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  January 1, 2020

The Potential National Health Cost Impacts to Consumers, Employers and Insurers Due to the Coronavirus (COVID-19)

Introduction

This policy/actuarial brief provides projections and models the potential costs associated with coronavirus (COVID-19) testing and treatment on the national commercial health insurance markets (individual, small and large group employers — including both those employers that are insured and self-funded). There are additional cost and access implications for Medicare, Medicaid, other public programs, and the uninsured, but this brief focuses only on the impacts on Americans with commercial insurance coverage. Major findings include:

- **The one-year projected costs in the national commercial market range from $34 billion to $251 billion** for testing, treatment and care specifically related to COVID-19 — with the potential that costs could be higher than the high end of the range.
- **Potential COVID-19 costs for 2020 could range from about 2 percent of premium to over 21 percent of premium** if the full first-year costs of the epidemic had been priced into the premium.
- Health carriers are in the process of setting rates for 2021. If carriers must recoup 2020 costs, price for the same level of costs next year, and protect their solvency, **2021 premium increases to individuals and employers from COVID-19 alone could range from 4 percent to more than 40 percent**.

Background

The coronavirus (COVID-19) pandemic is causing large financial and personal impacts to virtually all Americans. In addition to the impacts on individuals and the major disruption of the national economy, this disruption is particularly acute in the health care sector. The impacts of the COVID-19 pandemic is huge in the United States with a possibility that 50%

Highlights

The potential impacts detailed in this report reflect what could happen absent decisive federal action. If these impacts are not mitigated, the public health and economic consequences to consumers, small and large employers and health insurers are potentially staggering, including:

- Consumers and employees not getting needed testing or treatments due to cost barriers, both for COVID-19 but also for other health conditions.
- Employers no longer being able to offer affordable coverage, or dramatically shifting costs to employees.
- Consumers and employers no longer being able to afford coverage, leading to employer groups dropping coverage or individuals deciding to go uninsured.
- Even more unsubsidized marketplace enrollees being priced out of individual markets.
- Small insurers risk insolvency, and if they close, put covered consumers at financial risk, damaging competition that benefits consumers and the employers that purchase on behalf of millions of Americans.
- Dramatic cost increases, many of which will be borne by the federal government in the form of higher Advanced Premium Tax Credits (APTC), or by both federal and state governments paying for increased Medicaid enrollment as individuals and employers drop coverage.

This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

of the total population may be infected with COVID-19. COVID-19 may have a devastating impact on America's seniors which will be reflected in illness, deaths and Medicare costs. It will have large impacts on Americans served by Medicaid programs and the state that operate these vital safety net programs; and it will affect the millions who remain uninsured. This policy/actuarial brief, however, focuses on the commercial market that includes up to 20 million high-risk people under age 60 who are at higher risk of having significant health needs due to the virus, and many in the commercial market who are not high-risk but will need testing and care when infected by COVID-19.

As roughly half of the US population receives its health care coverage through employers or through direct purchase in the individual market and exchanges, much of the COVID-19 testing and treatment will be paid through commercial health insurers. Claims for testing, hospitalization and other treatment will likely begin to emerge in a significant way in 2020, with those costs continuing into future years. Commercial-population insurance premium rates for 2020 were set six to nine months before January of this year and well before there was even any hint of the virus. The health care and insurance industries were unprepared for the onset of such an unexpected occurrence.

Projections of Potential National Commercial Market COVID-19 Costs

The summary of low, medium and high projections for the potential testing and treatment costs of COVID-19 on the Commercial Market is summarized in Table 1: Projected First Year Costs for National Commercial Market COVID-19 Testing and Table 2: Projected First Year COVID-19 National Commercial Market Treatment Costs.

As described in the discussion that follows these tables, while there is substantial uncertainty regarding many of the important variables for this analysis, all parameters were chosen based on best-available data and input from actuarial and clinical advisors.

The Medium Estimates in the tables are meant to reflect a "best estimate" given what we know today and the huge uncertainty in making projections. The Low Estimate may occur if mandatory "shelter in place" actions have a big effect. The High Estimate is not a "worst case" but represents a possible outcome with somewhat higher than expected positive test results and the percentage of patients requiring hospitalization is somewhat higher (i.e., 25%) than currently being observed in other countries.

Table 1: Projected First Year Costs for National Commercial Market COVID-19 Testing[1]			
ESTIMATE RANGE	LOW	MEDIUM	HIGH
Commercially Insured Population	170 million		
Estimated Number at Higher Risk	20 million		
Assumed % of Higher Risk Tested	25%	50%	75%
Modeled Number Tested	5 million	10 million	15 million
Remaining Non-Higher Risk	150 million		
Assumed % of Non-Higher Risk Tested	10%	20%	30%
Modeled Number of Non-HR Tested	15 million	30 million	45 million
Estimated Number of All Tested	20 million	40 million	60 million
Lab-only Test Costs (includes what would have been consumer out of pocket portion)	$120		
% for Lab-only or Drive-Through	75%	25%	20%
Number of Lab-only or Drive-Thru	15 million	10 million	12 million
Lab AND PCP or Televisit Average Cost (includes what would have been consumer out of pocket portion)	$240		
% for Lab and PCP/Televisit	25%	75%	80%
Number for Lab and PCP/Televisit	5 million	30 million	48 million
Total Cost at Commercial rates (includes what would have been consumer out of pocket portion)	$3.0 billion	$8.4 billion	$13.0 billion

Table 2: Projected First Year COVID-19 National Commercial Market Treatment Costs[1]			
ESTIMATE RANGE	LOW	MEDIUM	HIGH
Projected number of positive cases (among those tested)	4.0 million	8.0 million	15 million
Assumed % requiring hospitalization (for those under 60)	10%	15%	20%
Projected number of cases requiring hospitalization	400,000	1,200,000	3,000,000
Assumed Length of Stay (severe cases)	12 days		
Assumed Insurance Reimbursement — Commercial (includes consumer out of pocket portion)[2]	$72,000		
Projected Hospital Costs for severe cases	$28.8 billion	$86.4 billion	$216.0 billion
Assumed % of cases that require outpatient services	90%	85%	80%
Projected number of cases that require outpatient services	3,600,000	6,800,000	12,000,000
Assumed physician reimbursement for cases that require outpatient services — Commercial (includes consumer out-of-pocket portion)	$600	$1,200	$1,800
Projected physician cost for cases that require outpatient services	$2.2 billion	$8.2 billion	$21.6 billion
Total projected costs for treatments at commercial insurance rates (includes consumer out of pocket portion)	$31.0 billion	$94.6 billion	$237.6 billion

Assumptions and Methodology

1. Likely People Affected Nationally by COVID-19 in the Commercial Market

- The total market for individuals covered by private health Insurance is about 170 million — which does not include those eligible for Medicare and Medicaid, or those who are uninsured.[3]
- Of those with private health insurance, there might be 29 million people *under* age 60 at risk due to health conditions.[4] (Many more people over 60 will also be at risk, but most will be covered by Medicare.) Of this number, there may be 4 million uninsured and, possibly 20% who are covered by Medicaid. Thus, we project that there are 20 million people under age 60 who are at higher risk of serious illness from COVID-19. This number may need to be revised to include people aged 61 to 64 with commercial coverage.

2. Estimates of Potential Testing Costs Nationally

- **Summary:** Assuming that there is a large outbreak of the disease, some estimates are that 120 million of the 170 million non-elderly Americans could show some symptoms (i.e., fever, etc.). If this happens, then consideration would likely be given to testing all of these individuals. But assuming that "only" 20 to 60 million get tested the costs could be around $3 billion to $13 billion for one year of testing.

- **Basis for this estimate:** The two variables that affect cost are the number of those in the commercially insured population who will get tested and the cost of providing those tests (see Table 1. Projected First Year Costs for National Commercial Market COVID-19 Testing, which shows the assumptions and calculations).

  - **Number of people getting tested:** For the purpose of developing these estimates, we modeled a Low Estimate of 25% of those at Higher Risk and 10% of non-Higher Risk individuals getting tested. For the High Estimate, we modeled 75% of those at Higher Risk and 30% of non-Higher Risk individuals getting tested. Some individuals might be triaged using online survey tools that could indicate they may not require testing.

  - **Costs of testing:** The costs of testing may vary dramatically. Generally, testing costs entail clinician/visit costs and the costs of the actual lab work. Based on expert review, the costs incurred for a primary care physician (PCP) visit or televisit could range from about $75 to $25, respectively, and lab work ranging from $36 to $51 at Medicare rates — for a total cost ranging from $61 to $126. For the purpose of estimating the cost of testing with a related clinician visit, we have used an average total cost of $100 (at Medicare rates), corresponding to $240 at estimated commercial rates. However, if the healthcare system widely offers "drive-through" visits as currently being done in South Korea and some U.S. cities, the physician component might be mostly eliminated, for such testing we have used a total cost figure of $50. The Low Estimate models the costs if testing is evenly split between "lab-only" testing and Lab and PCP/televisit testing, while the High Estimate models only 25% of the testing being lab-only. It is also possible that much of the cost taken be borne directly by the federal, state and local governments. To the extent direct public funding pays the testing costs, all of these estimates would need to be adjusted.

3. Estimates of Potential Treatment Costs Nationally

- **Summary:** Assuming that there is a large outbreak of the disease, which may result in half of the population getting infected, with from 4 to 15 million individuals in the national commercial market having confirmed cases after testing, the main cost drivers will be how many of those require hospitalization versus out-patient care and the costs of those services. Modeling from 10% to 20% of those getting infected needing hospitalization, and commercial rates, the costs could range from $31 billion to $238 billion for the first year.

- **Basis for this estimate:** The two variables that affect the treatment costs are the number of those in the commercially insured population who will get infected, the level of services needed for those infected and the costs of those services (see Table 2. Projected First Year COVID-19 National Commercial Market Treatment Costs, which shows the assumptions and calculations).

  - **Number of people getting infected and level of treatment:** For the 20 million high risk individuals in the commercial markets, there are not good estimates of the percent of people who would actually get infected and, of those, how many might need hospitalization and the length of their hospitalization.

We expect that relatively few COVID-19 cases for those under age 65 will end up in a hospitalization, but that the cases involving hospitalization will have lengths of stay around 10-14 days. While it is far more likely those that infected high-risk individuals will require hospitalization and other treatment, there will be lower risk infected individuals also requiring care, including hospitalization. These projections are based on best evidence that the majority of those infected with the virus will not need either outpatient services or hospitalization. For the purpose of developing these estimates, we modeled a low estimate of 20 million people being tested with an infection rate of 20%; and of those infected 10% requiring hospitalization. For the high estimate we modeled 60 million people being tested with an infection rate of 25%; and of those infected 20% requiring hospitalization. Those not hospitalized are modeled as cases receiving out-patient care. Under these models, assuming 50 percent of the individuals in the commercial market are infected, these projections assume between 5 percent at the Low Estimate and 17 percent at the High Estimate may need hospitalization or outpatient care. Also, while it is possible that as hospitals and doctors get more experience with COVID-19 patients, they may be able to divert lower-risk patients to alternative facilities, like Urgent Care and avoid high cost (and over-worked) hospitals, that is not modeled given the short-term nature of this potential program.

- **Costs of treatment:** The costs of treatment may vary dramatically. Costs could be roughly $30,000 per admission, based on Medicare rates and an average length of stay of 12 days (based on similar length of stay for flu or pneumonia patients), which translates to an average commercial cost of $72,000 (an estimate we validated with health plans and counsel from external actuaries. For cases requiring outpatient care, we have modeled the average cost at $600 per infected individual in the Low Estimate and $1,800 per infected individual in the High Estimate. The basis for these estimates is an assumption that each person with a case requiring outpatient care would have one primary care physician office visit and two televisits. The $600 is a best estimate based on estimated $250 that Medicare would pay for these three visits and applying the 2.4 multiplier.

Note that the cost estimates for 2020 are based only on the impacts due to testing and treatment for COVID-19 and do not include any estimates of cost impacts related to the potential impact to utilization for other conditions that may result from COVID-19's significant impact to the health care delivery system. These could include reductions in some services (e.g., elective surgeries), but also an unknown increase in adverse events due to delays in preventive care or disease management for chronic conditions.

Projected Costs for the Commercial Market Nationally for 2021

Given the significant uncertainty of projecting 2020 costs and the unknown incidence of the COVID-19 disease, projecting costs for 2021 is even more uncertain. In addition to the modeled testing, hospitalization and other treatment costs projected above for 2020 (which might be repeated in 2021), there could be additional treatment costs for:

- Anti-viral drug treatment at some unknown cost, perhaps in a wide range of $50 to $2,000 per dose. Some pharmaceutical companies are currently trying to determine if some of their current drugs might be effective in treating COVID-19; and
- There are multiple efforts underway to create and test a vaccine that would be effective on COVID-19 (much the same way the flu vaccine is effective in prevention of flu episodes). It is unknown when such a vaccine would be ready and whether it could be distributed for a 2021 COVID-19 season (if COVID-19 follows the "winter pattern" of the flu) and what its cost might be.

Another unknown factor for 2021 and later is that we do not know at this time whether COVID-19 will follow a seasonal pattern (i.e., higher in the winter and then very low in the summer months) like the flu or whether it would be a year-round affliction.

While projections of 2021 costs is difficult, we suggest that it is not prudent to plan today on lower costs related to COVID-19 in the 2021 calendar year than we project for 2020. Only when we know more about COVID-19 and whether drug treatments or a vaccine are effective should we consider modifying cost estimates for 2021.

Limitations of the Analysis of Potential National Commercial Market COVID-19 Costs

The analysis presented here is directional and needs fuller, more detailed review and modeling for a range of reasons. First, we note that there are currently many unknowns about the incidence of the COVID-19 virus in the American population. We also know very little at this point about the likely levels of severity and the length of hospital treatment needed. In all cases, we have tried to make reasonable estimates, based on treatment of similar conditions.

The analysis is further silent on the issues of facility capacity for treatment of individuals needing to be hospitalized for COVID-19 treatment. This analysis assumes that the United States will be at least somewhat successful in flattening the curve of the infection rate so that the healthcare system can manage the capacity needed. It is also silent on the supply of healthcare workers and does not address potential risks to healthcare workers and any potential staffing shortages.

This policy/actuarial brief was prepared by John Bertko, Covered California's Chief Actuary. Prior to joining Covered California, Mr. Bertko served as an actuarial consultant and director of special initiatives and pricing for CMS's Center for Consumer Information and Insurance Oversight, the federal office charged with implementing changes of the Patient Protection and Affordable Care Act impacting the individual and employer markets as well as working with states to establish new health insurance exchanges. In prior positions, Mr. Bertko was a senior fellow at the LMI Center for Health Reform, an organization that provides analysis and direction to government leaders on federal health reform. He's also been adjunct staff at RAND and a visiting scholar at both the Brookings Institution and the Center for Health Policy at Stanford University. Previously, Bertko was chief actuary at Humana Inc., a for-profit health plan in Louisville, KY. In that role, he directed work for Humana's major business units, including development of Part D, Medicare Advantage and consumer-driven health care products. He serves on the panel of health advisors for the Congressional Budget Office and completed a 6-year term on the Medicare Payment Advisory Commission (MedPAC).

The report reflects the engagement and counsel from experienced external actuaries with deep expertise in the commercial insurance markets, as well as expert clinical review and interviews with health insurance plans. It is informed by the best available data in a rapidly changing environment and has been prepared to inform the national response to the COVID-19 epidemic as policy makers prepare to cope with and mitigate its impacts. While informed by similar sources, this Covered California Policy/Actuarial Brief was prepared separately from work being done by the State of California to model the impacts of the COVID-19 pandemic on that state. Examples of data used to develop this report not referenced in the body of the report include those referenced in the Appendix.

Appendix – References

Kaiser Family Foundation. "How Many Adults Are at Risk of Serious Illness if Infected with Coronavirus?" https://www.kff.org/global-health-policy/issue-brief/how-many-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/ published March 2020

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CDC, Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) – United States, February 12-March 16, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm. March 18, 2020.

CMS posted a fact sheet providing a HCPCS code and fee schedule for COVID-19 testing performed by CDC laboratories and non-CDC laboratories: https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf.

https://www.cnn.com/2020/03/02/asia/coronavirus-drive-through-south-korea-hnk-intl/index.html

Review of treatments and outcomes in Wuhan, China. One source is The Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext

For estimate hospitalization length of stay, review of a consultant's proprietary claims data sets with DRGs associated with pneumonia, the flu, and sepsis, which may be reasonable proxies for the treatment protocol for COVID-19

COVID-19 codes were recently assigned and were recently published and are available online at: https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding- Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

For Medicare beneficiary costs: https://www.urban.org/urban-wire/covid-19-treatment-costs-could-hit-some-medicare-beneficiaries-high-out-pocket-expenses

Endnotes

1 All estimates for unit costs are derived from first calculating estimated costs at Medicare rates and then inflating those rates to estimated commercial rates based on published studies finding commercial payments to be on average 241 percent of Medicare across inpatient and outpatient settings – this Policy/Actuarial Brief uses a 2.4X multiplier for all costs originally derived from Medicare rates. See, White, Chapin, Whaley, Christopher, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely," 2019, https://www.rand.org/pubs/research_reports/RR3033.html.

2 Our research for hospital costs using a claims database from a large actuarial consulting firm suggests that the cost of hospitalization for related illnesses like the flu and pneumonia is approximately $72,000 for a 12-day average length of stay (ALOS), confirmed by interviews with commercial payers. We reviewed other publicly reported hospitalization costs based only on pneumonia from a different database, which estimated costs of approximately $20,000 and found those estimates to be far lower than actual costs. See https://www.healthsystemtracker.org/brief/potential-costs-of-coronavirus-treatment-for-people-with-employer-coverage/.

3 Kaiser Family Foundation. State Health Facts. Health Insurance Coverage of the Total Population. https://www.kff.org/other/state-indicator/total-population/ (accessed March 17, 2020).

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About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit CoveredCA.com.

COVERED CALIFORNIA

News Release

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FOR IMMEDIATE RELEASE
Jan. 23, 2020

Covered California's New Enrollment Surges Past Last Year's Mark with More than a Week Before the Upcoming Jan. 31 Deadline

- *More than 318,000 consumers have newly enrolled during the current open-enrollment period, surpassing last year's open enrollment total.*
- *However, new research shows that many Californians – particularly the uninsured – are unaware of a new state law which requires people to have health insurance or face a penalty.*
- *In addition, many Californians are unaware of the new financial help that is available for the first time this year, including first-in-the-nation assistance for middle-income consumers.*
- *Open enrollment, which continues through Jan. 31, is the one time when people can sign up for health insurance in the individual market without needing a qualifying life event.*

SACRAMENTO, Calif. — Covered California announced new enrollment data as it moved into the final week of open-enrollment and continued to reach out to consumers about the new state penalty and additional financial help that went into effect with the new year.

As of Wednesday, Jan. 22, more than 318,000 consumers had newly signed up for health insurance through Covered California during the current open-enrollment period, which surpassed last year's total of 295,000.

(more)

"With one week to go in open enrollment, Covered California has surpassed last year's open enrollment total, but thousands are signing up every day and we're not done yet," said Covered California Executive Director Peter V. Lee. "Californians have until midnight on January 31st to sign up and not only avoid paying a penalty to the Franchise Tax Board but — for almost a million Californians — get new help from the state to lower their health care costs."

The open-enrollment period runs through Jan. 31. It is the one time of the year when consumers can freely sign up for coverage without having to experience a qualifying life change. People who sign up by the deadline will have their coverage start on Feb. 1.

Having a health insurance plan in place this year is critical because of a new law that the state of California enacted that requires Californians to have coverage in 2020. Those who can afford coverage, but choose to go without it, could face a penalty when they file their taxes with the California Franchise Tax Board in 2021. The penalty can be more than $2,000 for a family of four.

"We do not want Californians to write a check to the Franchise Tax Board when they could get coverage that is way more affordable than they think," Lee said. "This year there is new financial help that will help nearly one million people lower the cost of their coverage."

A recent survey released by Covered California, Californians' Understanding of the Mandate to Have Health Coverage and the Awareness of Financial Help, found that many people, particularly the uninsured, are unaware of the new penalty and additional financial help. Among the findings:

Many Californians do not know about the new penalty

Many Californians reported being unaware of the new requirement to have health coverage in 2020 or face a penalty, including a majority of the *uninsured* (56 percent).

Many uninsured Californians are unaware that financial help is available

Among the *uninsured*, 62 percent are unaware that Covered California offers financial help to help pay for health insurance. In addition, only 27 percent of the uninsured are aware that Californians can receive even more financial help than ever before for health coverage.

"The new state subsidies and the requirement to have coverage are the two biggest changes effecting individuals who do not have employer coverage since Covered California first opened our doors in 2014 and we want to make sure consumers know that health insurance could be more affordable than they think," Lee said. "People need to take action by next Friday, so they do not get caught paying a significant penalty when they file their taxes a year from now."

(more)

In addition to the new state penalty California also expanded the amount of financial help available to many consumers, including a first-in-the-nation program to help middle-income consumers afford coverage.

