," U.S. Citizenship and Immigration Services, https://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet, accessed February 12, 2018.

[2] Under the proposed rule, if an individual has income below this standard, DHS would assess whether the total value of the individual's household assets and resources is at least five times the difference between the household's annual income and the federal poverty guidelines for his or her household size.

[3] The proposed changes would also affect certain people seeking to extend or adjust their non-immigrant status while in the U.S as well as LPRs seeking to return to the U.S. after a departure of six months or longer. The preamble clarifies that the proposed rule interprets public charge as it relates to inadmissibility, but not public charge deportability grounds, which will continue to be governed by Department of Justice precedent decisions.

[4] "Table 6. Persons Obtaining Lawful Permanent Resident Status by Type and Major Class of Admission: Fiscal Years 2015 to 2017," 2017 Yearbook of Immigration Statistics, Department of Homeland Security, https://www.dhs.gov/immigration-statistics/yearbook/2017/table6 , accessed October 8, 2018.

[5] Ibid.

[6] Findings show that recent immigration policy changes have increased fears and confusion among broad groups of immigrants beyond those directly affected by the changes. See Samantha Artiga and Petry Ubri, Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health, (Washington, DC: Kaiser Family Foundation, December 2017), https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/ and Samantha Artiga and Barbara Lyons, Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being (Washington, DC: Kaiser Family Foundation, September 2018), https://www.kff.org/disparities-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-health-and-well-being/. Similarly, earlier experiences show that welfare reform changes increased confusion and fear about enrolling in public benefits among immigrant families beyond those directly affected by the changes. See. Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/; Michael Fix and Jeffrey Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97* (Washington, DC: The Urban Institute, March 1, 1999) https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Namratha R. Kandula, et. al, "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants, *Health Services Research,* 39(5), (October 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/; Rachel Benson Gold, *Immigrants and Medicaid After Welfare Reform*, (Washington, DC: The Guttmacher Institute, May 1, 2003), https://www.guttmacher.org/gpr/2003/05/immigrants-and-medicaid-after-welfare-reform.

[7] 83 *Fed. Reg.* 51114-51296 (October 10, 2018) available at https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds, accessed October 10, 2018.

[8] Kaiser Family Foundation analysis of 2014 SIPP data.

[9] In our data analysis, we use the Census poverty threshold, which was $23,819 for a family of three in 2014. Census poverty thresholds are measured slightly differently than HHS poverty guidelines but lead to similar poverty levels for incomes of similar household size. See Methods for more detail.

[10] Earlier experiences show that welfare reform changes increased confusion and fear about enrolling in public benefits among immigrant families beyond those directly affected by the changes. See. Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/; Michael Fix and Jeffrey Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97* (Washington, DC: The Urban Institute, March 1, 1999) https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Namratha R. Kandula, et. al, "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants, *Health Services Research,* 39(5), (October 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/; Rachel Benson Gold, *Immigrants and Medicaid After*

Welfare Reform, (Washington, DC: The Guttmacher Institute, May 1, 2003), https://www.guttmacher.org/gpr/2003/05/immigrants-and-medicaid-after-welfare-reform.

[11] Because of existing Medicaid eligibility restrictions for immigrants, there are few groups of noncitizens who do not already have LPR status who can enroll in Medicaid. These groups primarily include certain pregnant women and children in states that have adopted an option to cover lawfully residing immigrant pregnant women and children. See: https://www.healthcare.gov/immigrants/lawfully-present-immigrants/

[12] 83 *Fed. Reg.* 51114-51296 (October 10, 2018) available at https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds, accessed October 10, 2018.

[13] Ibid.

[14] Ibid.

[15] Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/; Michael Fix and Jeffrey Passel, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform 1994-97* (Washington, DC: The Urban Institute, March 1, 1999) https://www.urban.org/sites/default/files/publication/69781/408086-Trends-in-Noncitizens-and-Citizens-Use-of-Public-Benefits-Following-Welfare-Reform.pdf; Namratha R. Kandula, et. al, "The Unintended Impact of Welfare Reform on the Medicaid Enrollment of Eligible Immigrants, *Health Services Research,* 39(5), (October 2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361081/; Rachel Benson Gold, *Immigrants and Medicaid After Welfare Reform*, (Washington, DC: The Guttmacher Institute, May 1, 2003), https://www.guttmacher.org/gpr/2003/05/immigrants-and-medicaid-after-welfare-reform.