The new state subsidies could extend to an individual making up to $74,940 and a family of four with a household income of up to $154,500.

Right now, the average subsidy for eligible consumers earning less than 400 percent of the federal poverty level is $447 per month; the average state subsidy for eligible middle-income consumers is $469 per month.

Californians Can Still Enroll

Covered California's open-enrollment period runs through Jan. 31. Consumers can easily find out if they are eligible for financial help and see which plans are available in their area by entering their ZIP code, household income and the ages of those who need coverage into Covered California's Shop and Compare Tool.

Those interested in learning more about their coverage options can:

- Visit www.CoveredCA.com.
- Get free and confidential in-person assistance, in a variety of languages, from a certified enroller.
- Have a certified enroller call them and help them for free.
- Call Covered California at (800) 300-1506.

"Californians owe it to themselves to take a few minutes of their day to see whether they qualify for financial help from the federal government, the state, or both," Lee said. "Visit CoveredCA.com and check out your options before the end of the month."

About Covered California

Covered California is the state's health insurance marketplace, where Californians can find affordable, high-quality insurance from top insurance companies. Covered California is the only place where individuals who qualify can get financial assistance on a sliding scale to reduce premium costs. Consumers can then compare health insurance plans and choose the plan that works best for their health needs and budget. Depending on their income, some consumers may qualify for the low-cost or no-cost Medi-Cal program.

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit www.CoveredCA.com.

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Resource

The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates

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California Health Benefits Review Program

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THE FEDERAL PREVENTIVE SERVICES HEALTH INSURANCE BENEFIT MANDATE AND CALIFORNIA'S HEALTH INSURANCE BENEFIT MANDATES

As a tool for analyzing legislation, the California Health Benefits Review Program (CHBRP) maintains this resource to identify potential overlap between the federal benefit mandate requiring health insurance coverage of some preventive services and California state benefit mandates. CHBRP provides independent evidence-based analysis of health insurance benefits-related legislation at the request of the California Legislature.

As indicated in federal[1] and California state[2] law, non-grandfathered group and individual health insurance plans and policies must cover certain preventive services *without cost-sharing when delivered by in-network providers* and *as soon as 12 months after a recommendation* appears in any of the following:

- The United States Preventive Services Task Force (USPSTF) A and B recommendations[3]
- The Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services[4]
- The HRSA-supported comprehensive guidelines for infants, children, and adolescents, which include:
  - The *Bright Futures* Recommendations for Pediatric Preventive Health Care[5], and
  - The recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children[6]
- The Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC)[7]

This resource is arranged as follows:

[1] Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act.
[2] California Health and Safety Code 1367.002 and California Insurance Code Section 10112.2.
[3] USPSTF created a concise document summarizing its A and B recommendations (Current as of June 2019), available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. However, for this resource CHBRP consulted USPSTF's A-Z Topic Guide because up-to-date summaries of recommendations are available through links on that webpage: https://www.uspreventiveservicestaskforce.org/BrowseRec/Index.
[4] Available at: https://www.hrsa.gov/womensguidelines2016/index.html.
[5] Available at: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx.
[6] Available at: https://www.hrsa.gov/advisory-committees/heritable-disorders/recommendations-reports/index.html.
[7] "Recommended immunization schedules for children and adolescents aged 18 years or younger—United States, 2019" available at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.

"Recommended immunization schedule for adults aged 19 years or older—United States, 2019" available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf.

Methods

For Table 1, CHBRP reviewed known benefit mandates in California's Health and Safety Code (H&SC) and the California Insurance Code (IC)[8] to identify state benefit mandates that seemed to overlap with the tests, treatments, or services partially or fully addressed by one or more of USPSTF's recommendations. Where there appears to be overlap, the relevant H&SC and IC are listed in the last column. If there does not appear to be overlap, "None identified" appears in the last column. CHBRP defines benefit mandates as per its authorizing statute.[9] Therefore, the listed mandates fall into one or more of the following categories: (a) offer or provide coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) offer or provide coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; and/or (c) offer or provide coverage permitting treatment or services from a specific type of health care provider. Listed mandates also include those that (d) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories.

USPSTF created a concise document summarizing its A and B recommendations[10] (last updated in June 2019). Table 1 is organized categorically by condition or disease groups addressed by a USPSTF recommendation. Categories are identified as cancer, chronic conditions, health promotion, pregnancy-related, and sexual health. The columns in Table 1 also indicate the specified test, treatment, or service, and any specified sex, age, or other characteristics of eligible enrollees. Blanks in these columns indicate that the USPSTF recommendation was not specific. It should be noted that USPSTF often does not specify age groups, but rather makes recommendations for "children," "adolescents," or "adults." The next column identifies specified terms of coverage. For clarity, the terms specified by the federal preventive services benefit mandate are always included and are in italics; the terms are "without cost-sharing when in-network" and "as soon as 12 months after recommendation release." If the USPSTF recommendation was released less than 12 months ago, that row is highlighted in the table. When the USPSTF recommendation seems to imply terms (e.g., frequency of event) which could affect the terms of benefit coverage, these are listed in the same column, without italics. When updates are made to any of the schedules, new benefit mandates are listed individually and highlighted, in order to indicate which are less than 12 months old and therefore may not be among the list for which benefit coverage is required.

For Table 2, CHBRP used complimentary methods, except that the known benefit mandates in the H&SC and IC were reviewed to identify overlap with HRSA-supported health plan coverage guidelines for women's preventive services,[11] developed by the Institute of Medicine (IOM)[12] in 2011 and updated by the Women's Preventive Services Initiative[13] in 2016.

For Table 3 and Table 4, CHBRP used complimentary methods with a few exceptions. For Table 3, the known benefit mandates in the H&SC and IC were reviewed to identify overlap with HRSA-supported comprehensive guidelines for infants, children, and adolescents, which include: (1) The *Bright Futures*

[8] CHBRP maintains a list of benefit mandates current in California, available at: http://www.chbrp.org/other_publications/index.php.
[9] Available at: http://www.chbrp.org/faqs.php.
[10] Available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[11] Available at: http://www.hrsa.gov/womensguidelines/.
[12] The Institute of Medicine (IOM) is now known as the National Academy of Medicine (NAM).
[13] More information about the Women's Preventive Services Initiative can be found at: http://www.womenspreventivehealth.org/.

Recommendations for Pediatric Preventive Health Care;[14] and (2) the recommendations of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.[15] For Table 4, the known benefit mandates in the H&SC and IC were reviewed to identify overlap with ACIP recommendations that have been adopted by the Director of the CDC.[16] For both Table 3 and Table 4, CHBRP has not listed each federal health insurance benefit mandate as specified by reference to HRSA and ACIP. Because individual recommendations often relate to multiple conditions and diseases, and because the schedules often imply complex variation by age—and sometimes by sex—we have aggregated the benefit mandates as screenings or treatments related to "wellness" or as "vaccine preventable diseases." Links to HRSA- and ACIP-supported schedules are provided in the tables.

[14] Available at: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx.
[15] Available at: https://www.hrsa.gov/advisory-committees/heritable-disorders/recommendations-reports/index.html.
[16] "Recommended immunization schedules for children and adolescents aged 18 years or younger—United States, 2017" available at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.

"Recommended immunization schedule for adults aged 19 years or older—United States, 2019" available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf.

Table 1. Federal Health Insurance Benefit Mandates as Specified by Reference to USPSTF A and B Recommendations[17] & Related Mandates in California State Law[18,19]

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
In the rows that follow, recommendations released less than 12 months prior to 2/3/2020 are highlighted in the same color as this cell. If the new recommendation revises an older recommendation, the change is underlined and defined.							
Cancer							
1	Breast cancer	An appropriate brief familial risk assessment tool. Women with a positive result should receive genetic counseling followed by genetic testing for BRCA1 or BRCA2, if indicated.	Women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with *BRCA1* or *BRCA2* gene mutation		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing	BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing1 (August 2019) Grade: B	Breast cancer screening, diagnosis, and treatment: H&SC 1367.6 IC 10123.8 Cancer screening tests: H&SC 1367.665 IC 10123.20

[17] Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act.
[18] For brevity, CHBRP has not listed in each row the California mandate (H&SC 1367.002 & IC 10112.2) which requires compliance with federal laws and regulations requiring coverage of preventive services without cost-sharing (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act).
[19] CHBRP is aware that state regulation may also require benefit coverage, but is focusing this resource on health insurance benefit mandate laws.
[20] Unless otherwise noted, the links listed below were accessed on or before 2/3/2020.
[21] Unless otherwise noted, the mandates listed below were reviewed on or before 2/3/2020.
[22] "Other" is included here in order to specify pregnant or non-pregnant women.
[23] "Other" is included here when more details are available about the intended group, beyond age.
[24] *Italicized terms* are explicit in the federal law (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act). Non-italicized terms of benefit coverage are implied by the referenced recommendation.

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
2	Breast cancer	Offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors	Women at increased risk for breast cancer and at low risk for adverse medication effects		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Breast Cancer: Medication Use to Reduce Risk https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-medications-for-risk-reduction1 (September 2019) Grade: B	Breast cancer screening, diagnosis, and treatment: H&SC 1367.6 IC 10123.8 Cancer screening tests: H&SC 1367.665 IC 10123.20
3	Breast Cancer (2016)	Screening mammography	Asymptomatic women who do not have preexisting breast cancer and who are not at high risk for breast cancer	50 to 74 years	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Biennial	Screening for Breast Cancer (2016) https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1 (January 2016) Grade: B	Mammography: H&SC 1367.65 IC 10123.81 Breast cancer screening, diagnosis, and treatment: H&SC 1367.6 IC 10123.8 Cancer screening tests: H&SC 1367.665 IC 10123.20

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
4	Cervical cancer	Cytology (Pap smear)	Women	21 to 65 years* *Women ages 30 to 65 have the option of this recommendation or the recommendation below	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Every 3 years	Screening for Cervical Cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2 (August 2018) Grade: A	Cancer screening tests: H&SC 1367.665 IC 10123.20 Cervical cancer screening: H&SC 1367.66 IC 10123.18
5	Cervical cancer	Cytology and high-risk human papillomavirus (hrHPV) testing (cotesting) or hrHPV testing alone* *The 2018 recommendation specifies cotesting or hrHPV alone (every 5 years) as an alternative to cytology alone every 3 years	Women	30 to 65 who want to lengthen screening interval* *Women have the option of this lengthened screening interval or the alternate recommendation above	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Every 5 years	Screening for Cervical Cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2 (August 2018) Grade: A	Cancer screening tests: H&SC 1367.665 IC 10123.20 Cervical cancer screening: H&SC 1367.66 IC 10123.18
6	Colorectal Cancer (Topic is in the process of being updated)	Aspirin		50 to 59 with a ≥10% 10-year CVD risk	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Aspirin for the Prevention of Cardiovascular Disease and colorectal cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer (April 2016) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
7	Colorectal cancer (CRC) (Topic is in the process of being updated)	Screening		50 to75 years	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Screening should begin at age 50 and continue until age 75. Frequency of screening is dependent upon the chosen method.[25] The risks and benefits of these screenings may vary	Screening for Colorectal Cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2 (June 2016) Grade: A	Cancer screening tests: H&SC 1367.665 IC 10123.20
8	Lung cancer (Topic is in the process of being updated)	Screening with low-dose computed tomography		Adults 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	Screening for Lung Cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening (December 2013) Grade: B	Cancer screening tests: H&SC 1367.665 IC 10123.20

[25] The frequency for tests is not mentioned in the Summary of Recommendations; however it is included in the Recommendation Statement available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#tab.

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
9	Ovarian, tubal, or peritoneal cancer	An appropriate brief familial risk assessment tool. Women with a positive result should receive genetic counseling followed by genetic testing for BRCA1 or BRCA2, if indicated.	Women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with *BRCA1* or *BRCA2* gene mutation		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing	BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing1 (August 2019) Grade: B	Cancer screening tests: H&SC 1367.665 IC 10123.20
10	Skin cancer	Counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer		Persons aged 6 months to 24 years, including parents of young children, who have fair skin	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Behavioral Counseling to Prevent Skin Cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/skin-cancer-counseling2 (March 2018) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
Chronic Conditions							
11	Abdominal aortic aneurysm (AAA)	Ultrasonography	Men	65 to 75 who have ever smoked	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* One-time	Screening for Abdominal Aortic Aneurysm https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/abdominal-aortic-aneurysm-screening1 (December 2019) Grade: B	None identified
12	Abnormal Blood Glucose and Diabetes (Topic is in the process of being updated)	Screening		40 to 70 who are overweight or obese	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Aspirin for the Prevention of Cardiovascular Disease and colorectal cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer (April 2016) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
13	Cardiovascular disease (CVD) (Topic is in the process of being updated)	Aspirin		50 to 59 with a ≥10% 10-year CVD risk	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Aspirin for the Prevention of Cardiovascular Disease and colorectal cancer https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer (April 2016) Grade: B	None identified
14	Cardiovascular disease (CVD) (Topic is in the process of being updated)	Intensive behavioral interventions to promote a healthful diet and physical activity		Adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Disease Risk Factors https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd (August 2014) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
15	Cardiovascular disease (CVD)	Statin		40 to 75 with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of ≥10%	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Low- to moderate-dose statin Requires universal lipids screening.	Statin Use for the Primary Prevention of Cardiovascular Disease in Adults https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/statin-use-in-adults-preventive-medication1 (November 2016) Grade: B	None identified
16	Depression	Screening for major depressive disorder (MDD)		12 to 18 years	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* When systems are in place to ensure accurate diagnosis, effective treatment, and follow-up	Major Depressive Disorder in Children and Adolescents https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1 (February 2016) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
17	Depression	Screening	Includes pregnant and postpartum women	Adults	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* When staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up	Screening for Depression in Adults https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1 (January 2016) Grade: B	Maternal mental health: H&SC 1367.625 IC 10123.867
18	Hepatitis B virus (HBV) infection (Topic is in the process of being updated)	Screening	Persons at high risk for infection		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Hepatitis B Virus Infection https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-b-virus-infection-screening-2014 (May 2014) Grade: B	None identified
19	Hepatitis C virus (HCV) infection (Topic is in the process of being updated)	Screening		Adults at high risk for infection and adults born between 1945 and 1965	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* One-time screening for HCV infection to adults born between 1945 and 1965	Screening for Hepatitis C Virus Infection in Adults https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-c-screening (June 2013) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
20	Hypertension (Topic is in the process of being updated)	Blood pressure screening		18 and older	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Obtain measurements outside of clinical setting for diagnostic confirmation Adults 18 to 39 with normal blood pressure should be screened every 3 to 5 years Adults ages 40 and older and those at increased risk should be screened annually	Screening for High Blood Pressure in Adults https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/high-blood-pressure-in-adults-screening (October 2015) Grade: A	Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55
21	Latent Tuberculosis Infection	Screening for latent tuberculosis infection (LTBI)		Asymptomatic adults at increased risk for infection	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Latent Tuberculosis Infection https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening (September 2016) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
22	Obesity	Screening and comprehensive, intensive behavioral interventions to promote improvement in weight status		Children and adolescents age 6 years and older[26]	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Obesity in Children and Adolescents https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening1 (June 2017) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5
23	Obesity	Intensive, multicomponent behavioral interventions		Adults with body mass index (BMI) of 30 kg/m2 or higher	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for and Management of Obesity in Adults https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-interventions1 (September 2018) Grade: B	None identified
24	Osteoporosis	Screening	Women	Postmenopausal women younger than 65 who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Osteoporosis https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/osteoporosis-screening1 (June 2018) Grade: B	Osteoporosis: H&SC 1367.67 IC 10123.185

[26] The Summary Recommendation does not define obesity. Obesity is defined in the Recommendation Statement "as having a BMI at >95th percentile for age and gender", but the recommendation is not explicitly restricted to obese children and adolescents. The Recommendation Statement is available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening1.

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
25	Osteoporosis	Screening	Women	65 and older	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Osteoporosis https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/osteoporosis-screening1 (June 2018) Grade: B	Osteoporosis: H&SC 1367.67 IC 10123.185
Health Promotion							
26	Alcohol misuse	Screening		Adults aged 18 years or older	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions (November 2018) Grade: B	Alcoholism treatment: H&SC 1367.2(a) IC 10123.6 Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities: H&SC 1367.2(b) IC 10123.6

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
27	Alcohol misuse	Brief behavioral counseling interventions to reduce alcohol misuse		Persons engaged in risky or hazardous drinking	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions (November 2018) Grade: B	Alcoholism treatment: H&SC 1367.2(a) IC 10123.6 Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities: H&SC 1367.2(b) IC 10123.6 Maternity services: IC 10123.865 IC 10123.866
28	Dental caries (Topic is in the process of being updated)	Oral fluoride supplementation		6 months of age through 5 years whose primary water source is deficient in fluoride		Prevention of Dental Caries in Children from Birth through Age 5 Years https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening (May 2014) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
29	Dental caries (Topic is in the process of being updated)	Fluoride varnish		Age of primary tooth eruption through 5 years	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Prevention of Dental Caries in Children from Birth through Age 5 Years https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening (May 2014) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5
30	Falls	Exercise interventions		65 and older who are community-dwelling and at increased risk for falls	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Prevention of Falls in Community-Dwelling Older Adults https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/falls-prevention-in-older-adults-interventions1 (April 2018) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
31	Gonococcal opthalmia neonatorum	Prophylactic ocular topical medication		Newborns	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Ocular Prophylaxis for Gonococcal Opthalmia Neonatorum https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/ocular-prophylaxis-for-gonococcal-ophthalmia-neonatorum-preventive-medication1 (January 2019) Grade: A	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5
32	Intimate Partner Violence	Screening for intimate partner violence Provide or refer women who screen positive to ongoing support services* *The 2018 recommendation references ongoing support services as compared to the previous support services	Women of reproductive age		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Intimate Partner Violence https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening1 (October 2018) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
33	Tobacco use (Topic is in the process of being updated)	Interventions including education or brief counseling to prevent initiation of tobacco use		School-aged children and adolescents	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Primary Care Interventions to Prevent Tobacco Use in Children and Adolescents https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions (August 2013) Grade: B	None identified
34	Tobacco use (Topic is in the process of being updated)	Ask about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation		Adults	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Behavioral and Pharmacotherapy Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Women https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1 (September 2015) Grade: A	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
35	Visual impairment	Vision screening for amblyopia and its risk factors		Children aged 3-5 years	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* At least once	Screening for Visual Impairment in Children Ages 6 months to 5 Years https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/vision-in-children-ages-6-months-to-5-years-screening (September 2017) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5
Pregnancy Related							
36	Alcohol misuse	Screening	Pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions (November 2018) Grade: B	Alcoholism treatment: H&SC 1367.2(a) IC 10123.6 Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities: H&SC 1367.2(b) IC 10123.6 Maternity services: IC 10123.865 IC 10123.866

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
37	Bacteriuria	Urine culture	Pregnant women who are asymptomatic		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* At 12 to 16 weeks' gestation or at the first prenatal visit, if later	Screening of Asymptomatic Bacteriuria https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/asymptomatic-bacteriuria-in-adults-screening1 (September 2019) Grade: B	Maternity services: IC 10123.865 IC 10123.866
38	Breastfeeding	Interventions to support breastfeeding	Pregnant women, new mothers, and their children		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* During pregnancy and after birth	Primary Care Interventions to Support Breastfeeding https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breastfeeding-primary-care-interventions (October 2016) Grade: B	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5
39	Depression	Counseling interventions (provision of or referral to)	Pregnant and postpartum persons who are at increased risk of perinatal depression		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Perinatal Depression: Preventive Interventions https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/perinatal-depression-preventive-interventions (February 2019) Grade: B	Maternity services: IC 10123.865 IC 10123.866 Maternal mental health: H&SC 1367.625 IC 10123.867

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
40	Gestational diabetes (Topic is in the process of being updated)	Screening	Asymptomatic pregnant women after 24 weeks gestation		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Gestational Diabetes Mellitus https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/gestational-diabetes-mellitus-screening (January 2014) Grade: B	Maternity services: IC 10123.865 IC 10123.866 Diabetes (including gestational): H&SC 1367.51 IC 10176.61
41	Hepatitis B virus (HBV) infection	Screening	Pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* At first prenatal visit	Screening for Hepatitis B Virus Infection in Pregnancy https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-b-virus-infection-in-pregnant-women-screening (July 2019) Grade: A	Maternity services: IC 10123.865 IC 10123.866
42	Human immuno-deficiency virus (HIV)	Screening	Pregnant women - including women who present in labor who are untested and whose HIV status is unknown		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for HIV https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening1 (June 2019) Grade: A	Maternity services: IC 10123.865 IC 10123.866 HIV testing: H&SC 1367.46 IC 10123.91