[16] Neeraj Kaushal and Robert Kaestner, "Welfare Reform and Health Insurance of Immigrants," *Health Services Research*,40(3), (June 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361164/

Center on Budget and Policy Priorities

Immigration Officials Given Extremely Broad Authority Under Trump Administration's Proposed Rule

BLOG POST | OCTOBER 10, 2018 AT 9:15 AM | BY SHELBY GONZALES

Update, October 11: We've updated this post.

The Trump Administration officially proposed a rule today that would radically alter the U.S. immigration system, making it much harder for many immigrants lawfully in the country to remain here and for many seeking legal entry to come. The rule directs immigration officials to reject applications from individuals who seek to remain in, or enter, the country if they have received — or are judged *likely* to receive in the future — any of an extensive array of benefits tied to need.

The authority that the rule would confer on immigration officials is extremely broad. It risks having officials, potentially acting in some cases in response to the current political environment (or to their own biases), turn down many hard-working individuals who labor in jobs that the economy needs but that pay low or modest wages (or who would work in such jobs if admitted to the United States).

Under longstanding immigration law, an official can deny individuals the opportunity to come to the United States — or deny an adjustment to their immigration status that allows them to remain here and have a chance ultimately to become a citizen — if the official rules that they're likely to become a "public charge." But the proposed rule greatly expands the definition of what a "public charge" can mean. Under the new rule, an immigration official would take into account whether an individual receives — or is likely to receive in the future — basic health coverage through Medicaid, basic food assistance through SNAP (food stamps), rental assistance, or subsidies to help Medicare beneficiaries of modest means afford prescription drugs. (Immigration officials would also consider the receipt of cash assistance that falls under the *current* definition of public charge, such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).)

Even individuals legally in the United States who have *never* received any assistance through these programs could be denied adjustment of status allowing them to stay here — based on an immigration official's judgment that they are likely to receive assistance from one of these programs sometime in the future and, thus, become a "public charge."

As noted, under the rule, there would be risk that the political views of whoever is President at the time, or immigration officials' own biases, could influence these judgments. An immigration official may assume that any individual person of color is likelier to have low income, and thus to qualify for benefits like SNAP or Medicaid, and might deem them likely to become a public charge without fairly considering all factors.

The public charge standard that the proposed rule lays out differs sharply from the policy that's been in place for decades under Republican and Democratic administrations alike. Currently, immigration officials consider whether an individual applying for a status adjustment or entry into the United States is, or is likely to become, reliant on the government for *more than half* of his or her cash income by receiving *cash assistance* (aid under TANF, SSI, or state or local General Assistance programs) or if the individual receives or is likely to receive long-term care benefits under Medicaid. Receipt or potential future receipt of Medicaid, SNAP, or other such non-cash programs, which serve *many times* the number of people that the cash assistance programs and Medicaid long-term care do, is *not* considered.

The programs that the proposed rule would sweep into the public charge determination process enable tens of millions of people to obtain health coverage or put food on the table, often for short periods until their prospects improve. Nearly *one-third* of all *U.S.-born citizens* participated in these programs at some point in 2015; a substantially larger share of U.S.-born citizens will receive one or more of these benefits at some point over their lifetimes. By contrast, only 5 percent of U.S.-born citizens participated in 2015 in any of the much narrower group of programs (i.e., the cash assistance or long-term care programs) that are part of the *current* public charge determination process.

Nor is that the full extent of the sweeping nature of the proposed rule. It also specifies how immigration officials should consider a variety of other factors — including income, age, health, education, and skills — when determining whether an individual is likely to become a public charge. In particular, an immigration official could count against an individual the fact that his or her family has income below 125 percent of the poverty line — about $31,375 for a family of four, which is more than *twice* what full-time, minimum-wage work pays. Many low-wage workers have earnings below this level and hence could be deemed likely to become a public charge, even if they receive no benefits. That suggests that few individuals with low or modest incomes would be granted status adjustment or lawful entry to the United States. For many people seeking to enter the United States from a country where incomes in general are much lower, that standard could simply be out of reach.

Without congressional involvement, the Administration would thus effect major changes in the nation's immigration system, shifting it away from family-based immigration toward one restricted to people who are already relatively well-off or highly skilled when they enter the country. Doing that, however, would ignore our nation's centuries-long experience — still true today — of immigrants coming to our shores, building a better life for themselves and future generations, and contributing thereby to our economy. It reflects a pinched, narrow view of who contributes to our communities and our society, how our economy works, and what our nation should look like.