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
43	Neural tube defects	Folic acid supplementation to prevent neural tube defects	Women who are planning or are capable of pregnancy		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid	Folic Acid to Prevent Neural Tube Defects https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication (January 2017) Grade: A	Maternity services: IC 10123.865 IC 10123.866
44	Preeclampsia	Screening with blood pressure measurements	Pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Preeclampsia: Screening https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/preeclampsia-screening1 (April 2017) Grade: B	Maternity services: IC 10123.865 IC 10123.866
45	Preeclampsia (Topic is in the process of being updated)	Low-dose Aspirin (81 mg/d)	Pregnant women at high risk for preeclampsia, after 12 weeks gestation		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Low-Dose Aspirin for the Prevention of Morbidity and Mortality from Preeclampsia https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication (September 2014) Grade: B	Maternity services: IC 10123.865 IC 10123.866

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
46	Rh (D) incompatibility	Rh (D) blood typing and antibody testing	Pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* During first visit for pregnancy-related care	Screening for Rh (D) Incompatibility https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/rh-d-incompatibility-screening (February 2004) Grade: A	Maternity services: IC 10123.865 IC 10123.866
47	Rh (D) incompatibility	Repeated Rh (D) antibody testing	Pregnant women who are unsensitized Rh (D)-negative at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Rh (D) Incompatibility https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/rh-d-incompatibility-screening (February 2004) Grade: B	Maternity services: IC 10123.865 IC 10123.866
48	Syphilis infection	Early screening	Pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Syphilis Infection in Pregnancy https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/syphilis-infection-in-pregnancy-screening1 (September 2018) Grade: A	Maternity services: IC 10123.865 IC 10123.866

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
49	Tobacco use (Topic is in the process of being updated)	Ask about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation	Pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Behavioral and Pharmacotherapy Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Women https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1 (September 2015) Grade: A	Maternity services: IC 10123.865 IC 10123.866
Sexual Health							
50	Chlamydial infection (Topic is in the process of being updated)	Screening	Sexually active women	24 and younger and older women at increased risk for infection	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Chlamydia and Gonorrhea https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening (September 2014) Grade: B	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
51	Gonorrhea (Topic is in the process of being updated)	Screening	Sexually active women	24 and younger and older women at increased risk of infection	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Chlamydia and Gonorrhea https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening (September 2014) Grade: B	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
52	Human immune-deficiency virus (HIV)	Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy		Adolescents, adults and seniors who are at high risk of HIV acquisition	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis (June 2019) Grade: A	PrEP and PEP for prevention of HIV: H&SC: 1342.74 IC 10123.1933 Combination antiretroviral drug treatments for prevention of HIV: H&SC 1342.72 IC 10123.1931 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55
53	Human immuno-deficiency virus (HIV)	Screening		Adolescents and adults aged 15 to 65 as well as younger and older persons at increased risk	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for HIV https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening1 (June 2019) Grade: A	HIV testing: H&SC 1367.46 IC 10123.91 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
54	Sexually transmitted infections (STIs) (Topic is in the process of being updated)	Intensive behavioral counseling		Adolescents who are sexually active	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Behavioral Counseling to Prevent Sexually Transmitted Infections https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/sexually-transmitted-infections-behavioral-counseling1 (September 2014) Grade: B	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55
55	Sexually transmitted infections (STIs) (Topic is in the process of being updated)	Intensive behavioral counseling		Adults at increased risk for STIs	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Behavioral Counseling to Prevent Sexually Transmitted Infections https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/sexually-transmitted-infections-behavioral-counseling1 (September 2014) Grade: B	None identified

#	Federal Mandates as Specified by Reference to USPSTF					USPSTF A or B Recommendation[20]	Related Health Insurance Benefit Mandate(s) in California State Law[21]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[22]	Specified Age/Other[23]	Terms[24]		
56	Syphilis infection	Screening		Asymptomatic non-pregnant adolescents and adults at increased risk	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for Syphilis Infection https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/syphilis-infection-in-nonpregnant-adults-and-adolescents (June 2016) Grade: A	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

Table 2. Federal Health Insurance Benefit Mandates as Specified by Reference to HRSA-Supported Health Plan Coverage Guidelines for Women's Preventive Services[27] & Related Mandates in California State Law[28,29]

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Health Plan Coverage Guidelines for Women's Preventive Services[30]	Related Health Insurance Benefit Mandate(s) in California State Law[31]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[32]	Specified Age/Other[33]	Terms[34]		
HRSA-supported Health Plan Coverage Guidelines for Women's Preventive Services were updated on 12/20/2016.							
1	Breast Cancer	Mammography	Women at average risk of breast cancer	Initiate between ages 40 and 50 through at least age 74	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Biennially and as frequently as annually	Breast Cancer Screening for Average-Risk Women https://www.hrsa.gov/womens-guidelines-2016/index.html	Breast cancer screening, diagnosis, and treatment: H&SC 1367.6 IC 10123.8 Cancer screening tests: H&SC 1367.665 IC 10123.20

[27] Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act.
[28] For brevity, CHBRP has not listed in each row the California mandate (H&SC 1367.002 & IC 10112.2) which requires compliance with federal laws and regulations requiring coverage of preventive services without cost-sharing (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act).
[29] CHBRP is aware that state regulation may require benefit coverage, but is focusing this resource on health insurance benefit mandate laws.
[30] Unless otherwise noted, the links listed below were accessed on or before 2/3/2020.
[31] Unless otherwise noted, the mandates listed below were reviewed on or before 2/3/2020.
[32] "Other" is included here in order to specify pregnant or non-pregnant women.
[33] "Other" is included here when more details are available about the intended group, beyond age.
[34] *Italicized terms* are explicit in the federal law (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act). Non-italicized terms of benefit coverage are implied by the referenced recommendation.

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Health Plan Coverage Guidelines for Women's Preventive Services[30]	Related Health Insurance Benefit Mandate(s) in California State Law[31]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[32]	Specified Age/Other[33]	Terms[34]		
2	Breastfeeding	Comprehensive lactation support services, including counseling, education, and breastfeeding equipment and supplies	Women, during the antenatal, perinatal, and the postpartum period		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Breastfeeding services and supplies https://www.hrsa.gov/womens-guidelines-2016/index.html	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5
3	Cervical Cancer	Cervical Cytology (Pap test)		21 to 65	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Women 21 to 29 should be screened every 3 years Women 30 to 65 should be screened with cytology and HPV testing every 5 years, or cytology alone every 3 years Women with average risk should not be screened more than once every 3 years	Screening for Cervical Cancer https://www.hrsa.gov/womens-guidelines-2016/index.html	Cancer screening tests: H&SC 1367.665 IC 10123.20 Cervical cancer screening: H&SC 1367.66 IC 10123.18

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Health Plan Coverage Guidelines for Women's Preventive Services[30]	Related Health Insurance Benefit Mandate(s) in California State Law[31]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[32]	Specified Age/Other[33]	Terms[34]		
4	Contraception	Full range of Food and Drug Administration (FDA) approved contraceptive methods, effective family planning practices, and sterilization procedures. Counseling, initiation of contraceptive use, and follow-up care NOTE: Exemptions for religious employers or employers with moral objections may be granted by HRSA[35]	Women with reproductive capacity		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Contraceptive methods and counseling https://www.hrsa.gov/womens-guidelines-2016/index.html	Contraceptive devices requiring a prescription: H&SC 1367.25 IC 10123.196 Reproductive health care services: H&SC 1367.31 IC 10123.202
5	Diabetes	Screening	Post-partum women with a history of gestational diabetes and who have not been previously diagnosed with type 2 diabetes		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Should occur within the first year and as early as 4-6 weeks post-partum Women with negative tests should be rescreened at least every 3 years for a minimum of 10 years after pregnancy	Screening for Diabetes Mellitus after pregnancy https://www.hrsa.gov/womens-guidelines-2016/index.html	Diabetes (including gestational): H&SC 1367.51 IC 10176.61

[35] See Federal Register /Vol. 82, No. 197 /Friday, October 13, 2017 /Rules and Regulations available at: https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21851.pdf.

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Health Plan Coverage Guidelines for Women's Preventive Services[30]	Related Health Insurance Benefit Mandate(s) in California State Law[31]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[32]	Specified Age/Other[33]	Terms[34]		
6	Gestational diabetes	Screening	Pregnant women, between 24 and 28 weeks of gestation (or at first prenatal visit for women at high risk for diabetes)		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Screening for gestational diabetes https://www.hrsa.gov/womens-guidelines-2016/index.html	Maternity services: IC 10123.865 IC 10123.866 Diabetes (including gestational): H&SC 1367.51 IC 10176.61
7	Human immuno-deficiency virus (HIV)	Prevention education and risk assessment	Adolescent and adult women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Annually	Screening for human immune-deficiency virus https://www.hrsa.gov/womens-guidelines-2016/index.html	HIV testing: H&SC 1367.46 IC 10123.91
8	Human immuno-deficiency virus (HIV)	Screening	Adolescent and adult women, women with an increased risk of HIV infection, pregnant women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* All women should be tested for HIV at least once during their lifetime Screening annually or more often may be appropriate for women with an increased risk of HIV infection All pregnant women upon initiation of prenatal care with retesting based on risk factors	Screening for human immune-deficiency virus https://www.hrsa.gov/womens-guidelines-2016/index.html	HIV testing: H&SC 1367.46 IC 10123.91

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Health Plan Coverage Guidelines for Women's Preventive Services[30]	Related Health Insurance Benefit Mandate(s) in California State Law[31]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[32]	Specified Age/Other[33]	Terms[34]		
9	Interpersonal and domestic violence	Screening and, when needed, providing or referring for initial intervention services	Women	Adolescent and adult	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* At least annually	Screening and counseling for interpersonal and domestic violence https://www.hrsa.gov/womens-guidelines-2016/index.html	None identified
10	Sexually transmitted infections (STI)	Counseling	Women who are sexually active and at an increased risk for STIs	Adolescent and adult	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Directed behavioral counseling by a health care provider or other appropriately trained individual	Counseling for sexually transmitted infections for all sexually active women https://www.hrsa.gov/womens-guidelines-2016/index.html	None identified
11	Urinary Incontinence	Screening	Women		*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Annually Women should be referred for further evaluation and treatment if indicated	Screening for Urinary Incontinence https://www.hrsa.gov/womens-guidelines-2016/index.html	None identified

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Health Plan Coverage Guidelines for Women's Preventive Services[30]	Related Health Insurance Benefit Mandate(s) in California State Law[31]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other[32]	Specified Age/Other[33]	Terms[34]		
12	Wellness	Well-woman preventive care visit(s), including preconception, prenatal and interconception care, that are age and developmentally appropriate[36]	Women	Adolescents and adults	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Annually, although several visits may be needed to obtain all necessary recommended preventive services, depending on health status, health needs, and other risk factors	Well-woman visits https://www.hrsa.gov/womens-guidelines-2016/index.html	Multiple mandates relate. See specific conditions or disorders. Any related health insurance benefit mandate in California state law in this document that relates to women.

[36] The guideline indicates that the well-woman visit includes, as appropriate, any test, treatment, or service referenced by the HRSA-supported health plan coverage guidelines for women's preventive services (which are the focus of this table) as well as any referenced by the federal preventive services health insurance benefit mandate (which are the focus of this resource).

Table 3. Federal Health Insurance Benefit Mandates as Specified by Reference to HRSA-Supported Comprehensive Guidelines for Infants, Children, and Adolescents[37] & Related Mandates in California State Law[38,39]

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Comprehensive Guidelines for Infants, Children, and Adolescents[40]	Related Health Insurance Benefit Mandate(s) in California State Law[41]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other	Specified Age/Other	Terms[42]		
In the rows that follow, recommendations released less than 12 months prior to 2/3/2020 are highlighted in the same color as this cell.							
1	Wellness	Screening (many, which includes autism screening)—for full list, see *Bright Futures* schedule (see link in this row, next to last column)		21 and younger, with varied ages for varied screenings – for full list, see *Bright Futures* schedule (see link in this row, next to last column)	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Per-child screening repetition coverage requirements vary by age and screening – for full list, see *Bright Futures* schedule (see links in this row, next to last column)	Recommendations for Pediatric Preventive Health Care Bright Futures/ American Academy of Pediatrics https://www.aap.org/en-us/Documents/periodicity_schedule.pdf (2019)	Comprehensive preventive care for children aged 16 years or younger:[43] H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: 42 H&SC 1367.3 IC 10123.55

[37] Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act.
[38] For brevity, CHBRP has not listed in each row the California mandate (H&SC 1367.002 & IC 10112.2) which requires compliance with federal laws and regulations requiring coverage of preventive services without cost-sharing (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act).
[39] CHBRP is aware that state regulation may require benefit coverage, but is focusing this resource on health insurance benefit mandate laws.
[40] Unless otherwise noted, the links listed below were accessed on or before 2/3/2020.
[41] Unless otherwise noted, the mandates listed below were reviewed on or before 2/3/2020.
[42] *Italicized terms* are explicit in the federal law (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act). Non-italicized terms of benefit coverage are implied by the referenced recommendation.
[43] This statute references a similar but older (1987) set of American Academy of Pediatrics recommendations.

#	Federal Mandates as Specified by Reference to HRSA-Supported Guidelines					HRSA Supported Comprehensive Guidelines for Infants, Children, and Adolescents[40]	Related Health Insurance Benefit Mandate(s) in California State Law[41]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other	Specified Age/Other	Terms[42]		
2	Wellness	Screening (many)—for full list, see Heritable Disorders panel (see link in this row, next to last column)		Newborns and children – for full list, see Heritable Disorders panel (see link in this row, next to last column)	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release*	Recommended Uniform Screening Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/rusp-uniform-screening-panel.pdf (Includes recommendations in effect as of July 2018)	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.542

Table 4. Federal Health Insurance Benefit Mandates as Specified by ACIP Recommendations [44,45]

#	Federal Mandates as Specified by Reference to ACIP Recommendations					ACIP Recommendations [46]	Related Health Insurance Benefit Mandate(s) in California State Law[47]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other	Specified Age/Other	Terms[48]		
In the rows that follow, recommendations released less than 12 months prior to 2/3/2020 are highlighted in the same color as this cell.							
1	Vaccine preventable diseases	Immunizations (many) – for the full list, see the ACIP schedule (see link in this row, next to last column)		0 through 18 years, with varied ages for varied immunizations – for the full list, see ACIP schedule (see link in this row, next to last column)	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Per-child/adolescent immunization repetition coverage requirements vary by age and immunization – for the full list, see ACIP schedule (see link in this row, next to last column)	Recommended immunization schedules for children and adolescents aged 18 years or younger—United States, 2019 (Table 1) https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf (Includes recommendations in effect as of February 22, 2019)	Maternity services: IC 10123.865 IC 10123.866 Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55

[44] For brevity, CHBRP has not listed in each row the California mandate (H&SC 1367.002 & IC 10112.2) which requires compliance with federal laws and regulations requiring coverage of preventive services without cost-sharing (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act).
[45] CHBRP is aware that state regulation may require benefit coverage, but is focusing this resource on health insurance benefit mandate laws.
[46] Unless otherwise noted, the links listed below were accessed on or before 2/3/2020.
[47] Unless otherwise noted, the mandates listed below were reviewed on or before 2/3/2020.
[48] *Italicized terms* are explicit in the federal law (Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act). Non-italicized terms of benefit coverage are implied by the referenced recommendation.

#	Federal Mandates as Specified by Reference to ACIP Recommendations					ACIP Recommendations [46]	Related Health Insurance Benefit Mandate(s) in California State Law[47]
	Condition or Disease	Test, Treatment, or Service	Specified Sex/Other	Specified Age/Other	Terms[48]		
2	Vaccine preventable diseases	Catch-up immunizations (many) – for the full list, see the ACIP schedule (see link in this row, next to last column)		4 months through 18 years, who start late or who are more than 1 month behind, with varied ages for varied immunizations – for the full list, see ACIP schedule (see link in this row, next to last column)	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Per-child/adolescent immunization repetition coverage requirements vary by age and immunization - for the full list, see ACIP schedule (see link in this row, next to last column)	Catch-up immunization schedule for persons aged 4 months through 18 years who start late or are more than 1 month behind—United States, 2019 (Table 2) https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf (Includes recommendations in effect as of February 22, 2019)	Comprehensive preventive care for children aged 16 years or younger: H&SC 1367.35 IC 10123.5 Comprehensive preventive care for children aged 17 and 18 years: H&SC 1367.3 IC 10123.55
3	Vaccine preventable diseases	Immunizations (many) – for the full list, see the ACIP schedule (see link in this row, next to last column)		Adults 19 and older, with varied ages for varied immunizations – for the full list, see ACIP schedule (see link in this row, next to last column)	*Without cost-sharing when in-network* *As soon as 12 months after recommendation release* Per-adult immunization repetition coverage requirements vary by age and immunization – for the full list, see ACIP schedule (see link in this row, next to last column)	Recommended immunization schedule for adults aged 19 years or older—United States, 2019 https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf (Includes recommendations in effect as of February 19, 2019)	None identified

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

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When State Policy Makes National Politics: The Case of "Obamacare" Marketplace Implementation

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Abstract

Context: State governments have been powerful sites of Republican resistance to the implementation of the Affordable Care Act (ACA), the Democratic Party's signature 2010 law. By influencing how citizens experience the ACA, state-level implementation can affect the national-level *political* implications of the law.

Methods: I examine three largely unstudied areas of marketplace implementation: navigator laws, transitional plan termination, and rating area configurations. For each policy area, I use linear probability models to investigate the determinants of state lawmakers bolstering or eroding marketplaces.

Findings: In each case, Democrat-controlled states were more likely to bolster marketplaces than Republican-controlled states were, with decisions more polarized in those policy areas—navigator laws and transitional plan termination—and with greater potential for national-level feedback. For navigator laws, where Republican state lawmakers were most cross-pressured by national party interests and local interests, marketplace eroding policy was highly associated with strength of conservative networks.

Conclusion: Crafters of federal legislation cannot expect state lawmakers to universally implement federal law to maximize the direct benefits to their constituents. Rather, we should expect state lawmakers to, in many instances, implement federal law in ways that benefit their parties.

Keywords ACA implementation, Affordable Care Act, health insurance marketplaces, federalism, policy feedback

In 2017, following the failure of congressional Republicans to pass a "repeal and replace" bill, the Trump administration introduced several executive actions that have undermined the Affordable Care Act's (ACA)

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health insurance marketplaces (see, e.g., Giovannelli and Curran 2018). The administration cut the open enrollment period in half, slashed funding for organizations tasked with helping individuals enroll in health insurance plans (Bump 2017), and more dramatically, announced that the federal government would not be paying out Cost-Sharing Reduction subsidies in 2018 (Jost 2017b). The Trump administration's undermining of ACA marketplaces likely comes as no surprise to close observers of ACA implementation. Journalistic accounts have been noting for several years the subtler undermining of ACA marketplaces pursued mainly in Republican-controlled states (see, e.g. Levey 2016).[1]

Why would state governments choose policies that limited the choice and affordability of health insurance for constituents? In an era of extreme partisan polarization and nationalization of state politics (Hopkins 2018; Rogers 2017), I propose that state policy might be used as a tool for political competition between national-level parties and interest groups.

Political scientists have long understood that public policy can have important consequences for politics through "policy feedback" processes (e.g., Pierson 1993). But scholars have only recently analyzed the question of when strategic lawmakers might be able to use policy for political gain (Anzia and Moe 2016). Moreover, existing work has not considered explicitly cases in which state policy choices influence politics at the national level—or more generally, where policies have *multilevel* feedback effects.

This is potentially a serious oversight, since state policy can influence national political battles in crucial ways. Most directly, state governments determine how votes are translated into national-level representation by drawing congressional districts (Stephanopoulos and McGhee 2015). State policies, such as felon disenfranchisement, also influence who is eligible to cast ballots in the first place (see, e.g., Highton 2017). State policy can also strengthen or weaken organized groups like unions that seek to influence policy in multiple states and federally (Feigenbaum, Hertel-Fernandez, and Williamson 2018; Flavin and Hartney 2015). Finally, state policy can influence how a national law is experienced by citizens, and therefore shape the degree to which that policy produces political gains or losses. In the case of the ACA, state policies that led to poorly functioning marketplaces made the ACA more vulnerable to repeal and gave the national-level Republican Party the opportunity to lay blame on their

1. Interestingly, analysis from the Kaiser Family Foundation suggests that Trump Administration policies have led to reduced enrollment in Federally Facilitated Marketplaces (FFMs), but not in the generally Democrat-controlled State-Based Marketplaces (SBMs).

political opponents (Arnold 1992). On the other hand, state policies that led to well-functioning marketplaces gave the national-level Democratic Party the opportunity to claim credit.

ACA marketplace implementation is a well-suited and important case for considering the factors that motivate state governments to enact policies with national-level feedback effects. The high salience and polarized nature of the ACA renders marketplace performance, and therefore state marketplace implementation policy, highly consequential for national political battles. Furthermore, state control over technical, low-salience aspects of marketplace implementation provides a golden opportunity for lawmakers to influence marketplace performance while remaining firmly in voters' "blind spots" (Bawn et al. 2012).