TOPICS: Poverty and Inequality

Center on Budget and Policy Priorities

Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims

OCTOBER 9, 2018 | BY JESSE CROSS-CALL

As residents of Idaho, Nebraska, and Utah prepare to vote this November on initiatives to expand Medicaid as part of the Affordable Care Act (ACA), a large and growing body of evidence shows that Medicaid expansion has produced large gains in health coverage and improved beneficiaries' physical and financial health. "With dozens of scientific analyses spanning multiple years, the best evidence we currently have suggests that Medicaid expansion greatly improved access to care, generally improved quality of care, and to a lesser degree, positively affected people's health,"[1] according to the lead author of an analysis of peer-reviewed evidence on the expansion's impact.[2]

> A LARGE AND GROWING BODY OF EVIDENCE SHOWS THAT MEDICAID EXPANSION HAS PRODUCED LARGE GAINS IN HEALTH COVERAGE AND IMPROVED BENEFICIARIES' PHYSICAL AND FINANCIAL HEALTH.

In the face of this evidence, critics of Medicaid expansion (including the conservative Foundation for Government Accountability and similar state-level organizations) have centered their opposition on the claim that expansion has financially harmed states because some states underestimated the number of people who would enroll.[3] This argument doesn't hold up under scrutiny. As a review of studies on the cost of expansion concluded, "[c]laims that the costs of Medicaid expansion have far exceeded expectations are overstated, misleading, and substantially inaccurate, based on a review of the credible evidence from either academic or government sources."[4]

Medicaid Expansion Continues to Produce State Budget Savings

Under the ACA, the federal government paid 100 percent of the cost of Medicaid expansion coverage from 2014 to 2016. The federal share dropped to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019 and will settle at 90 percent in 2020 and each year thereafter. By comparison, the federal government pays between 50 and 76 percent of the cost of other Medicaid enrollees, depending on the state.

Many state and independent analyses have found that expansion produced *net savings* for state budgets while the federal government was paying the full cost of expansion enrollees, since expansion allowed states to spend less in other areas.[5] For example, as more people gained coverage, hospitals' uncompensated care costs — and thus, for some states, payments to hospitals to help cover those costs — fell. States also spent less on programs serving people with mental health or behavioral health needs since Medicaid paid for their treatment, and less on corrections as federal Medicaid dollars paid a greater share of the inpatient hospital costs of inmates eligible for and enrolled in Medicaid. And, in states that tax managed care plans serving Medicaid beneficiaries, increased enrollment has generated revenue gains that further offset the cost of expansion.

Going forward, even with the federal share of expansion dropping to 90 percent, some states project savings that will offset much (though not all) of their expansion costs, while others project expansion will continue producing net budget savings.

- **Arkansas**. Medicaid expansion will produce net state savings each year through fiscal year 2021, and $444 million total from 2018-2021, as the state pays less to hospitals to cover uncompensated care costs and collects more premium tax revenue, among other factors.[6]

- **Michigan**. Net savings from expansion will total more than $1 billion from 2018-2021 due to increased tax revenue and savings on state mental health programs.[7]

- **Montana**. Expansion has produced net savings for the state since coverage began in 2016. That's because the state now gets the higher match rate for some Medicaid beneficiaries it previously covered at its regular Medicaid match (66 percent) and generates savings in its corrections system.[8]

- **Virginia**. Expansion, which the legislature passed in June, is projected to save the Commonwealth $421 million in its first two years as Virginia claims the enhanced matching rate for some populations it previously covered at its regular Medicaid match (50 percent) and generates savings in its corrections system and elsewhere.[9]

In Idaho, where voters will decide on expansion in November, a recent report that the consulting firm Milliman prepared for the state found that expansion would allow Idaho to spend less on several state-funded programs for the low-income uninsured, such as its catastrophic care fund and inpatient hospital services for people in the corrections system.[10] These offsetting savings would reduce Idaho's net cost from expansion to $21.5 million during the first full year coverage would be offered. This means Idaho would spend about *$20 per month* on the Medicaid coverage for each of the more than 90,000 low-income residents gaining coverage.

The conservative Heartland Institute and the Idaho Freedom Foundation (IFF) claim that Milliman's enrollment projections are too low given that enrollment exceeded projections in some expansion states.[11] But Milliman incorporated the experiences of Arkansas, Montana, and other states that enrolled more people than they projected in its calculations for Idaho and *still* found a minimal cost to the state. The Heartland-IFF report also claims that spending on expansion has made it harder for states to fund other priorities like education and transportation, but a 2017 study in *Health Affairs* found no evidence of this.[12]

In fact, Medicaid enrollment and costs have stabilized after initial growth when expansion first took effect in 2014. Overall Medicaid enrollment grew by 8.8 percent in 2014 and 7.6 percent in 2015 but only 3.1 percent in 2016, according to the Centers for Medicare & Medicaid Services' (CMS) actuary.[13] CMS projects enrollment growth of 2.1 percent in 2017 and 1.3 percent annually from 2017 to 2026. Per-beneficiary costs were higher among expansion beneficiaries than among previously eligible adults in 2014 and 2015 but fell in 2016 and 2017 and are now *lower* than among previously eligible adults.

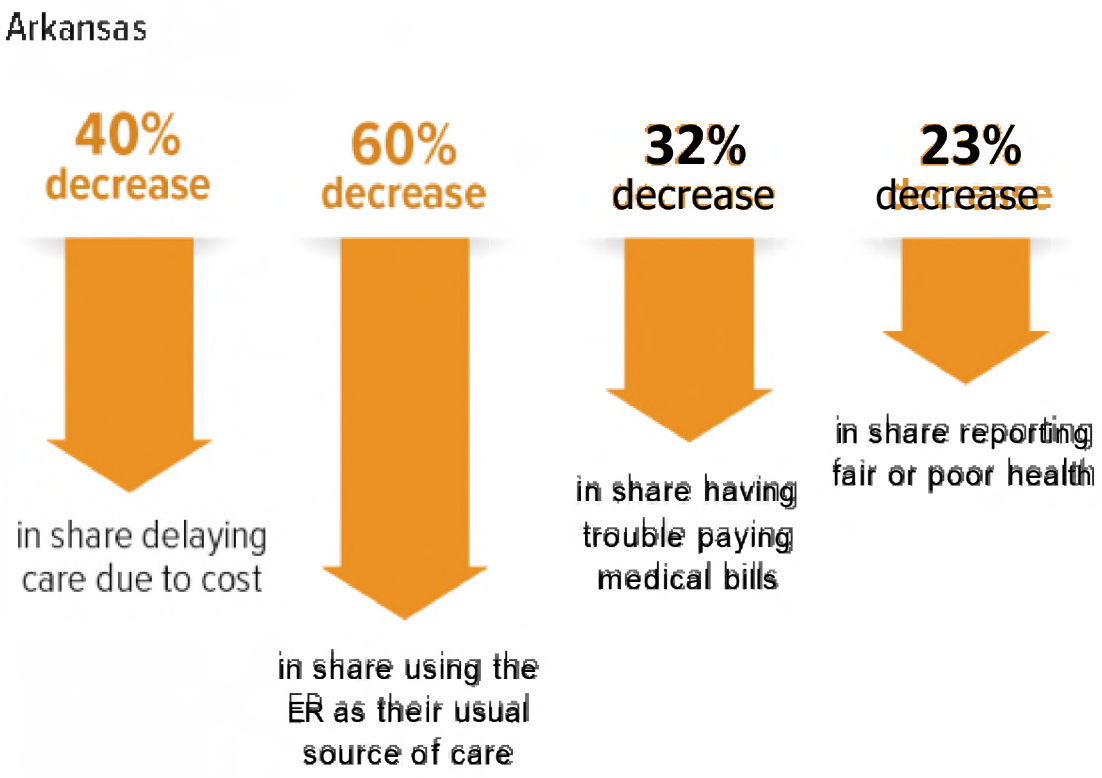
Medicaid Expansion Has Led to Large Coverage Gains, Improved Health, and Supported Work

Even as expansion imposes little if any burden on state budgets, evidence of its positive impacts continues to accumulate.

States that have adopted expansion have a much lower uninsured rate than states that haven't, and the gap continues to widen. The uninsured rate in expansion states dropped 6.4 percentage points from 2013 to 2017, from 13 percent to 6.6 percent, according to Census data.[14] In non-expansion states, it dropped 4.8 percentage points, from 17 percent to 12.2 percent. This gap between expansion and non-expansion states has grown each year beginning in 2014.

Improving Low-Income People's Financial Security in Arkansas and Kentucky

Estimated effect through 2016



Note: States have the option to expand their Medicaid programs under the Affordable Care Act. The study estimated changes in outcomes in Kentucky and Arkansas relative to changes in Texas, which did not expand Medicaid.