I propose a framework for understanding the politics of ACA marketplace implementation that accounts for implementation policies' potential to produce national-level political feedback. State lawmakers are generally likely to pass policies that benefit their political parties, meaning Democrats would tend to bolster marketplaces and Republicans would tend to erode them.[2] But for certain policy decisions state lawmakers faced a tension between local interests and the interests of the national party. Republican lawmakers in particular were cross-pressured by their constituents' interest in functional marketplaces and their party's interest in undermining the marketplaces. I highlight the importance of other mechanisms like federated ideological groups that might push state lawmakers to prioritize national-level interests at the expense of local interests.

I present evidence consistent with this framework from three largely unstudied areas of ACA marketplace implementation: navigator laws, transitional plan termination, and rating area configurations.[3] While these policies were generally low salience, they had the potential to meaningfully influence the performance of marketplaces.[4] In each case, Democrat-controlled states were more likely to bolster marketplaces than Republican-controlled states were, with decisions more polarized in those policy areas—navigator laws and transitional plan termination—with greater potential for national-level feedback. Moreover, for navigator laws, where Republican state lawmakers were most cross-pressured, marketplace-eroding policies were more common in states with strong conservative networks.

2. This political logic refers in particular to the Obama era, and has likely changed under the Trump administration.

3. While the effects of these decisions have been studied, little attention has been paid to their determinants.

4. Transitional plan termination was relatively higher salience for those constituents whose plans were terminated.

Background on ACA Marketplaces

The marketplaces provide a number of functions within the ACA health insurance regime. First, by eliminating medical underwriting, they pool risk across consumers such that those expected to incur high costs have greater access to affordable plans. Second, by mandating that plans are standardized, categorized into tiers according to actuarial value, and sold on government-run websites, the marketplaces allow consumers to more easily compare plans. Third, the marketplaces provide a mechanism for the delivery of income-based subsidies for both premiums and cost sharing.

Initial health reform packages proposed by Democratic congressional leaders in 2009 included a public option as a federal backstop in the case that private insurer offerings failed to offer consumers the competition-driven choice and affordability promised by marketplace proponents. However, the public option was ultimately dropped from legislation in order to retain the votes of conservative-leaning Senate Democrats like Ben Nelson of Nebraska (Klein 2013). Absent a public option, the fate of the ACA was heavily exposed to the ability and motivation of states to promote functional marketplaces.

This exposure has proven costly. State governments, particularly those controlled by Republicans, have adopted a variety of policies that studies demonstrate have had negative effects on the marketplaces. Most notably, nonexpansion of Medicaid pushed lower-income individuals, who tend to be of lower health status, onto marketplaces, reducing the health of the enrollee risk pool and putting upward pressure on premiums (Sen and DeLeire 2016). The vast majority of Republican-controlled states also declined to establish State-Based Marketplaces (SBMs) despite the financial incentives offered by the federal government to do so. Recent work indicates SBMs tend to outperform Federally Facilitated Marketplaces (FFMs), likely in part due to greater outreach and enrollment funding leading to higher enrollment rates (Zhu, Polsky, and Zhang 2018). Beyond these higher-profile measures, state governments have also enacted several lower-salience policies eroding local ACA marketplaces (e.g., Sommers et al. 2015).

Multilevel Policy Feedback and Cross-Pressured State Lawmakers

I propose a framework that can help to illuminate patterns of state behavior across implementation decisions, as well as state politics and policy more

broadly. Central to the framework is the idea that state policy choices can have implications for national-level political competition through a *multilevel* policy feedback dynamic.

In general, the policy feedback literature investigates "the ability of policies—through their design, resources, and implementation—to shape the attitudes and behaviors of political elites and mass public, as well as to affect the evolution of policymaking institutions, and through any of these dynamics potentially to affect subsequent policymaking processes" (Mettler and Sorelle 2014: 152). Scholars have applied a feedback lens to a wide range of policy areas from Social Security (e.g., Campbell 2003) to welfare (e.g., Pierson 1996; Soss 1999) to criminal justice (e.g., Weaver and Lerman 2010). More recently, scholars have analyzed the way in which the potential for policies to produce feedback shapes their politics (Anzia and Moe 2016). Yet, scholars have not paid much attention to the sites and levels of government at which feedback effects manifest.

While it is not generally framed this way, existing work in state health policy (including ACA implementation) demonstrates the clear consequences state policy choices can have for national-level politics. For instance, states that expanded Medicaid featured higher rates of voting relative to nonexpansion states, at least in the short term (Clinton and Sances 2018; Haselswerdt 2017). More generally, Medicaid beneficiaries participate in politics at greater rates across a number of dimensions in states with more generous programs (Michener 2018). Due to the federal structure of American politics, state policies that influence political participation influence national elections.[5]

I propose that, like the policies discussed above, state implementation of ACA marketplaces produced national-level feedback—and that considering these effects can help illuminate the politics of ACA marketplace implementation. There are two mechanisms by which state marketplace implementation decisions would be expected to "affect subsequent policymaking processes" at the national level. First, state implementation choices affect national-level electoral politics. Consider a hypothetical scenario in which states across the board chose marketplace-bolstering policies. As indicated by the existing literature (e.g., Dickstein et al. 2015; Huth and Karcher 2016; Sommers et al. 2015), marketplaces would generally feature greater insurer and individual participation in addition to lower prices. Recent estimates from Kogan and Wood (n.d.), comparing

5. Unless of course the increase is only observed for state-level elections, which is not borne out in the studies referenced.

voting in counties with high-performing versus poor-performing marketplaces, suggest Republicans benefited from poor marketplace performance in the 2016 presidential election. Note further that these types of analyses investigating the political consequences of county-level variation in marketplace performance likely underestimate the full effect of marketplace eroding. This is because, to the degree individuals factor marketplace performance into their vote choice, they are likely to take into account broader marketplace attributes in addition to the performance of marketplaces in their own county relative to other counties.

Due to the strong association between the ACA and the Democratic Party, the Democratic Party would generally benefit from marketplace bolstering, while the Republican Party would generally benefit from marketplace eroding. Furthermore, due to the United States' two-party system and winner-take-all elections, what is good for the Republican Party will tend to be bad for the Democratic Party, and vice versa.

Second, and related to the first, marketplace-eroding implementation policy would weaken the ACA and make it easier for Republicans in Congress to repeal the law—and vice versa for marketplace-bolstering policy. Between 2011 and 2016, Republicans in the House introduced 730 bills either retrenching or repealing the ACA (Rocco and Haeder 2018).[6] Marketplace struggles are often cited by opponents of the ACA as a rationale for repeal (see, e.g., Healy and Goodnough 2016). Moreover, higher-quality marketplaces might motivate beneficiaries to mobilize in support of the ACA, while lower-quality marketplaces might seed opposition or indifference to the law.[7]

How would these feedback effects influence the behavior of state lawmakers? Most basically, we might expect reelection-motivated state lawmakers to choose policies that benefit their broader parties (see, e.g., Mayhew 1974). Recent work suggests that voters prioritize national-level factors even in state elections, with presidential approval three times as predictive of votes for state legislative seats than state legislature approval (Rogers 2017). As a result, reelection-motivated state lawmakers have an incentive to use policy to burnish their broader party brand. To the degree that marketplace implementation policy would affect ACA repeal

6. The American Health Care Act of 2017, which would have repealed key provisions of the ACA, was passed in the House despite low public approval, but was narrowly defeated in the Senate.

7. Due to the importance of the ACA for key "policy demanders" (Bawn et al. 2012) in the national-level parties (Rocco and Haeder 2018), I consider effects of state policy decisions on repeal prospects to be a subset of effects on the parties.

prospects, we might also expect Republican state lawmakers to seek to erode marketplaces and Democratic state lawmakers to bolster them.

The feedback logic, in this way, aligns with other important reasons why state lawmakers might choose marketplace-eroding or -bolstering policies. For instance, state lawmakers might choose policies consistent with national party goals as an expression of ideology, or simply to be "team players." In addition, state lawmakers in Republican-controlled states might choose marketplace-eroding policies in response to the demands of anti-ACA constituents, and vice versa in Democrat-controlled states. Indeed, existing studies have emphasized the importance of partisan control of office in predicting ACA state implementation across several policy areas (e.g., Beland, Rocco, and Waddan 2016; Hertel-Fernandez, Skocpol, and Lynch 2016; Jacobs and Callaghan 2013; Jones, Bradley, and Oberlander 2014; Rigby and Haselswerdt 2013).

Yet, despite all of these factors pushing in the same direction, we see variation in implementation policies within partisan control of state government, particularly on the Republican side (see table 1). Republican-controlled states did not universally erode ACA marketplaces across each policy dimension. This suggests that state lawmakers were, on some policy choices, cross-pressured. While state lawmakers do have an incentive to promote national party brand, they also have an incentive to respond to local interests. Indeed, Hertel-Fernandez, Skocpol, and Lynch (2016) highlight cross-pressured Republican state lawmakers in their study of state Medicaid expansion. Similarly, in determining whether to bolster or erode marketplaces, Republican lawmakers, for certain policies, faced a tension between producing positive feedback for the party by eroding the ACA marketplaces and responding to local interests in functional marketplaces.

With all the factors pushing state lawmakers to align with their parties on ACA marketplace implementation, there are two important reasons (besides the very existence of variation in policy decisions within party control of government) to think lawmakers were cross-pressured. First, the logic of retrospective voting suggests voters would punish incumbents for adverse outcomes like expensive or low-quality health insurance options. This expectation stems from a well-developed literature demonstrating that voters tend to reward incumbents for strong economic performance and punish incumbents for weak economic performance (Healy and Malhotra 2013). Scholars have also demonstrated voter responsiveness to a number of other performance indicators like student test scores (Berry and Howell 2007), natural disaster assistance (Gasper and Reeves 2011), and, at the

local level, road quality (Burnett and Kogan 2017). Voters similarly might reward or punish incumbents on the basis of their access to affordable, high-quality health insurance options. Importantly, retrospective voting in the context of the ACA would not necessarily depend on the traceability of outcomes (Arnold 1992) to policy choices—only on voters' assessments of how they are doing.

Second, state lawmakers might discount national-level feedback effects. Anzia and Moe (2016) point out that even where lawmakers have the opportunity to use policy for political gain, collective action problems can prevent them from doing so, since individual lawmakers may benefit from a policy's feedback effects regardless of whether they contribute to its passage. The extent of the collective action problem is unclear in the case of ACA marketplace implementation, since state lawmakers may be rewarded by voters for representing national party interests. However, there remain clear externalities to the behaviors of individual lawmakers. Republicans as a whole benefit from weak marketplace performance produced by marketplace-eroding policies (regardless of whether they enact marketplace-eroding policies), and vice versa for Democrats. These externalities therefore might lead state lawmakers to privilege local interests over national party interests.

Applying the multilevel feedback framework thus suggests two central hypotheses. First, the partisan division of a policy would be a function of the policy's feedback potential. Policies with greater potential to produce political feedback are more likely to be polarized, and vice versa. Second, mechanisms that push state lawmakers to adopt policies that benefit the national-level party are likely to be particularly important for those policy areas on which state lawmakers are cross-pressured.

In this general case, Republican state lawmakers were more likely to be cross-pressured since producing positive feedback for the party required eroding local marketplaces. However, there was a clear mechanism pushing Republican state lawmakers to erode marketplaces: cross-state conservative groups like American Legislative Exchange Council (ALEC), State Policy Network (SPN), and Americans for Prosperity (AFP). Due to their federated structure and investments in state politics, cross-state conservative groups were well-positioned to coordinate resistance to the ACA in the lead-up to the opening of marketplaces (Skocpol and Hertel-Fernandez 2016) and had a long-term goal of ACA repeal that aligned with the interests of the national Republican Party (ALEC 2011).

Often working in concert, these groups use a number of mechanisms to influence state policy. Among other things, ALEC disseminates model

bills that members are encouraged to introduce and support. By subsidizing the crafting of legislation (Hertel-Fernandez 2014), ALEC reduces the cost of state lawmakers to erode ACA marketplaces. But, as Hertel-Fernandez, Skocpol, and Lynch (2016) show, the power of these federated conservative organizations goes well beyond writing model bills. AFP uses its vast resources to influence primary and general elections, encouraging the rise of sympathetic politicians and credibly threatening incumbents (Skocpol and Hertel-Fernandez 2016). Think tanks associated with the SPN disseminate studies and analysis supporting proposed policies—and attacking alternatives. Existing work suggests these groups were highly engaged, and often effective, in resisting the successful implementation of the ACA (Hertel-Fernandez, Skocpol, and Lynch 2016; Jones, Bradley, and Oberlander 2014). In particular, Hertel-Fernandez, Skocpol, and Lynch (2016) highlight the crucial role these groups played in pressuring state-level Republicans to neglect local interests by not expanding Medicaid.

In sum, the logic of multilevel policy feedback suggests we should expect Democrat-controlled state governments to bolster marketplaces, and Republican-controlled state governments to erode them. For Democratic state lawmakers, there is not generally a tension between what is good for constituents and what is good for the national party, since both benefit from marketplace bolstering. The national-level Republican Party benefits from marketplace-eroding policies, but state-level Republicans might be cross-pressured on certain policies. Where Republicans are cross-pressured, the strength of conservative networks might be a key predictor of whether states enact marketplace-eroding implementation policies. In the following section, I introduce three marketplace implementation decisions and map them onto this theoretical perspective.

Navigator Laws

The ACA includes funding for organizations and individuals—so-called navigators—to assist consumers with enrolling in and using health insurance. Navigator laws, laws that restrict the activities of health navigators, were enacted in a number of states in 2013 and 2014 legislative sessions. The restrictions included limitations on advice navigators can provide,[8] in-state residency requirements that prevent national groups from serving as navigators, prohibitions on receiving insurer compensation (which generally

8.This particular class of laws was preempted by a federal court ruling in 2016 (St. Louis Effort for AIDS v. Huff; media.npr.org/documents/2014/jan/missouriorder.pdf).

disqualifies health care providers from serving as assisters), and requirements that navigators carry certain types of insurance.[9]

While proponents of navigator laws argue that they are necessary for consumer protection, most ACA advocates believe these laws have little purpose besides hindering outreach and enrollment efforts (Jost 2013). Indeed, evidence suggests restrictive navigator laws have reduced ACA awareness and enrollment rates (Sommers et al. 2015). Since enrolling a large number of individuals is key to the long-term sustainability of marketplaces, these laws would tend to erode ACA marketplaces.

The case of navigator laws pitted local interests in well-functioning marketplaces against the national Republican Party's interest in the erosion of the ACA. Navigator laws would weaken ACA marketplaces and therefore produce positive feedback for the national Republican Party both by improving electoral prospects and enhancing prospects to repeal a law that key policy demanders within the party opposed. Yet, eroding marketplaces through navigator laws required actively moving the status quo policy in a way that would produce local costs in the form of greater difficulty finding health insurance and more poorly performing marketplaces (Sommers et al. 2015). Furthermore, due to navigator lows' salience, state lawmakers had little to gain among voters by signaling opposition to the ACA. These factors all suggest navigator laws would be uncommon in Democrat-controlled states and might only be enacted in states with strong elements of conservative networks promoting the laws.[10]

Transitional Plan Termination

The second state marketplace implementation decision considered is whether states terminated or extended transitional plans after marketplace opening. The grandfathering clause of the ACA stipulates that individuals enrolled in noncompliant plans prior to 2010 would be permitted to remain on those plans as long as they continued to be offered (CCIIO n.d.). This clause, however, did not apply to plans initiated between the passage of the law in 2010 and the opening of marketplaces in 2014 ("transitional" plans). Due to political pressure, the Obama administration announced in 2013

9. Roll-call votes for these laws are available for many of the states that passed navigator laws. However, these data are very noisy, since in many cases language concerning navigators was inserted into broader pieces of legislation. Moreover, final roll-call votes were not taken in the majority of states where laws were proposed but not enacted, restricting the scope of comparisons that could be made.

10. Indeed, ALEC's dissemination of a "model bill" (Hertel-Fernandez 2014) suggests the involvement of conservative networks in advancing navigator laws.

that it would *pass the buck* to states to decide whether to extend transitional plans (Jost 2017a).

Terminating transitional plans, while imposing salient costs on the younger, healthier individuals who enrolled in these plans, would be expected to bolster the long-term sustainability of marketplaces. This is because marketplace sustainability requires enrollment of a balanced pool of healthier and less healthy individuals. Allowing healthier individuals to remain in a separate risk pool would tend to increase premiums on the marketplace and increase the risk of a premium "death spiral" (Cutler and Zeckhauser 1998). Existing analysis suggests these decisions mattered for marketplace enrollee composition, with nonterminating states tending to feature less healthy enrollees on average (Huth and Karcher 2016; Semanskee, Cox, and Levitt 2016).

Due to its positive effects on the marketplaces, namely, in putting downward pressure on premiums and promoting long-run sustainability, termination of transitional plans would produce positive feedback for the national-level Democratic Party. However, unlike for navigator laws, in this case *bolstering* local marketplaces required state lawmakers to actively move the status quo policy. In addition, bolstering marketplaces required imposing salient, concentrated costs on constituents whose plans would be terminated. Thus, in this area, we can expect a tension for Democrat-controlled state governments as opposed to Republican-controlled state governments. For Republicans, not terminating transitional plans avoided political costs while contributing to ACA marketplace erosion, which benefits the party. Democrats, though, had to choose between imposing a salient cost on transitional plan enrollees, on the one hand, and undermining long-run marketplace stability, on the other.

Under what conditions would states terminate transitional plans? First, we might expect Democrat-controlled state governments to be more likely to invest in long-run marketplace robustness by terminating transitional plans in states where the Republican coalition was weaker and so did not pose a strong electoral threat. Second, we might expect the decision calculus to depend on the degree to which state governments were politically invested in the ACA marketplaces, which can be measured by whether they were on track to establish an SBM. State governments without SBM's might be less likely to terminate transitional plans in order to bolster the marketplaces, since they were less likely to receive credit for marketplace functioning (or blame for marketplace dysfunction) (Arnold 1992).[11]

11. By the time state governments were making decisions about transitional plans, they would have already determined whether or not to establish an SBM.

Rating Area Configurations

The final ACA marketplace implementation policy I consider is the configuration of rating areas within states. States were required to set geographic rating areas within which specific plan premiums would vary only by defined age and smoking bands—defining the geographic level of risk pooling. While the literature on optimal rating area configurations is sparse, the existing work suggests that rating area configurations should aim for large enrollee populations with low heterogeneity of health risk, or projected health spending (Dickstein et al. 2015). This allows insurers to spread risk across a large number of individuals while not encountering too much potential variation in expected costs depending on who enrolls in their plans.

In determining marketplace rating areas, states could choose configurations based on 1) counties, 2) zip codes, or 3) Metropolitian Statisical Areas (MSA). Alternatively, they could default to the federal standard, which would set each MSA as a rating area, with all non-MSA territory constituting an additional rating area (so the total number would be the number of MSA's in a state, plus one). Nondefaulting states could configure rating areas by counties, zip codes, or MSA's, but if the total proposed number exceeded the number of MSA's plus one they were required to apply for approval from the federal government.

The effort states spent determining rating areas varied considerably. In several states, choosing rating area configurations was an intensive, analytical process. For instance, in California, where the rating area configuration was determined through legislation, the Department of Insurance produced and disseminated to the legislature an actuarial study arguing that their proposed plan would minimize disruption to consumer rates. On the other end of the spectrum, a number of states did not—at least based on what is discernable from public information—spend any resources evaluating rating area configurations options, and simply defaulted to the federal standard.

The case of rating areas is similar in some ways and different in others from the previous two. The basic framework remains. With the power to configure rating areas, state governments could choose either a configuration well suited to the health geography of their states, thus bolstering the local ACA marketplace and producing positive feedback for Democrats—or one ill-suited to the health geography of their states, thus eroding the local marketplace and producing positive feedback for Republicans.

However, unlike in the case of navigator laws, where eroding required erecting burdensome regulations, suboptimal rating area configurations

do not impose clear costs to states (beyond the effect on the marketplace itself). Unlike in the case of transitional plan termination, which required taking low-cost plans away from constituents, there were not clear costs to marketplace bolstering. Moreover, unlike in the other policy areas discussed, rating area configuration decisions had to be approved federally if they departed significantly from Health and Human Services standards. This raised the transaction costs to trying to use rating areas to erode marketplaces, in addition to lowering the likelihood of successful erosion. This meant there was minimal scope for state-level Republicans to produce positive feedback for the national party. Given these factors, I would hypothesize a reduced role of partisanship and conservative networks.

Data and Methods

Testing the hypotheses outlined above requires a data set linking ACA implementation policy choices to various state characteristics, including partisan control of government and strength of conservative networks, in addition to a set of control variables to address potential confounding. Policy choice data was drawn from several sources. The navigator law outcome variable was produced for a report from the Commonwealth Fund, while transitional plan termination data came from healthinsurance.org (Norris 2016). Rating area configuration data was drawn from the Centers for Medicare and Medicaid Services (CMS 2018).

I use a measure of conservative network strength at the state level developed and applied by Hertel-Fernandez, Skocpol, and Lynch (2016) in their paper on Medicaid expansion. As discussed in that paper, the measure includes four components. The first component accounts for the strength of ALEC, measured by the share of state legislators who were ALEC members as of 2013 as well as how many of the state's top four legislative leaders were affiliated with ALEC. The second component accounts for the presence of SPN-affiliated think tanks, and is measured as the relative budget of SPN-affiliated think tanks to the budget of think tanks on the center left and left. The third component accounts for the cross-state lobbying efforts of representatives of the Foundation for Government Accountability (FGA), an SPN-affiliated think tank formed to lobby on issues of health and welfare in the states. This component is measured by the activity of FGA in a state regarding Medicaid expansion, which is likely highly correlated with activity on the marketplace implementation policies analyzed here. The fourth component accounts for the strength of AFP,

recording whether AFP had an office during the ACA implementation period and the length of time the office had existed beforehand. Appendix A displays the distribution of the measure across the states.[12]

For each of the policies, I first inspect cross-tabs of policy choices by state control of government. Second, I estimate linear probability models to more systematically test which factors were predictive of policy choices across the three areas.[13] In regression models, I incorporate a number of variables that prior studies have shown to be predictive of ACA implementation policy, including policy legacies (Beland, Rocco, and Waddan 2016; Jacobs and Callaghan 2013), administrative capacity (Jacobs and Callaghan 2013), and ideology (Shor 2018).

Results

Cross-tabs displaying state government choices across the three policy areas outlined above are presented in table 1. As expected, the vast majority of the variation in navigator law enactment is within Republican-controlled and divided states. On the other hand, not a single Republican-controlled state terminated transitional plans, while there was some variation in policy choices among divided and Democrat-controlled states. Finally, very few states defaulted to the federal standard when it came to rating area configurations, suggesting minimal marketplace erosion through this policy mechanism.[14]

I turn next to estimating linear probability models of policy choices. Table 2 presents results from estimating linear probability models using a number of model specifications with navigator law enactment as the dependent variable, and state-level attributes as independent variables. The model featuring only state control of office explains just 16% of the variation in navigator law enactment. Adding conservative network strength to the model improves explanatory power markedly, with conservative

12. Some of these measures are recorded after ACA implementation was underway, raising concerns of posttreatment bias, where the measure itself is a function of the outcome variable. That said, it seems unlikely that how a state was implementing the ACA would exert a strong influence on ALEC membership.

13. Results are robust to using a generalized linear model like logit, but linear probability estimates are presented since they are easier to interpret.

14. Of course, it is possible that states actively selected ill-suited rating area configurations to erode marketplaces. I address this concern using regression analysis (see Appendix B), where I am able to investigate a continuous measure of rating area quality that I cannot capture using cross-tabs. Note, however, that of the 7 states that defaulted to the federal standard, 5 (Alabama, New Mexico, North Dakota, Oklahoma, and Texas) featured rating area quality scores below the median, while 3 were among the 10 lowest-scoring states.

Table 1 State Decisions across Three Implementation Areas

		Unified Republican	Divided	Unified Democratic
Navigator laws	Law enacted (eroding)	AZ, FL, GA, IN, LA, NE, OH, OK, TN, TX, UT, WI	AR, IA, ME, MO, MT, VA	IL
	No law (bolstering)	AL, AK, ID, KS MI, MS, NC, ND, PA, SC, SD, WY	KY*, NV*, NH, NJ, NM*, RI*	CA*, CO*, CT*, DE, DC*, HI*, MD*, MA*, MN*, NY*, OR*, VT*, WA*, WV
Transitional plans	Terminate (bolstering)		NV*, NM, RI*	CA*, CO*, CT*, DE, DC*, MD*, MA*, MN*, NY*, OR*, VT*, WA*
	Extend (eroding)	AL, AK, AZ, FL, GA, ID, IN, KS, LA, MI, MS, NE, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, WI, WY	AR, IA, KY*, ME, MO, MT, NH, NJ, VA	HI*, IL, WV
Rating areas	Nondefault (bolstering)	AK, AZ, FL, GA, ID, IN, KS, LA, MI, MS, NE, NC, OH, PA, SC, SD, TN, UT, WI	AR, IA, KY*, LA, ME, MI, MO, NV*, NH, NJ, RI*	CA*, CO*, CT*, DE, DC*, HI*, MD*, NY*, IL, MA*, MN*, OR*, VT*, WA*, WV
	Federal default (eroding)	AL, ND, OK, TX, WY	NM, VA	

Note: * Denotes SBM establishment states. Policy status reported as of marketplace opening in 2014.

Table 2 Determinants of Navigator Law Enactment

	(1)	(2)	(3)	(4)
Unified Republican	0.00	–0.09	–0.15	–0.18
	(0.18)	(0.15)	(0.15)	(0.16)
Unified Democratic	0.43***	–0.24	–0.07	–0.21
	(0.16)	(0.16)	(0.15)	(0.19)
Conservative network index		0.97***	0.78**	0.81**
		(0.33)	(0.34)	(0.34)
SBM			0.39***	0.41***
			(0.15)	(0.16)
ACA favorability				–1.01
				(1.01)
Democrat ideology mean				–0.06
				(0.21)
Republican ideology mean				0.27
				(0.19)
Democrat SD				0.52
				(0.29)
Republican SD				–0.68*
				(0.35)
Pre-ACA Medicaid				0.06
				(0.04)
Administrative capacity				0.00
				(0.03)
Observations	50	50	50	50
R-squared	0.16	0.29	0.35	0.45

Note: *p < .1 **p < .05 ***p < .01. Estimates are derived from linear probability model. Standard errors calculated using heteroscedasticity-robust estimator. Policy reported as of marketplace opening in 2014.

Source: Commonwealth Fund.

network strength predictive of navigator law enactment.[15] Column 3 adds SBM establishment to the model, which I find to be negatively associated with navigator law enactment.[16] This suggests that states investing politically in marketplaces by establishing SBMs were less likely to erode those marketplaces.

15. Since Virginia is a positive outlier on the conservative network measure and passed a navigator law, results might be driven by this single case. However, the finding is robust to excluding Virginia from the data.

16. Similar factors likely influenced both navigator law enactment and SBM establishment, complicating interpretation of these models. Results are generally robust to excluding SBM establishment from models.

Column 4 estimates a model featuring several additional covariates to account for confounding and test some alternative hypotheses. First off, to the degree that conservative network strength or SBM establishment are associated with general state conservatism, results could alternatively be driven by legislator ideology or constituent preferences regarding the ACA. To address this concern, I include measures of state-level favorability toward the ACA as of 2012, as well as the mean estimated ideology in each party across state legislative chambers from Shor and McCarty's American Legislatures Project (Shor and McCarty 2011).[17] The measure of state-level ACA favorability comes from Barrilleaux and Rainey (2014) and is generated by applying a multilevel regression and model to Kaiser Health Tracking Poll data.[18] Strikingly, the results indicate neither ACA favorability nor legislator ideology are (conditional on other covariates) strongly related to navigator law enactment.[19]

I also include measures of ideological dispersion of state legislators in each of the parties, testing Anzia and Moe's (2016) argument that ideologically heterogeneous coalitions are less likely to produce positive feedback. While the direction of the coefficients on measures of dispersion are consistent with Anzia and Moe (2016), with more heterogeneous Republican coalitions less likely to pass navigator laws, and the opposite for Democrats, estimates are not statistically significant.[20] Finally, I include measures of pre-ACA Medicaid generosity and administrative capacity from Callaghan and Jacobs (2016, 2017). Neither is a statistically significant predictor of navigator law enactment. In the fully specified model, the only statistically significant predictors of navigator law enactment are conservative network strength and SBM establishment.

I turn next to transitional plan termination. Linear probability models, presented in table 3, demonstrate that a significant portion of the variation in transitional plan termination can be explained by a simple model featuring control of state office (Republican control being associated with extension of transitional plans). Adding conservative network strength only increases explanatory power marginally. While the coefficient on the conservative network strength variable is significant in this model, it is not significant in the model including SBM establishment (column 3),

17. Results are also robust to using mean estimated ideology across the state legislative chambers (versus by party).

18. See github.com/carlislerainey/aca-opinion/blob/master/README.md for more information on the measure.

19. Results are robust to substituting Obama's 2012 vote share for ACA favorability.

20. Lack of statistical significance should not be considered evidence against this theory, especially given the low sample size and resultant low power in the present analysis.

Table 3 Determinants of Transitional Plan Termination

	(1)	(2)	(3)	(4)
Unified Republican	–0.25*	–0.21*	–0.14	–0.05
	(0.13)	(0.11)	(0.10)	(0.09)
Unified Democratic	0.54***	0.44**	0.25	0.12
	(0.17)	(0.19)	(0.21)	(0.20)
Conservative Network Index		0.49***	–0.28	–0.3
		(0.20)	(0.18)	(0.21)
SBM			0.43**	0.41***
			(0.20)	(0.17)
ACA favorability				1.21
				(0.75)
Democrat ideology mean				–0.05
				(0.12)
Republican ideology mean				–0.07
				(0.12)
Democrat SD				–0.24
				(0.15)
Republican SD				0.68***
				(0.27)
Pre-ACA Medicaid				0.00
				(0.03)
Administrative capacity				0.02
				(0.02)
Observations	50	50	50	50
R-squared	0.54	0.58	0.68	0.77

Note: *p < .1 **p < .05 ***p < .01. Estimates are derived from linear probability model. Standard errors calculated using heteroscedasticity-robust estimator. Policy reported as of marketplace opening in 2014.

Source: healthinsurance.org.

suggesting a weak association. On the other hand, including SBM establishment increases model fit substantially, with SBM establishment significantly associated with transitional plan termination. This suggests that, as expected, Democratic lawmakers in SBM states were more willing to incur short-term costs to bolster marketplaces in the long run.

Similar to the prior analyses, I do not find ACA favorability or legislator ideology to be significantly related to the outcome. However, transitional plan termination was more common in states with ideologically heterogeneous Republican coalitions. One explanation for this result is that heterogeneous Republican coalitions posed less of a threat to a government

Table 4 Determinants of Rating Area Defaulting

	(1)	(2)	(3)	(4)
Unified Republican	0.04	0.05	0.02	–0.05
	(0.14)	(0.17)	(0.17)	(0.17)
Unified Democratic	–0.17	–0.18	–0.12	0.00
	(0.11)	(0.12)	(0.09)	(0.17)
Conservative network index		–0.09	–0.16	–0.34
		(0.47)	(0.50)	(0.56)
SBM			–0.15	–0.17
			(0.09)	(0.13)
ACA favorability				–0.55
				(1.10)
Democrat ideology mean				–0.03
				(0.17)
Republican ideology mean				0.09
				(0.22)
Democrat SD				0.09
				(0.23)
Republican SD				–0.03
				(0.36)
Pre-ACA Medicaid				–0.02
				(0.03)
Administrative capacity				–0.03
				(0.03)
Observations	50	50	50	50
R-squared	0.07	0.07	0.09	0.17

Note: *p < .1 **p < .05 ***p < .01. Estimates are derived from linear probability model. Standard errors calculated using heteroscedasticity-robust estimator. Policy reported as of marketplace opening in 2014.

Source: Centers for Medicare and Medicaid Services (CMS).

controlled by Democrats, making them more willing to take on the risks of terminating transitional plans.

I turn finally to rating area configurations. Recall that, since state lawmakers had less scope to influence marketplaces using rating area configurations, I expected less polarization. As a first cut at exploring the political determinants of rating area configurations, I code the outcome variable based on whether or not states defaulted to the federal standard. While this is not a precise measure of marketplace eroding, it signals a lack of interest in actively promoting optimal rating areas. Regression results, presented in table 4, demonstrate that, while Democratic control is

associated with nondefault, the relationship is weak and not statistically significant. Indeed, none of the variables is significantly associated with rating area defaulting in any of the four models.

The measure of eroding based on defaulting to the federal standard is a rough measure, though. It is likely that for some states the federal standard was decently suited to the state's health geography, while other states may have actively chosen poor rating area configurations. As a robustness check, I compute a measure of the quality of a state's rating area configuration based on the degree to which rating areas reduced the pooling of highly heterogeneous health risk. I code health risk scores at the county level using measures published by Blue Cross Blue Shield (BCBS 2017) reflecting the actual health spending of enrollees, run an analysis of variance (ANOVA), and compute the corresponding F-statistic for each state. Higher F-statistics indicate that a greater proportion of the total variation in health risk is accounted for by the rating area divisions, which would tend to have positive effects on the marketplaces (Dickstein et al. 2015).[21]

This measure is also imperfect. Most problematically, it cannot be applied to states like Vermont that use one rating area for the whole state, or to states like Florida that classify each county as a separate rating area, reducing sample size considerably. Despite these problems, I recover similar results, presented in appendix B, using this measure as with the simple measure based on states defaulting to the federal standard.[22]

Discussion

Patterns of state marketplace implementation policy across the three policy areas explored support the hypotheses put forward, and the corresponding theoretical framework. Passing navigator laws would produce positive feedback for the Republican Party, but required actively making policy that would be costly to many constituents. I hypothesized that conservative networks would be key to pressuring state lawmakers to enact these laws. Indeed, in this policy area, strength of conservative networks was an important predictor of whether states eroded marketplaces.

21. Defaulting to the federal standard is associated with more poorly rating area configuration ($p < .05$, correlation coefficient = .23), lending support to the validity of the measures.

22. Note that in the fully specified model (column 4) for the rating area quality-robustness check (appendix B) having a more conservative state Republican party coalition is associated with lower-quality rating area configurations. However, in this model (but not in others), strength of conservative networks is also associated with *higher-quality* rating area configurations, suggesting potentially spurious associations. Instability of estimates depending on model specification reflects the relatively small sample size (reduced to 40).

With respect to transitional plans, eroding the marketplaces was much easier. Terminating transitional plans (the marketplace-bolstering policy) required a change from the status quo, and provoked a backlash from consumers whose plans would be canceled. As a result, variation in this case generally occurred among Democrat-controlled states. Moreover, the evidence suggests Democrat-controlled states were more likely to bolster the marketplaces—producing positive feedback for the national party—where they had invested in marketplace performance by establishing SBM's, and where the Republican coalition posed less of a threat.

While investigating rating area configurations poses some measurement problems, the results, on balance, suggest that factors like control of state office, strength of conservative networks, and prior SBM establishment played a weaker role than in the other implementation areas examined. The potential feedback effects were minimal in this case, since configurations had to be approved federally. In addition, the fact that rating area configurations were determined bureaucratically perhaps limited the power of the cross-state conservative groups, which tend to exert the most influence over state legislators (Hertel-Fernandez, Skocpol, and Lynch 2016).

The analysis also provides evidence that the role of ideological homogeneity in state party coalitions plays less of a role in determining whether state-national feedback is produced than it does in cases where strong within-state feedback effects would be expected (Anzia and Moe 2016). This makes theoretical sense. If ideological homogeneity leads rank and file state lawmakers to invest additional authority in state party leaders (Aldrich and Battista 2002), it likely also facilitates the enactment of policies that are politically beneficial in those states. Investment of greater authority in state party leaders is likely to be less consequential in an environment where state parties can free-ride off of policies passed in other states that produce political benefits for the national-level party.

There are several limitations of the study that I address here. First, I do not measure variation in the strength or preferences of concentrated local interests like health insurance companies with a stake in these policy decisions. Indeed, Hertel-Fernandez, Skocpol, and Lynch (2016) argue that Medicaid expansion in Republican-controlled states depended on the relative power of local business groups versus cross-state ideological groups, with local Chambers of Commerce tending to support expansion. While I do not deny that local interests likely matter in the cases I study as well, they seem less relevant than in the case of Medicaid expansion. One reason is that in several of the cases I examine there are likely competing local groups, as opposed to a unified local front. For instance, laws restricting

publicly funded navigators benefited competing private health insurance navigators but likely hurt health insurers to the degree they reduced enrollment. Similarly, transitional plan termination benefited insurers with a large portfolio of transitional plan enrollees but likely hurt health insurers committed to the marketplace. Perhaps due to divided local interests, combined with the relatively lower stakes of these policies, I do not find evidence of state Chambers of Commerce taking clear stands on the implementation issues I study. Additionally, it seems unlikely that the variation in strength and preferences of local interests is both meaningful enough and sufficiently associated with the factors I study to drive the findings.

Second, this study does not address the degree to which state lawmakers *intentionally* eroded or bolstered marketplaces to produce certain national-level feedbacks. The proposed theory is concerned with the conditions under which state lawmakers would enact policy that advantages their party, as opposed to the intentions of state lawmakers. While the intentions of state lawmakers will likely remain unknown, conservative groups have not been shy about their willingness to undermine ACA marketplaces as a step toward repealing the law.[23]

Third, there are limits to the inferences that can be drawn from observational data. While the evidence is consistent with the proposed theoretical framework, the design does not permit strong causal claims. More specifically, there is always the potential for omitted variable bias. One alternative explanation for the patterns uncovered in the empirical analysis is that the measures of conservative network strength are simply serving as proxies to other factors like ideology. Relatedly, there is the concern that the strength of conservative networks in a state is in itself endogenous to preexisting factors that themselves are associated with implementation policy decisions.

Yet, the evidence suggests these confounding factors are not driving results. Inspecting table 2, the coefficient associated with conservative network strength is larger in the fully specified model featuring measures of ideology and ACA favorability than in the model featuring only state control of government, SBM establishment, and conservative network index. If conservative networks were taking hold generally in those ideologically conservative states predisposed to erode ACA marketplaces, we would expect that controlling for ideology would reduce the magnitude of

23. ALEC's 2011 *State Legislatures' Guide to Repealing ObamaCare* includes a section titled "Decline to Build the ObamaCare Edifice," which recommends states reject grants to establish marketplaces and decline to enact ACA rulemaking.

the conservative network coefficient. Beyond the empirical evidence, patterns of state passage of navigator laws provide reason to believe that state ACA marketplace implementation is not driven by principled expression of ideology. In particular, the marketplace-eroding policy required writing additional government regulations aimed at consumer protection, which is not generally associated with conservative principles. Finally, if preexisting factors associated with conservative network strength were driving results, we might expect conservative network strength to predict implementation policy across each policy dimension—but, the measure is only strongly predictive of navigator laws.

Conclusion

State policy can have important consequences for national-level competition between political parties and interest groups (Feigenbaum, Hertel-Fernandez, and Williamson 2018; Flavin and Hartney 2015; Stephanopoulos and McGhee 2015;). Yet, political scientists have not addressed the question of how these dynamics might influence state policy choices. This article provides an early step to begin to answer this question.

With state policy increasingly nationalized (Hopkins 2018) and polarized (Grumbach 2018), we should expect state lawmakers to generally adopt policies that benefit their national-level parties. However, national-level groups and parties face limitations in using state policy to promote their broader political interests. In particular, state lawmakers might be cross-pressured by national party interests and local interests. In these cases, producing positive feedback is likely to depend on other mechanisms like federated policy networks.

Evidence from ACA marketplace implementation lends support to this theoretical framework. Democrat-controlled states generally bolstered marketplaces, while Republican-controlled states generally eroded marketplaces. However, comparing patterns across multiple implementation policies deepens this story in two important ways. First, polarization in implementation was stronger for policies with greater potential for national-level feedback. Second, cross-state variation in the strength of conservative groups played a more important role where eroding marketplaces required a locally costly departure from the status quo.

Theoretically, this work brings together two areas of political science—federalism and policy feedback—in a way that should be fruitful for future research. Recent literature in federalism has emphasized the increasing

degree to which states act not as separate sites of governing authority, but rather as alternative venues of partisan contestation (Bulman-Pozen 2013). Moreover, scholars have shown that policy increasingly diverges based on state control of government (Caughey, Warshaw, and Xu 2017; Grumbach 2018). In addition, at least on the Right, organized networks focused on influencing state policy have grown in strength over time (Skocpol and Hertel-Fernandez 2016). These trends are important in their own right, but they also have serious implications for policy feedback.

If nationally organized groups have sway in statehouses, they are likely to promote policy with feedback effects that improve their national position. Moreover, state lawmakers may not provide much resistance, since evidence suggests they are evaluated by voters primarily based on national-level politics (Rogers 2017). I argue that in the case of the ACA these forces led to the erosion of state marketplaces in Republican-controlled states, which generally produced adverse outcomes for constituents, but positive outcomes for the Republican Party.

This work has important implications for policy makers. The framework and analysis suggests crafters of federal legislation cannot expect state lawmakers to universally implement federal law in order to maximize the direct benefits to their constituents. Rather, as a result of the greater role of national-level political forces at the state level, we should expect state lawmakers to, in many instances, implement federal law to maximize benefits to their party.

Implementation of highly polarized national law is only one of several potential mechanisms of state-national policy feedback that scholars might investigate. Future work might apply the framework developed here to state policy decisions in areas like labor, energy, voting rights, and criminal justice that are likely to have meaningful political effects at the national level.