Source: CBPP calculations from Sommers, et al., Health Affairs, 2017

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Beneficiaries gaining coverage through expansion are using it to obtain cancer screenings, prescription drugs, and treatment for chronic health conditions. Evidence suggests that expansion coverage leads to more appropriate use of care by increasing the use of primary care services and reducing emergency room visits by the uninsured.[15] And expansion has reduced the medical debt of low-income Americans and improved their financial situation generally.[16] (See Figure 1.)

Medicaid also supports work. "No studies have found negative effects of expansion on employment or employee behavior," a comprehensive literature review by the Kaiser Family Foundation found,[17] and expansion hasn't significantly affected other economic measures like labor force participation and the number of work hours per week.

The Heartland-IFF report claims that expansion could "pull tens of thousands of hard-working Idahoans out of the labor force."[18] To the contrary, ample evidence suggests that Medicaid expansion has been a crucial work support for people with low incomes. In studies conducted in Michigan[19] and Ohio,[20] expansion beneficiaries with jobs said Medicaid coverage has made it easier for them to maintain employment, while those without jobs said coverage made it easier for them to look for employment.

Conclusion

Voters in Idaho, Nebraska, and Utah will decide in November whether to expand Medicaid as part of the ACA, while policymakers in Georgia, Kansas, and other non-expansion states are giving renewed consideration to expansion. There is ample evidence of the benefits of expansion, from increased health coverage to improved physical and financial health among those who gain coverage. Claims that higher-than-expected enrollment in some states has harmed state budgets don't hold up under scrutiny. Expansion continues to save states money or come at a minimal cost.

TOPICS: Health, Medicaid and CHIP

End Notes

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Immigrants and the New Proposed "Public Charge" Rule

OCTOBER 2, 2018

By Billy Wynne <https://www.chcf.org/person/billy-wynne/>, Dawn Joyce <https://www.chcf.org/person/dawn-joyce/>

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This article was updated to include formal publication of the proposed rule in the Federal Register.

On October 10, 2018, the Department of Homeland Security (DHS) published in the Federal Register highly anticipated proposed changes to "public charge" rules that could disqualify many immigrants from gaining permanent residency in the US.

Public charge is the determination that evaluates whether someone is likely to become reliant on public benefits, and consequently whether he or she may enter the country or modify his or her immigration status to become a permanent resident (a "green card" holder). Historically, the determination has only considered cash benefits like Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), local General Assistance (GA) payments, and long-term care benefits. Use of benefits previously has only been examined if they were used by the immigrant themselves — not by a member of their family. The proposed rule would expand the benefits under consideration to include core safety-net programs, including health, nutrition, and housing benefits. It would change the meaning of the term public charge, redefine and expand the types of benefits considered in public charge determinations, and outline new processes for conducting what's called the "totality of circumstances" test, the test used to examine a range of factors to determine whether an immigrant is likely to become a public charge.

Last year, the government announced that it would propose changes by July 2018, but none were officially published in that timeframe. However, in the spring of 2018, the press acquired two draft versions of the proposal, enabling the policy and advocacy communities to delve into the details before the rule's formal release.

On September 22, a draft of the text of the proposed changes was officially released <https://www.dhs.gov/news/2018/09/22/dhs-announces-new-proposed-immigration-rule-enforce-long-standing-law-promotes-self> by DHS, and on October 10 the proposed rule was formally published <https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds>. Public comments can be submitted until 8:59

p.m. Pacific Time on December 10, 2018. DHS will consider those comments before issuing the final rule. It is unclear when the final rule would take effect. The proposed rule solicits comments about the implementation schedule. A companion rule regarding public charge deportability is also pending at the Department of Justice.

Significant Public Confusion

Even though the DHS rule is not retroactive, it has caused public confusion and reportedly led families to withdraw from benefits out of fear that they will be penalized in immigration considerations if family members have received Medicaid, Supplemental Nutrition Assistance Program (SNAP), or other forms of government assistance.

The proposal calls for DHS to define a public charge as "an alien who receives one or more public benefits." It would expand the types of benefits considered in public charge determinations by adding the following to the cash assistance and long-term care benefits that are currently considered:

- Non-emergency Medicaid (with exceptions for certain services, as well as for foreign-born children of US citizens)
- SNAP
- Premium and cost-sharing subsidies within Medicare Part D
- Housing programs (Section 8 Housing Choice Voucher Program, Section 8 Project-Based Rental Assistance, and subsidized public housing)

The draft rule also solicits comments on whether the Children's Health Insurance Program or other benefits not currently included in the proposal should be added.