■ ■ ■

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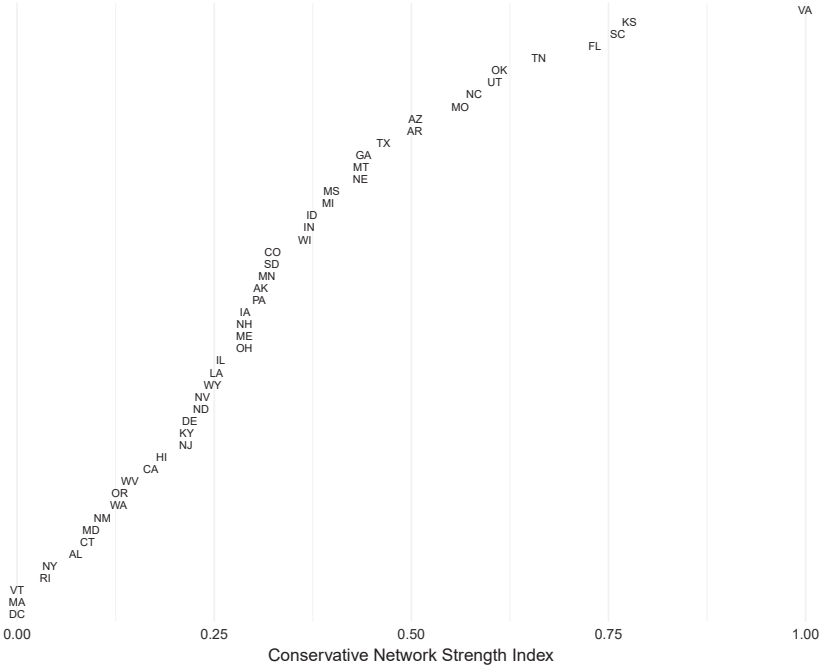
Appendix A Conservative Network Organizational Capacity Measure



Note: Figure demonstrates distribution of conservative network index measure from lowest capacity (0) to highest capacity (1). The measure accounts for the activities of ALEC, SPN, FGA, and AFP.

Source: Hertel-Fernandez, Skocpol, and Lynch (2016).

Appendix B Rating Area Quality Robustness Check

Determinants of Rating Area Quality

	(1)	(2)	(3)	(4)
Unified Republican	–0.13	–0.14	–0.19	–0.15
	(0.94)	(0.92)	(0.99)	(0.96)
Unified Democratic	1.32	1.65	1.78	1.91
	(1.32)	(1.24)	(1.1)	(1.58)
Conservative network index		1.45	1.35	3.99**
		(1.62)	(1.65)	(1.96)
SBM			–0.28	0.59
			(0.85)	(1.09)
ACA favorability				–5.94
				(4.83)
Democrat ideology mean				1.62
				(1.75)
Republican ideology mean				–3.85**
				(1.69)
Democrat SD				1.21
				(1.7)
Republican SD				0.96
				(2.68)
Pre-ACA Medicaid				0.32
				(0.22)
Administrative capacity				–0.06
				(0.15)
Observations	40	40	40	40
R-squared	0.07	0.08	0.08	0.36

Note: *p<.1 **p<.05 ***p<.01. Estimates are derived from linear probability model. Standard errors calculated using heteroscedasticity-robust estimator. Policy reported as of marketplace opening in 2014. Outcome variable based on proportion of total variation in health cost within a state captured by rating area divisions.

Source: Centers for Medicare and Medicaid Services (CMS) and Blue Cross Blue Shield.

California
Health Benefits
Review Program

California Health Insurance

John Lewis
Associate Director

January 23, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Health Insurance …

- Covers the cost of an enrollee's medically necessary health expenses (excepting some exclusions).
- Protects against some or all financial loss due to health-related expenses.
- Can be publicly or privately financed.

Health Insurance …

- is regulated at the federal level or at both the federal and state level

- may be (or may not be) subject to state laws, such as benefit mandates

State-regulated health insurance…

health care service plan contracts are:

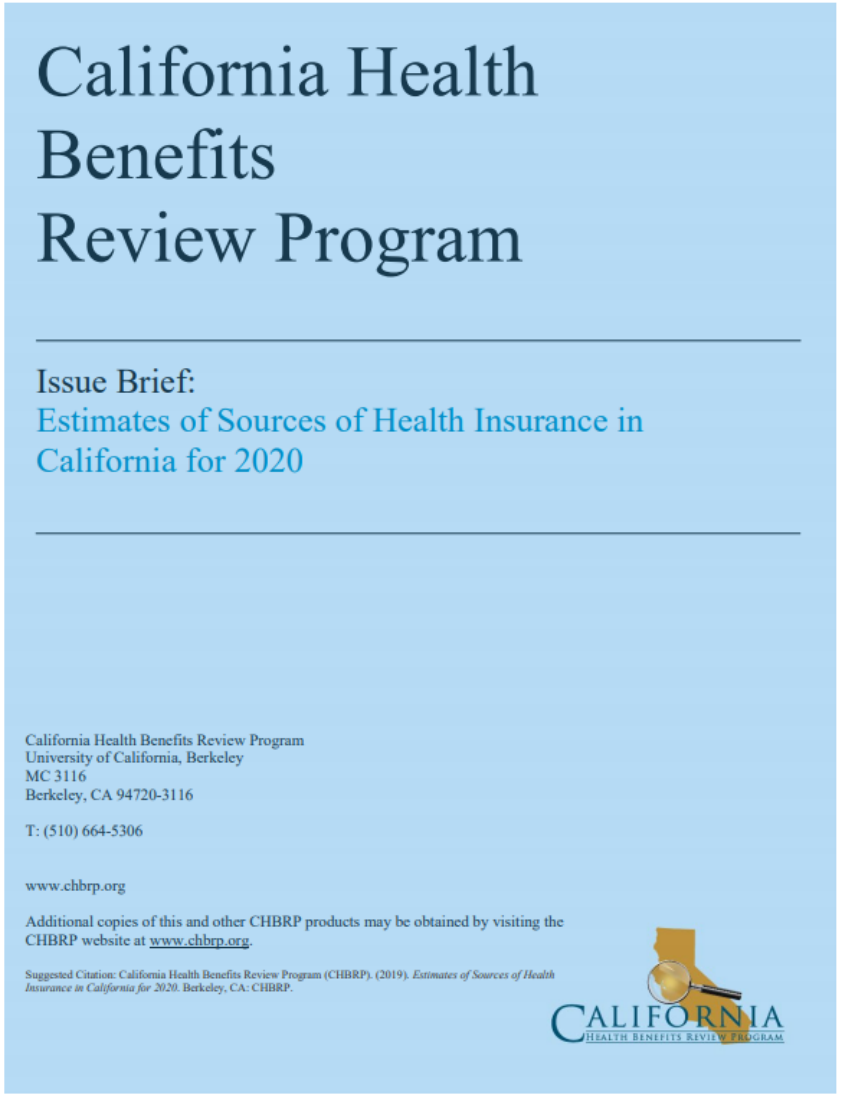
- Subject to CA Health & Safety Code
- Regulated by DMHC

State-regulated health insurance…

health insurance policies are:

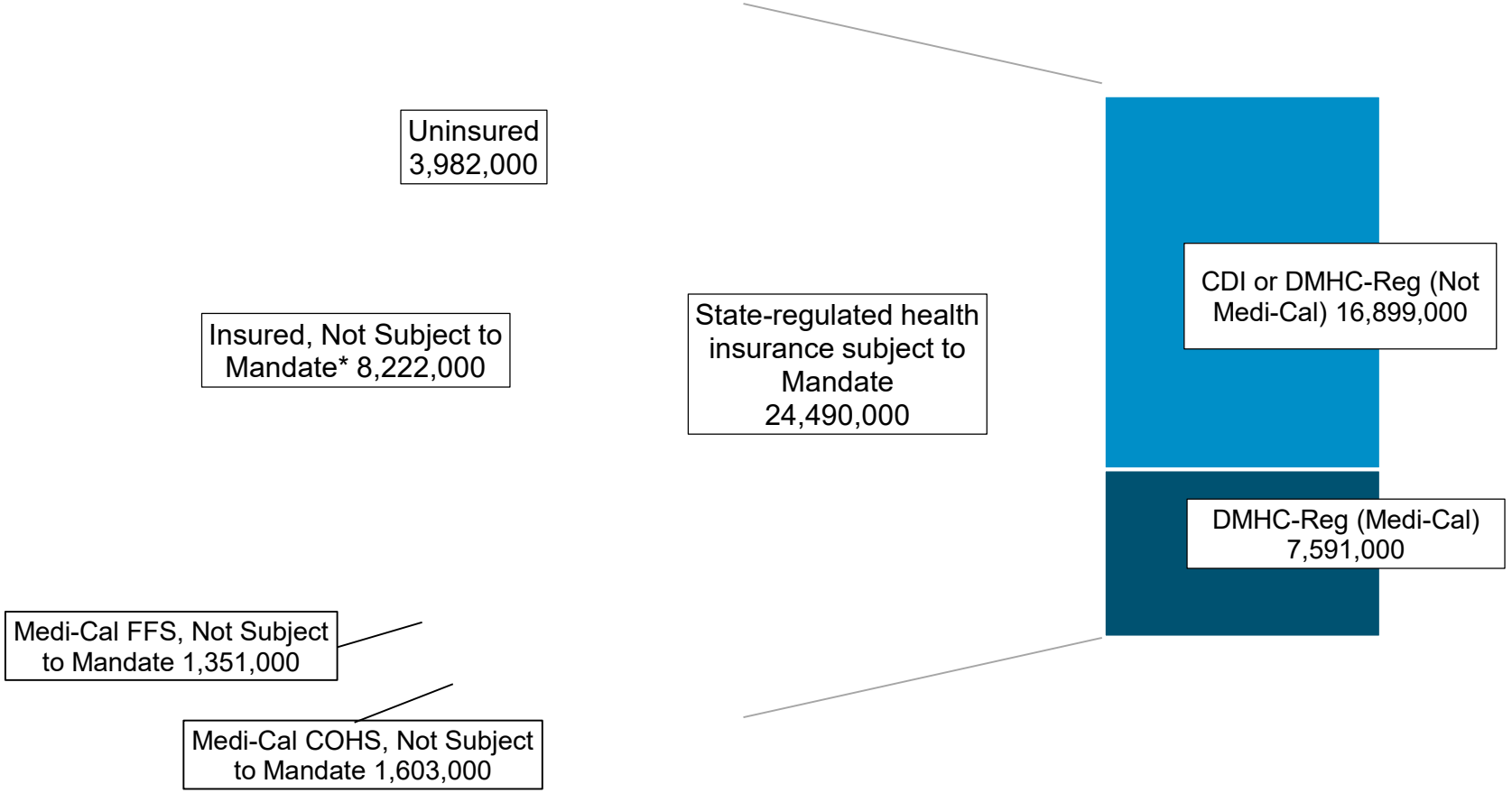
- Subject to CA Insurance Code
- Regulated by CDI

Sources of Health Insurance



2020 Estimates – CA Health Insurance

Total CA Population – **39,648,000**



*Such as enrollees in Medicare or self-insured products

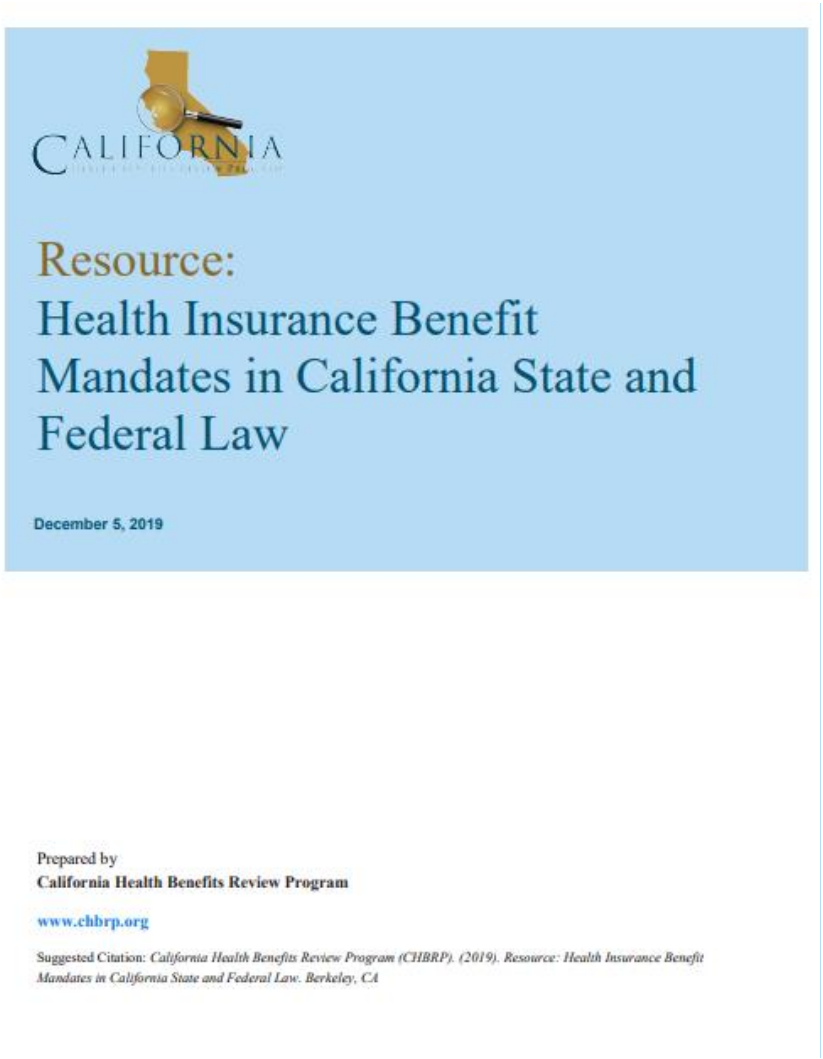
Source: California Health Benefit Review Program, 2019

Health Insurance Markets in California

DMHC-Regulated Plans	CDI-Regulated Policies
Large Group (101+)	Large Group (101+)
Small Group (2-100)	Small Group (2-100)
Individual	Individual
Medi-Cal Managed Care*	----------

*except county organized health systems (COHS)

Benefit Mandates List



Benefit Mandates

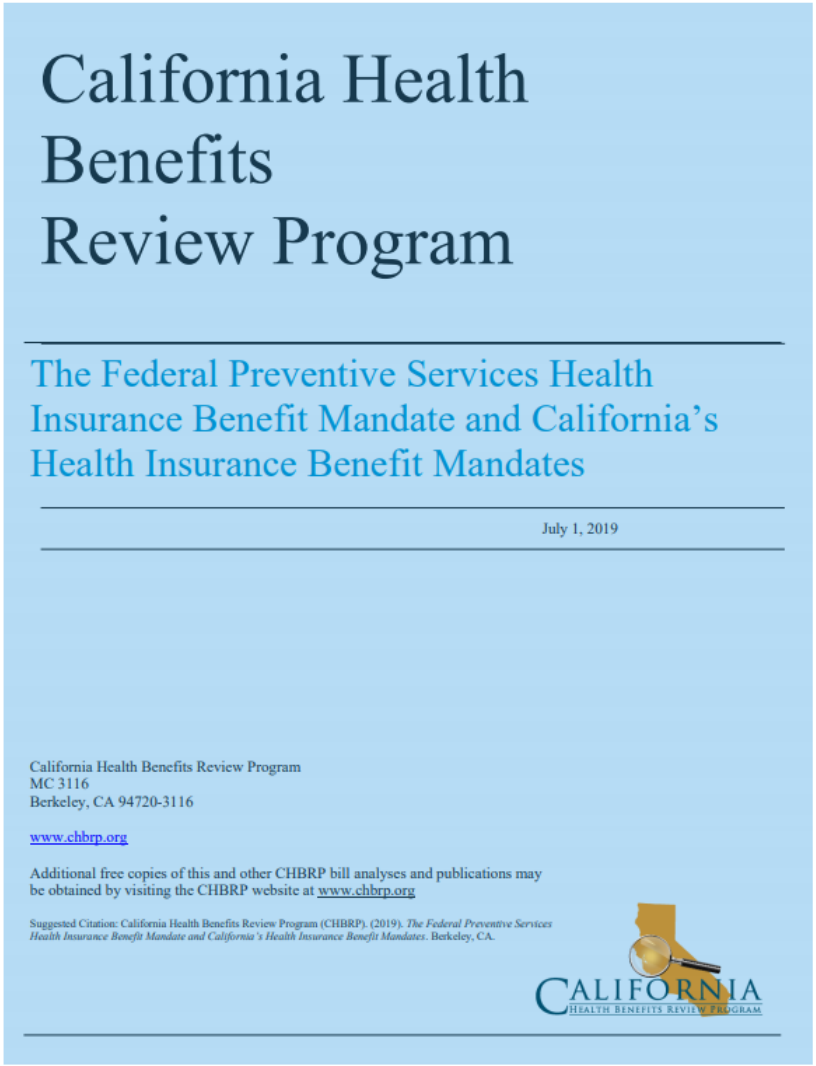
State Laws (Health & Safety/Insurance Codes)

- 79 benefit mandates in California

Federal Laws

- Pregnancy Discrimination Act
- Newborns' & Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Mental Health Parity and Addiction Equity Act
- Affordable Care Act (ACA)
    - Federal Preventive Services
    - Essential Health Benefits (EHBs)

Federal Preventive Services



California Health Benefits Review Program

The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates

July 1, 2019

California Health Benefits Review Program
MC 3116
Berkeley, CA 94720-3116

www.chbrp.org

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Suggested Citation: California Health Benefits Review Program (CHBRP). (2019). *The Federal Preventive Services Health Insurance Benefit Mandate and California's Health Insurance Benefit Mandates*. Berkeley, CA.

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

Federal Preventive Services

~70 Benefit Mandates from these sources:

- **USPSTF** (United States Preventive Services Task Force) A and B recommendations
- **HRSA** (Health Resources and Services Administration)
  - health plan coverage guidelines for women's preventive services
  - comprehensive guidelines for infants, children, and adolescents
- **ACIP** (Advisory Committee on Immunization Practices) recommendations adopted by the CDC (Centers for Disease Control and Prevention)

Essential Health Benefits (EHBs)

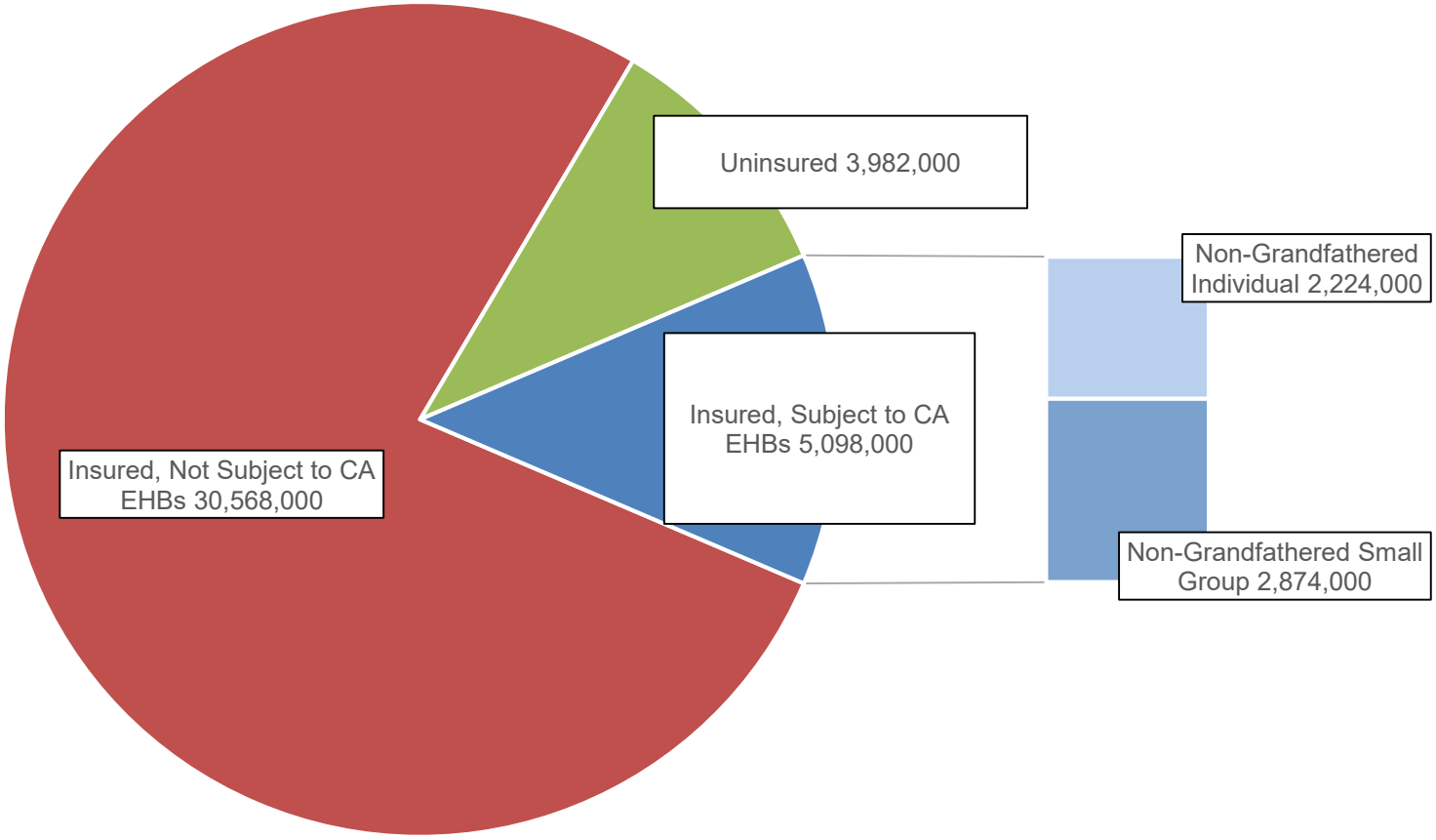
Essential Health Benefits (EHBs)

Categories

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

ESSENTIAL HEALTH BENEFITS

Total CA Population – **39,648,000**



Notes: "Insured, Not Subject to CA EHBs" includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies, and enrollees in grandfathered individual and small group plans/policies

California
Health Benefits
Review Program

California Health Insurance

John Lewis
Associate Director

January 23, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

California Health Benefits Review Program

Providing Evidence-Based Analysis to the California Legislature

2020 Legislative Briefing

Ana Ashby

Policy Analyst

WHAT IS CHBRP?

- Independent, analytic resource grounded in objective policy analysis
- Multi-disciplinary
- Rapid, evidence-based information to the Legislature, leveraging faculty expertise
- Neutral and unbiased analysis of introduced health insurance benefit mandate bills at the **request** of the Legislature

CHBRP'S STATUTE

- Health and Safety Code Section 127660-127665
- Health insurance benefit mandates and repeals
- Public health impacts
- Medical impacts
- Cost impacts
- Analysis within 60 days
- Funding
- Conflict of Interest

WHO IS CHBRP?

- CHBRP Staff (based at UC Berkeley)
- Task Force of faculty and researchers
- Actuarial firm: Milliman, Inc.
- Librarians
- Content Experts
- National Advisory Council

HOW CHBRP WORKS

- Upon receipt of the Legislature's request, CHBRP convenes analytic teams to provide analysis ***before*** policy committee hearing
- CHBRP staff act as project managers and provide context
- CHBRP analyzes health insurance benefit mandates

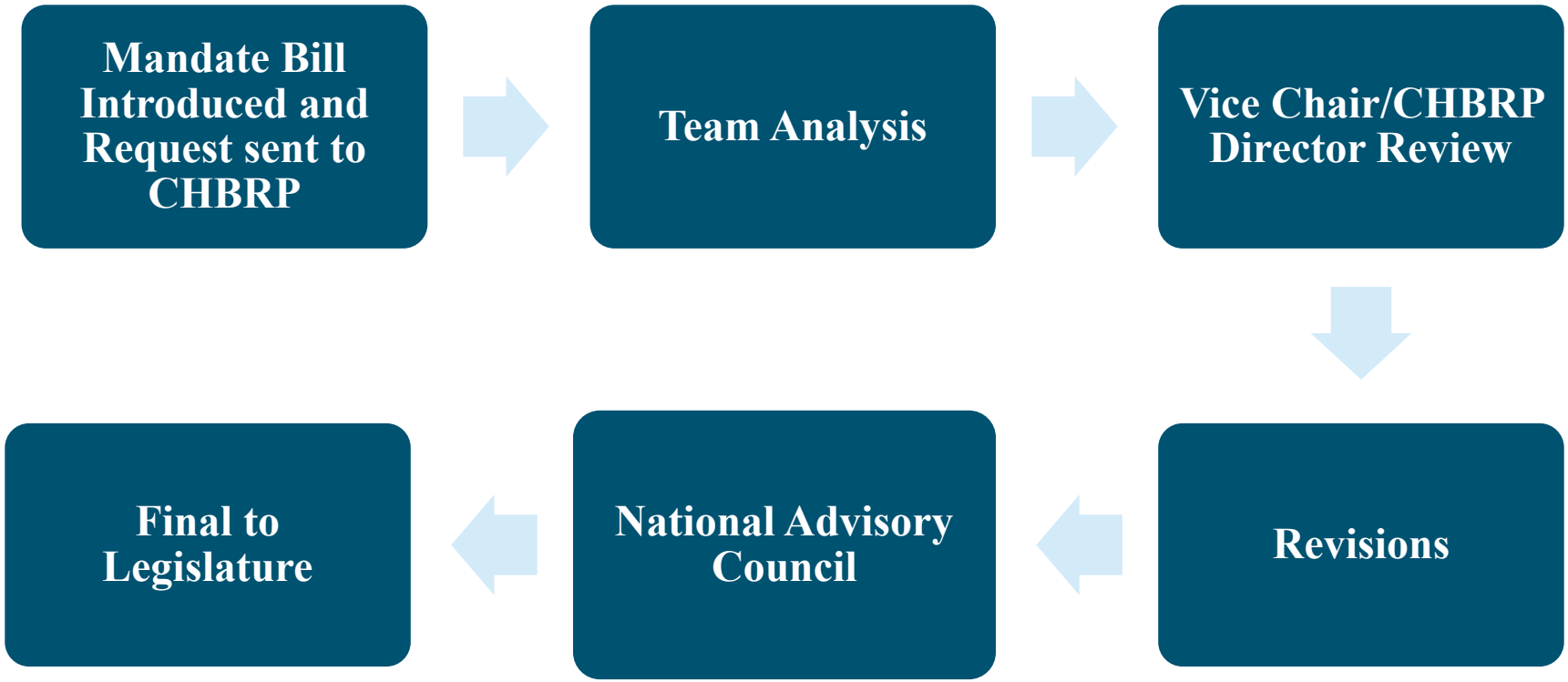
HEALTH INSURANCE BENEFIT MANDATES

- Test/treatments/services for the treatment of one or more conditions/diseases
- May pertain to:
  - Provider type
  - Screening, diagnosis, or treatment of a specific disease/condition
  - Coverage for a particular type of test/treatment/service
  - Benefit design

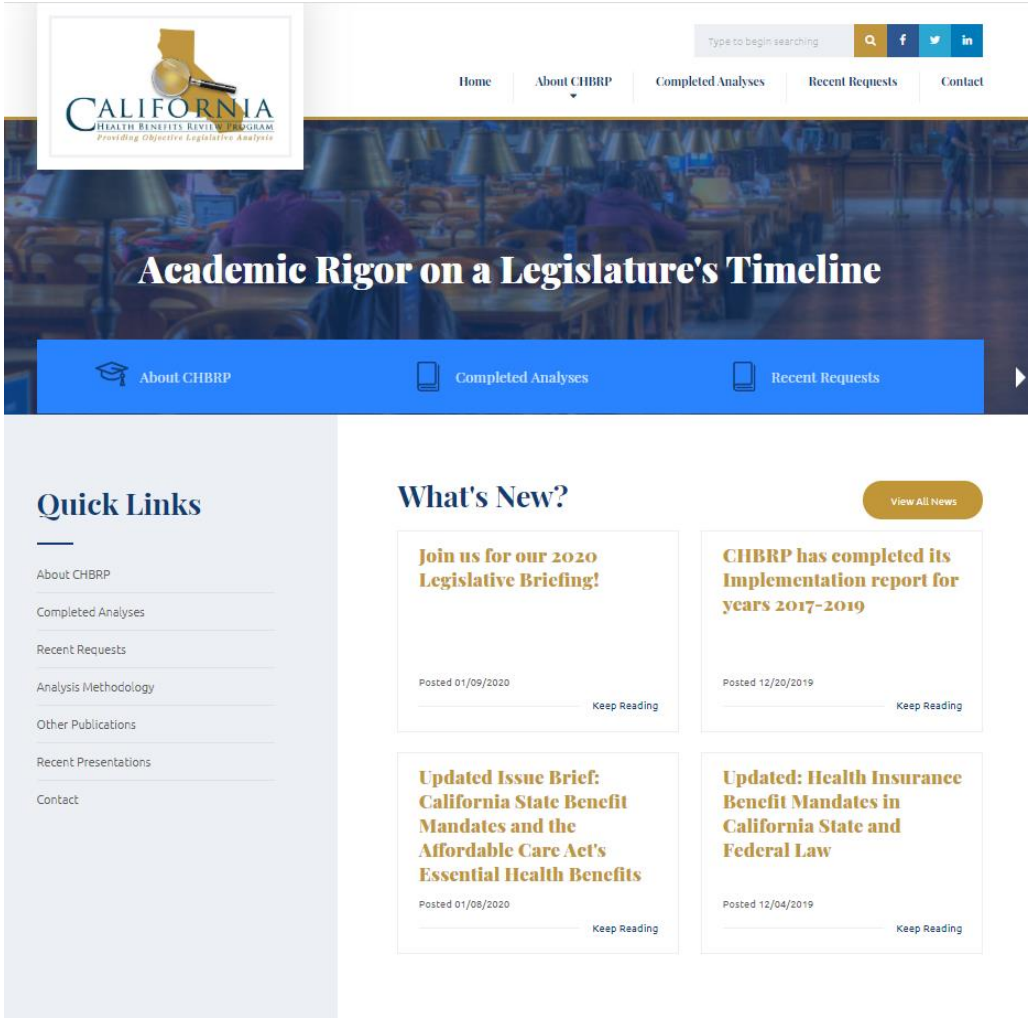
A CHBRP REPORT ANSWERS THE FOLLOWING:

- Does scientific evidence indicate whether the treatment/service works?
- What are the estimated impacts on benefit coverage, utilization and costs of the treatment/service?
- What is the potential value of a proposed health benefit mandate? What health outcomes are improved at what cost?
- What are the potential benefits and costs of a mandate in the long-term?
- If relevant, what is the impact on the social determinants of health?

CHBRP's 60-Day Timeline



CHBRP's Website: www.chbrp.org



California Health Benefits Review Program

Providing Evidence-Based Analysis to the California Legislature

2020 Legislative Briefing

Ana Ashby

Policy Analyst

California Health Benefits Review Program

Showcasing CHBRP's Methods: A review of AB 767 Infertility

Adara Citron, MPH
Principal Analyst

January 23, 2020

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

CHBRP Analyses Provide:

Policy Context

Whose health insurance would have to comply?	Are related laws already in effect?

Medical Effectiveness

Which services and treatments are most relevant?	Does evidence indicate impact on outcomes?

Impacts

Would benefit coverage, utilization, or cost change?	Would the public's health change?

2019 ANALYSIS: AB 767 INFERTILITY

As introduced, AB 767 would require coverage of infertility treatments, including in vitro fertilization, and mature oocyte cryopreservation.

Prevalence of infertility in the US:

- 12% of women ages 15-44
- 9% of men of age 19-44

KEY FINDINGS

Key Findings:
Analysis of California Assembly Bill 767
Infertility

Summary to the 2019–2020 California State Legislature, April 18, 2019

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Assembly Bill (AB) 767 analyzed by CHBRP would require coverage of infertility treatments, including in vitro fertilization (IVF), and mature oocyte cryopreservation (OC).

1. CHBRP estimates that, in 2020, of the 24.5 million Californians enrolled in state-regulated health insurance, 14.6 million of them will have insurance subject to AB 767.
2. **Benefit coverage.** Benefit coverage for infertility treatments, including IVF, would increase from 4.3% premandate to 100% postmandate. Benefit coverage of planned OC would increase from 0% premandate to 100% postmandate. AB 767 would likely exceed EHBs.
3. **Utilization.** Utilization of infertility services would increase between 9% for diagnostic tests and 350% for IVF with intracytoplasmic sperm injection (ICSI). Utilization of planned OC is expected to increase from 0% to between 2% and 5%.
4. **Expenditures.** AB 767 would increase total net annual expenditures by $627,288,000 or 0.39% due to a $537,777,000 increase in total health insurance premiums, adjusted by decrease in enrollee expenses for covered and/or noncovered benefits.
    a. Enrollees with uncovered expenses at baseline would receive on the whole a $133,897,000 reduction in their out-of-pocket spending for covered and noncovered expenses.
    b. Per member per month premiums would increase between $2.76 for enrollees in CalPERS HMOs (an increase of 0.47%) and $3.72 in the DMHC-regulated small group market (an increase of 0.68%).
5. **Medical effectiveness.**
    a. There is a *preponderance of evidence* that IVF is an effective treatment for infertility.

AT A GLANCE, CONT.

    b. There is a *preponderance of evidence* that IVF is associated with certain maternal harms.
    c. There is *clear and convincing evidence* that IVF can lead to multiple gestation and preterm delivery. However, these outcomes can be mitigated by single embryo transfers.
    d. CHRBP found a *preponderance of evidence* that IVF mandates are associated with lower numbers of embryos transferred per cycle, lead to fewer births per cycle, and a reduction in overall harms of IVF.
6. **Public health.** The number of pregnancies resulting from infertility treatments in the first year postmandate will increase the number of pregnancies by 6,000 (from 7,000 to 13,000) and the number of live births by 5,000 (from 6,000 to 11,000).
7. **Long-term impacts.** For each cohort of females electing to undergo mature OC for the prevention of age-related infertility in a given year, CHBRP estimates the long-term marginal impact of AB 767 would yield about 685 more live births among these women over a 20 year period.

CONTEXT

Infertility is the inability to have a child and is a complex condition that can take many forms. Approximately 12% of women aged 15–44 experience infertility and approximately 9% of men aged 19–44 report some type of infertility.

The cost of undergoing infertility treatments such as assisted reproductive technology (ART) can be a prohibitive factor for couples and individuals faced with infertility.[1]

[1] Refer to CHBRP's full report for full citations and references.

BILL SUMMARY

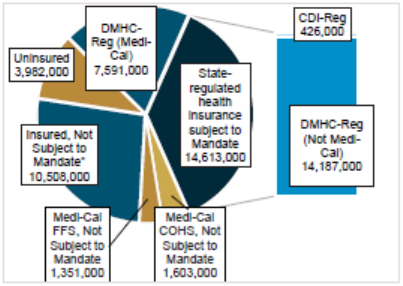
Current law requires most group health plans and policies to offer coverage for infertility services, excluding in vitro fertilization. AB 767 would require group health plans and policies, excluding the individual market and Medi-Cal, to provide coverage for infertility treatments, including in vitro fertilization (IVF), and mature oocyte cryopreservation (OC).

AB 767 defines infertility as the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility. "Treatment of infertility" includes procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons, including, but not limited to, diagnosis, diagnostic tests, medication, surgery, gamete intrafallopian transfer, and in vitro fertilization.

Mature OC is a form of fertility preservation. While fertility preservation usually refers to the preservation of fertility in advance of medical procedures that can lead to iatrogenic infertility (medically caused infertility), such as treatment for cancer or during sex transition, AB 767 could expand coverage of mature OC to a woman seeking to preserve her fertility for age-related reasons or to women seeking to preserve their fertility if they experience other medical conditions, such as endometriosis.

Figure A notes how many Californians have health insurance that would be subject to AB 767.

Figure A. Health Insurance in CA and AB 767



Source: California Health Benefits Review Program, 2019.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Revision

The initially released version of these Key Findings (April 18) referenced an incorrect figure (see the updated full report for more). This version has been updated using the correct total expenditures impact figure, 0.39%.

Benefit Coverage, Utilization, and Cost

To capture the full cost of coverage of infertility services for each year, CHBRP included the cost of pregnancies and births resulting from infertility services in year 1 into year 1 cost estimates.

No utilization data are available for planned OC in MarketScan claims data. There are no studies that estimate utilization of OC for non-iatrogenic or planned use, thus the approach to CHBRP's estimation of utilization change postmandate due to AB 767's coverage of mature OC included an estimate of potential increase in utilization per CHBRP's content expert. The estimates of utilization change do not include planned fertility preservation, however CHBRP offers an estimate of potential cost increase if a modest proportion of females of reproductive age opt to use the service in the *Planned Oocyte Cryopreservation* section.

Benefit Coverage

Currently, 4.3% of enrollees with health insurance that would be subject to AB 767 in DMHC-regulated plans or CDI-regulated policies have coverage for infertility treatments, including in vitro fertilization. No enrollees currently have coverage for mature OC as defined by AB 767. Benefit coverage for infertility treatments and planned OC would increase to 100% postmandate.

Utilization

In California, there are approximately 53,000 users of female diagnostic tests at baseline and about the same number of users of medications for infertility (i.e., only medications and no other service). IUI baseline utilization is about 9,000 users annually. IVF services alone (i.e., without ICSI) is estimated to have about 2,000 users and ICSI, which is done with IVF, is 2,000 users annually. For males, at baseline there are 25,000 users of diagnostic tests and 11,000 users of any male treatment.

MEDICAL EFFECTIVENESS IMPACTS

Definitions:

- Infertility treatments include: Diagnostic tests, medications, in vitro fertilization (IVF), IVF plus intracytoplasmic sperm injection, and intrauterine insemination.
- Mature oocyte cryopreservation (OC) is referred to as “planned OC”: Freezing eggs when a woman is younger to use at a later time.

Key Questions:

1. What is the effectiveness of IVF and planned OC as treatments for infertility?
2. What are the harms associated with IVF and planned OC?

MEDICAL EFFECTIVENESS IMPACTS, CONT.

Key Findings

1. Preponderance of evidence IVF and planned OC are effective treatments for infertility
2. Preponderance of evidence IVF is associated with certain maternal harms

Figure 1. Effectiveness of IVF as a Treatment for Infertility

BENEFIT COVERAGE, UTILIZATION, AND COST IMPACTS

- Benefit coverage among enrollees:

  4.3% at baseline ➡ 100% postmandate

- ⬆ utilization across all treatment types, but mostly for IVF and IVF-ICSI
- ⬆ total net annual expenditures by $627,288,000 or 0.39%
- Per member per month premiums ⬆ between $2.76 among CalPERS HMO enrollees and $3.72 in the DMHC-regulated small group market

PUBLIC HEALTH IMPACTS

- 5,000 live births in the first year postmandate
- mental health and quality of life
- financial barriers

Questions? Want more info?
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Getting to Affordability:
Spending Trends and Waste in California's Health Care System

JANUARY 2020

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Contents

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This work was conducted independently by RAND Corporation, a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier, and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

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.

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Introduction

While California has made impressive strides in increasing the number of residents who have health insurance coverage — and proposals for reaching the remaining uninsured continue to be debated at the state and federal level — health care is still far too expensive for the three million Californians who lack coverage and the 37 million who do not. The average cost of a family health insurance plan in California is nearly $20,000 per year, almost one-third of median family income in the state. Premiums for the average family health plan in the employer market in California have increased 133% since 2002, vastly outpacing inflation. The average deductible facing a California family now exceeds $3,000, while the average copay for a physician office visit is nearly $25.[1]

Californians are desperate for relief from these costs. In a 2018 statewide survey, more residents were extremely or very worried about paying for health care than those worried about paying for housing, transportation, or utilities.[2] This fear at least partially reflects Californians' direct experience. About one out of five Californians reported problems paying medical bills for themselves or a family member in the past year, leading them to cut back on basic household spending, use up all of their savings, or delay or forgo medical treatments or prescription drugs.[3] Nearly half experienced some type of cost-related access problem for themselves or a member of their family.[4] Part I of this report further explores how health care costs are affecting the state's residents and forcing state officials to make unnecessary trade-offs.

Part II of this report describes sources of health insurance coverage in the state, spending by payer, and trends in spending over time. Individuals with employer-sponsored insurance are the largest segment of the population, and they account for the largest percentage of health spending in the state. Both inflation-adjusted premiums and deductibles for employer-sponsored insurance increased substantially from 2000 to 2017, with worker contributions to health care more than tripling at businesses with fewer than 25 workers. Office-based visits, inpatient hospital stays, and prescription drugs drive much of health care spending across market segments in California.

There is nothing inherently wrong with rapid growth or high absolute levels of health care spending if the increased expenditure expands coverage or leads to improved care. However, Part III uncovers a troubling pattern in the state: Prices for the same medical treatments vary widely across California, even though these differences do not necessarily reflect higher-quality care. Significant evidence shows that health spending could be reduced without reducing access or undermining quality.

Part IV explores six areas of focus for understanding cost containment approaches targeting unnecessary spending across the state's health care system: (1) overtreatment, (2) failures of care delivery and inadequate prevention, (3) failures of care coordination, (4) administrative complexity, (5) pricing and market inefficiencies, and (6) fraud and abuse. These areas suggest significant opportunities to reduce health spending without adversely affecting patient health outcomes. In 2010, the Institute of Medicine (now the National Academy of Medicine) estimated that almost one-third of the nation's health care spending was wasteful and unnecessary. Shrank et al. updated the IOM estimates using more recent data and found that between 20% and 25% of national health spending can be attributed to waste.[5] Assuming that California has a similar proportion of unnecessary spending, we estimate that the state could save between $58 and $73 billion per year by eliminating unnecessary spending.

Crucial to any cost containment effort is a detailed understanding of what costs are being reduced, where they are coming from, and who has the potential to capture the savings. In this report we focus on the landscape of health care spending and a framework for understanding cost containment approaches in California. The financial impact of a wide range of policy proposals aimed at reducing health care spending will be the subject of a second, follow-up report in this series.