Looking Back 36 Months at "Positive" and "Negative" Factors

DHS proposes reviewing the previous 36 months of benefit use. This "look back" period is markedly different from current public charge determinations, which are exclusively prospective.

In the new rule, DHS put forward that it will continue making public charge inadmissibility determinations within the context of an immigrant's overall situation — referred to as the "totality of circumstances" test. The test includes consideration of:

- Age
- Health
- Family status
- Assets, resources, and financial status
- Education and skills
- A required affidavit of support from a sponsor

DHS proposes codifying the totality of circumstances test by using a weighted evaluation system that compiles "positive factors" and "negative factors" to determine whether an immigrant is a public charge. DHS estimates that it will take applicants four and a half hours to complete a new form and submit the required documentation about these factors, including past medical records in certain circumstances.

As noted by immigration policy consultant Ignatius Bau, part of the impact of the proposal stems from the fact that the list of negative factors is much longer than the list of positive ones, which increases the likelihood of someone being deemed a public charge. For example, simply being under age 18 or over age 62 would automatically be a negative factor. Not having a college education would be a negative factor. Speaking English with limited proficiency would be a negative. Having any health condition that might require treatment (and not having private health insurance to pay for anticipated treatment) would be a "heavily weighted negative factor." A poor credit rating would be a negative, and all applicants would have to submit credit reports. Having a household income above 250% of the Federal Poverty Guidelines (FPG) would be a heavily weighted positive factor, while a household income below 125% of FPG would be a negative. These characteristics would be weighed for all permanent residency applicants in addition to the questions about previous use of public benefits on the expanded list.

A household income above 250% of the Federal Poverty Guidelines would be a heavily weighted positive factor, while a household income below 125% of the Guidelines would be a negative.

DHS proposes to establish thresholds above which it would consider use of public benefits as a "heavily weighted negative factor" when evaluating an applicant. Two types of thresholds would be used: the dollar value of the benefit and the length of time during which an applicant receives a benefit. For cash and cash-like "monetized" benefits — SSI, TANF, GA, SNAP and housing vouchers — the threshold would be set at 15% of FPG for a single person in a 12-month period ($1,821 in 2018). If an applicant exceeded this 15% threshold, it would be a "heavily weighted negative factor." For "non-monetized" benefits including non-emergency Medicaid coverage, premium and cost-sharing subsidies within Medicare Part D, and subsidized public housing, the rule outlines a limit of 12 months over the last 36 months, or nine months if an applicant is also receiving monetized benefits, such as a combination of SNAP and subsidized public housing.

Effects on US Citizen Children with a Relative Seeking a Visa or a Green Card

There are important differences between the formal rule proposal <https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds> and what was reported in the media last spring. The new version would not count benefits used by US citizen children against a family member seeking to enter the country or applying for permanent immigration status. The earlier drafts proposed to weigh Medicaid enrollment, SNAP, and other health and human service benefits received by US citizen children as a negative factor when a parent applied for an immigration status change. The latest draft would consider US citizen children when looking at household size for determining either the 125% or 250% FPG income test, but "the direct receipt of public benefits by those children would not factor into the public charge inadmissibility."

The September draft omits the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) from the list of public benefits it proposes weighing in public charge determinations. The spring version proposed to consider WIC benefit use, which led to a national outcry.

Another notable distinction between the drafts is that DHS is now seeking comments regarding how public charge determinations should be conducted for "alien children" who received public benefits while minors. With a 36-month look back period, an 18-year-old applying to change immigration status could be viewed as a public charge based on benefits received at ages 15, 16, or 17.

The new draft could expand the categories of immigrants that are evaluated for self-sufficiency. DHS states that it seeks to clarify the agency's authority to set conditions for nonimmigrant extension of stay and applications for change of status "even though public charge inadmissibility does not apply to them." DHS' draft changes also state that in "certain limited circumstances" a lawful permanent resident returning from a trip abroad will be considered an applicant for admission and therefore subject to an inadmissibility determination, despite the precedent that permanent residents are not otherwise subject to public charge determinations.

DHS estimates the government will save $2.27 billion annually due to disenrollment or forgone enrollment in public benefit programs because of individuals' concern about the immigration impact of receiving public benefits. The September rule also contemplates reduced revenue for a range of entities as a consequence of disenrollment in public benefits, including health care providers, pharmacies, and grocery stores.

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