I. Why Health Care Costs Matter

The vigorous public debate often swirling around health care policies may at times obscure the influence that health care costs have on the well-being of the population. To truly understand the importance of lowering the rapid growth of health care spending, it is illuminating to reflect on how citizens themselves are affected by health care costs.

Health care costs and access to quality care are very much on the minds of California residents. In late 2018, the Kaiser Family Foundation and the California Health Care Foundation conducted a representative survey of the state's residents to gauge their views on the health policy priorities facing the state, as well as their experiences in the health care system.[6] Among respondents, making health care affordable was a top priority. About 45% called affordability extremely important, second only to improving public education. When asked specifically about health care, Californians said their highest priorities were ensuring that people with mental health problems could get treatment, increasing access to coverage, and lowering the cost of health care.

Survey respondents' concerns about health care costs appeared to stem from their own experiences. As indicated above, about one out of five Californians reported problems paying medical bills for themselves or a family member in the past year. This number rises to nearly a third of Californians with debilitating medical conditions, those on Medi-Cal or without health insurance, and those with incomes below 200% of the federal poverty level. Residents, especially those without health insurance, reported concerns that they could not pay unexpected medical bills. Some residents who struggled to pay medical bills reported cutting spending on basic household items, putting off vacations or major purchases, and using up all of their savings.

Health care costs caused some Californians to delay or forgo medical treatments or prescription drugs. More than two out of five respondents said they or another family member in their household postponed or skipped care in the past year due to cost, including dental appointments and medical tests (Figure 1). Some didn't fill prescriptions or skipped doses. Californians with lower incomes, those who lack health insurance, and Black and Latino residents were more likely than their white or Asian American counterparts to postpone or forgo care because they feared they would not be able to afford it.

For the 2019–2020 budget year, California allocated $67 billion in total state funds to health and human services, $42 billion of which came from the state general fund.[7] Allocations for health and human services accounted for 28% of all general fund expenditures,

Figure 1. Two Out of Five Californians Postponed or Skipped Getting Health Care Due to Cost

Source: KFF/CHCF California Health Policy Survey (November 12 to December 27, 2018).

up from 25% in the 2018–2019 budget year. Concerns about waste in the system raise the possibility that other public policy priorities like education or housing may be shortchanged at the expense of low-value health care. As former Centers for Medicare & Medicaid Services (CMS) Administrator Donald Berwick discussed in a recent editorial, the degree of wasteful spending in our health system raises the possibility that "schools, small businesses, road builders, bridge builders, scientists, individuals with low income, middle-class people, would-be entrepreneurs, and communities as a whole could make much, much better use of that money."[8]

II. A Snapshot of Health Spending Trends in California

Expenditures on personal health care for Californians totaled $292 billion in 2014, according to CMS.[9] California accounts for roughly 10% of total health spending in the nation.[10]

Individuals with employer-sponsored insurance (ESI) account for the largest portion of both the population and health spending in the state (see Table 1). Inflation-adjusted premiums and deductibles for ESI both increased substantially since 2000, and large increases affected small and large firms alike. At approximately $11,900 per year, Medicare beneficiaries have per-capita health spending that is roughly twice as high as that of other Californians. Spending by Californians without health insurance now accounts for only about 2% of total spending on health care.

Per-capita health spending in the state has grown steadily over time. Those with private health insurance coverage have faced the highest growth rates — about 4% per year. Office-based visits, inpatient hospital stays, and prescription drugs disproportionately fuel increases in health spending in California. With an average annual growth rate of more than 7%, prescription drug spending has far outpaced inflation.

This section uses data from the Medical Expenditure Panel Survey Household Component (MEPS-HC), conducted by the Agency for Healthcare Research and Quality (AHRQ), to explore these and other health spending trends in California from 2000 through 2016.[11] (More details about the report's methodology are in Appendix A.) The remainder of this section presents a detailed analysis of the 2000–2016 MEPS data, including health spending by insurance type, site of service, and employer size.[12]

Table 1. Population Size and Health Spending in California, by Insurance Type, in 2016 Dollars

MARKET SEGMENT	POPULATION SIZE (MILLIONS)	TOTAL SPENDING (BILLIONS)	AVERAGE SPENDING	PERCENTAGE OF POPULATION	PERCENTAGE OF SPENDING
Employer	17.3	$79.5	$4,600	43%	37%
Medicare	4.7	$55.8	$11,900	12%	26%
Medi-Cal	10.6	$56.4	$5,300	26%	27%
Non-group	3.3	$11.5	$3,500	8%	5%
Other	1.5	$5.8	$3,900	4%	3%
Uninsured	2.6	$3.6	$1,400	7%	2%
Totals	**40**	**$213**	**$5,300**	**100%**	**100%**

Note: Totals may not sum due to rounding.

Source: Authors' calculations based on MEPS-HC.

Health Spending by Insurance Type

Considering the wide variety of funding sources in health care is important when assessing the impact of programs on specific populations or groups. In California, with its highly diverse population, this is especially relevant.

Table 1 describes the size of health spending according to the primary source of insurance coverage for a given year. Because the team assigned each individual in the data to a primary source of health insurance, some segments of the market may be assigned lower levels of coverage than estimates that allow for multiple sources of coverage.

Californians with employer-sponsored insurance are the largest group in the market, with 17.3 million enrollees. With average per-capita health spending of $4,600, the ESI population accounts for 37% of health spending in California, as well as 43% of the population.

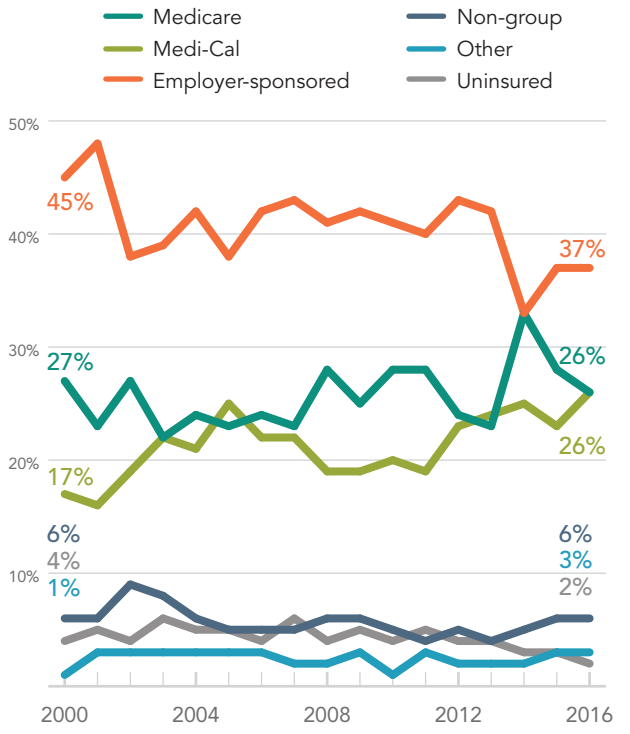
The next-largest group, those with Medi-Cal[13] as their primary source of coverage, accounts for 26% of the population and 27% of health spending. Medi-Cal is funded by state, local, and federal sources.[14] The federal government funds approximately 63% of Medi-Cal expenditures. Nonfederal sources, including California counties and municipalities, provide approximately 16% of Medi-Cal funding, and the remaining 21% comes from the California general fund.[15]

Medicare beneficiaries account for just under 12% of the California population, but they have the highest per-capita health spending ($11,900) and account for 26% of spending on health care. Individuals with non-group coverage (including those who receive coverage through Covered California or other sources of private, individual market insurance) and individuals with miscellaneous other forms of insurance (such as the military's TRICARE program) each have slightly less than $4,000 in health spending per year. The uninsured population accounts for roughly 7% of the California population and 2% of spending. Uninsured Californians spend an average of slightly less than $1,400 on health care per year, the smallest amount of any market segment.

As shown in Figure 2, the share of spending for each insurance type has changed over time.[16] While enrollees in employer-sponsored insurance account for the largest share of health spending, this share declined from 45% to 37% from 2000 through 2016. Medicare spending remained stable since 2000, while the share of California health care spending from patients with Medi-Cal as their source of primary coverage increased from 17% in 2000 to nearly 27% in 2016.

In 2000, the uninsured population accounted for 4% of California health care spending. This share peaked at 6% in 2007 but decreased to 2% in 2016. The most notable declines occurred in 2011, when California began an early expansion of Medi-Cal under the Affordable Care Act (ACA), and in 2014, when the

Figure 2. Share of Annual Health Spending, by Insurance Type, California, 2000–16



Source: Authors' calculations based on data from the MEPS-HC.

ACA's health insurance expansions through Covered California took effect. Spending for those with non-group private insurance and other forms of insurance (such as TRICARE) remained stable over this period.

Figure 3 presents these results in terms of inflation-adjusted per-capita health spending from 2000 through 2016. Unlike the data shown in Table 1, the data in Figure 3 are adjusted to account for variation in spending over time due to extreme outliers (people with spending in the top 1% of the distribution), which could be spurious. As a result, the 2016 estimates reported in Figure 3 (and other trend graphs) differ somewhat from the static estimates presented in Table 1. In each year, mean per-capita spending was highest for Medicare beneficiaries. Over the 2000–2016 time period, average inflation-adjusted per-capita spending for California Medicare beneficiaries increased from $7,700 to $11,000 (after adjustments for outlier spenders), an average annual growth rate of nearly 3%. Medi-Cal patients had the next highest per-capita health spending, although per-capita Medi-Cal spending increased by only about 2% per year during this period. Per-capita spending for the employer-sponsored population increased by just under 4% per year.

These spending differences are reflected in out-of-pocket health spending among patients in different types of insurance plans (see Figure 4). Medicare beneficiaries consistently have the highest out-of-pocket payments. However, after peaking in 2004, Medicare out-of-pocket payments have declined over time. This decrease may be due to the 2006 expansion of Medicare benefits to include prescription drug coverage through Medicare Part D. Out-of-pocket payments also have declined for uninsured Californians and for those with Medi-Cal (who have seen a 28% decrease in inflation-adjusted out-of-pocket patient spending).

In contrast, from 2000 through 2016, annual out-of-pocket patient spending increased by almost 36% for those with employer-sponsored coverage, an average annual increase of 2% per year. Of note, this increase in out-of-pocket spending is below the average annual growth rate of per-capita spending among those with

Figure 3. Mean Per-Capita Per-Enrollee Annual Health Spending, by Insurance Type, California, 2000–16

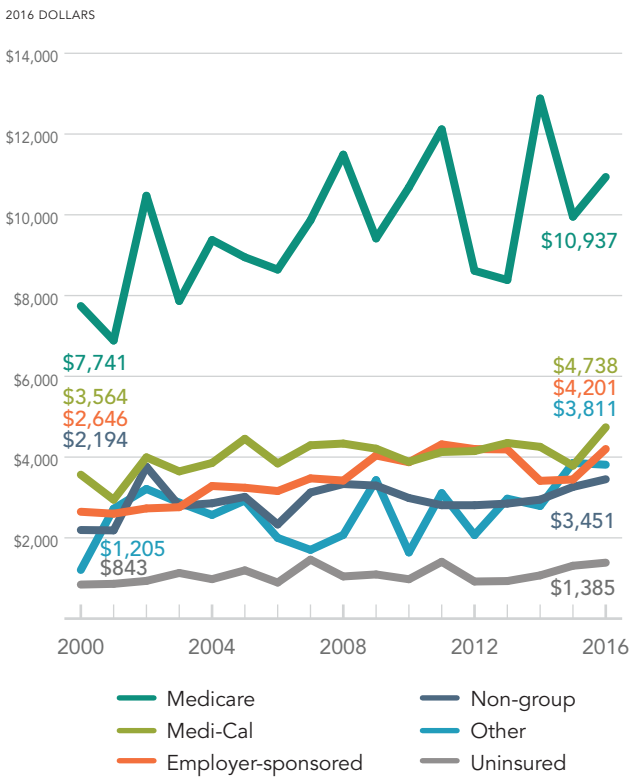
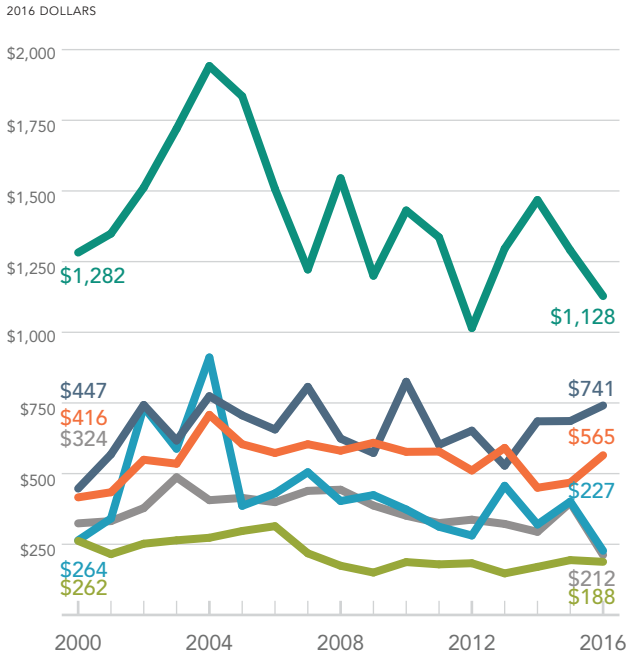


Figure 4. Mean Annual Patient Out-of-Pocket Payments, by Insurance Type, California, 2000–16



Source (Figures 3 and 4): Authors' calculations based on data from the MEPS-HC.

employer-sponsored coverage (just under 4%; see Figure 3). For those with private, individual market coverage rather than coverage from an employer, out-of-pocket payments increased by 66% from 2000 through 2016, an average annual growth rate of around 4%. These increases translate into cumulative increases in average spending from 2000 to 2016 of $149 for Californians with employer-sponsored insurance and $294 for those with non-group commercial insurance, after adjusting for outlier spenders.

Health Spending by Site of Service

Table 2 presents health spending by site of service. At nearly $60 billion per year for each, inpatient hospital and office-based medical provider services account for the largest shares of annual spending, approximately 28% each in 2016. Californians spent $45.6 billion on prescription drugs in 2016, which accounted for about 21% of spending that year.

Table 2. Health Spending, by Site of Service, 2016

SITE OF SERVICE	AMOUNT (BILLIONS)	SHARE OF TOTAL	AVERAGE PER-CAPITA
Office-based	$59.2	28%	$1,500
Inpatient	$59.1	28%	$1,500
Prescription drugs	$45.6	21%	$1,100
Dental	$16.9	8%	$400
Other	$14.7	7%	$400
Hospital outpatient	$9.4	4%	$200
Emergency	$7.9	4%	$200
Totals	**$213**	**100%**	**$5,300**

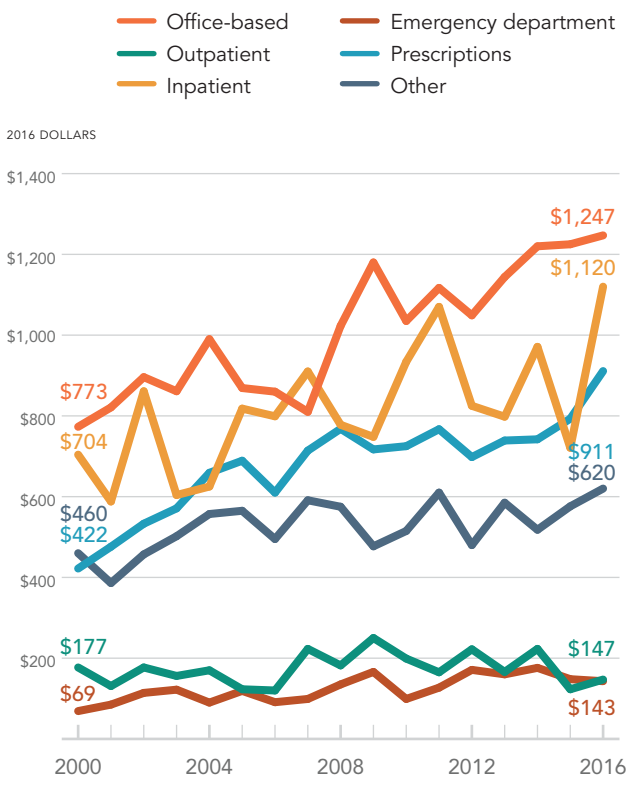
Note: Totals may not sum due to rounding.

Source: Authors' calculations based on MEPS-HC.

Figure 5 shows changes in spending by site of service, with adjustments for outlier spenders. From 2000 through 2016, the share of health spending attributed to each site of care increased for all but outpatient hospital services. Per-capita spending on office-based medical provider services increased by almost 4% per year, as did spending on inpatient hospital services. For prescription drugs, the growth rate was even larger, increasing by an average annual rate of about 7%.

These results have important implications for potential health policy options. Office-based medical provider services and inpatient visits account for the largest shares of health spending in California. Policies that address use of these services may create large potential savings opportunities. Likewise, prescription drug costs have grown more rapidly than growth in any other cost area studied. Policies that address rising drug prices can help reduce this growing cost burden.

Figure 5. Per-Person Annual Health Spending, by Site of Service, California, 2000–16



Source: Authors' calculations based on data from the MEPS-HC.

Employer-Sponsored Insurance Spending by Business Size

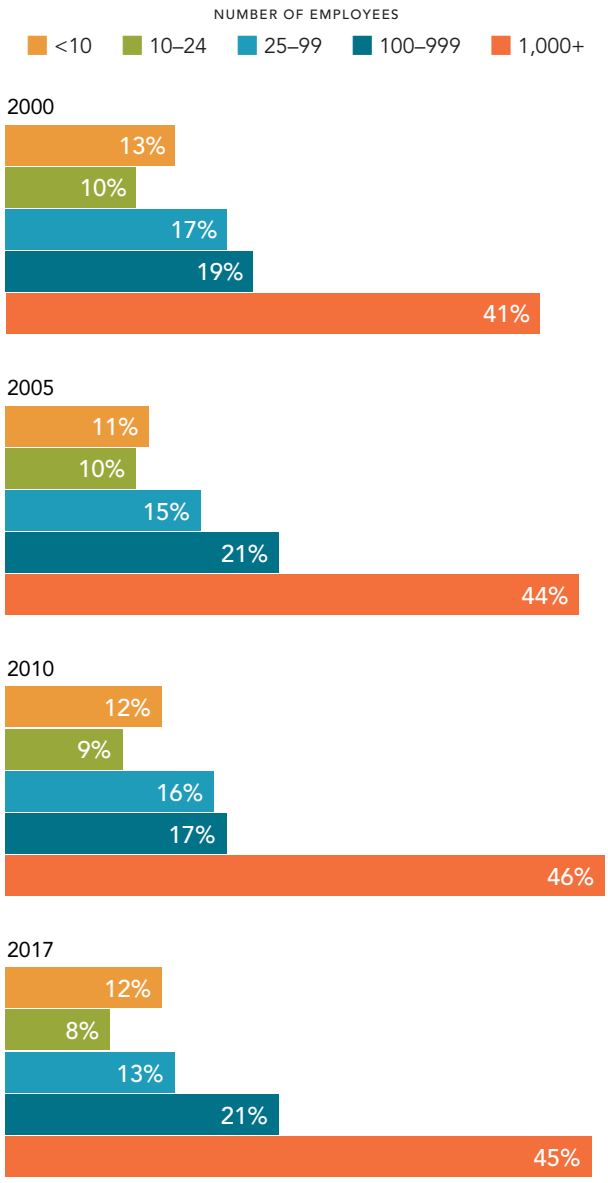
Individuals with employer-sponsored insurance (ESI) make up the largest population segment in California. To better understand this population, the research team also examined health spending for different types of ESI. Analysis of the California ESI market used MEPS Insurance Component (MEPS-IC) data specific to California employers.[17]

ESI plans have two options: (1) self-funding, in which the employer is responsible for health care costs but pays the insurer an administrative fee; or (2) remaining fully insured, in which the employer contracts with an insurer to provide health insurance benefits. Nationwide, about 60% of people with ESI were enrolled in self-funded health plans in 2017; in California, however, only about 46% of private-sector ESI enrollees were in self-funded plans.[18] The lower enrollment in self-funded plans in California may reflect the state's high level of HMO penetration, and also the dominance of Kaiser Permanente, which offers only fully insured plans. Self-funded insurance is more common at large firms than at small ones. According to the MEPS-IC data, 70% of California health insurance enrollees at firms with 1,000 or more workers were in self-funded plans, compared with only 12% of enrollees at firms with fewer than 50 workers.

In the figures below, the team used the MEPS-IC data to examine trends in both coverage and spending for Californians with ESI, breaking down the numbers according to firm size. The team examined ESI enrollment, the average premium for a single enrollee (that is, for a plan that covers only a single person and does not cover dependents), and the average deductible for a single enrollee.

Figure 6 presents the share of the total employer-sponsored health insurance population by firm size. Employees not eligible for health insurance are excluded from these percentages. Californians who work for a firm with 1,000 or more employees account for the largest portion of the ESI population, and this share has grown over time. From 2000 through 2017,

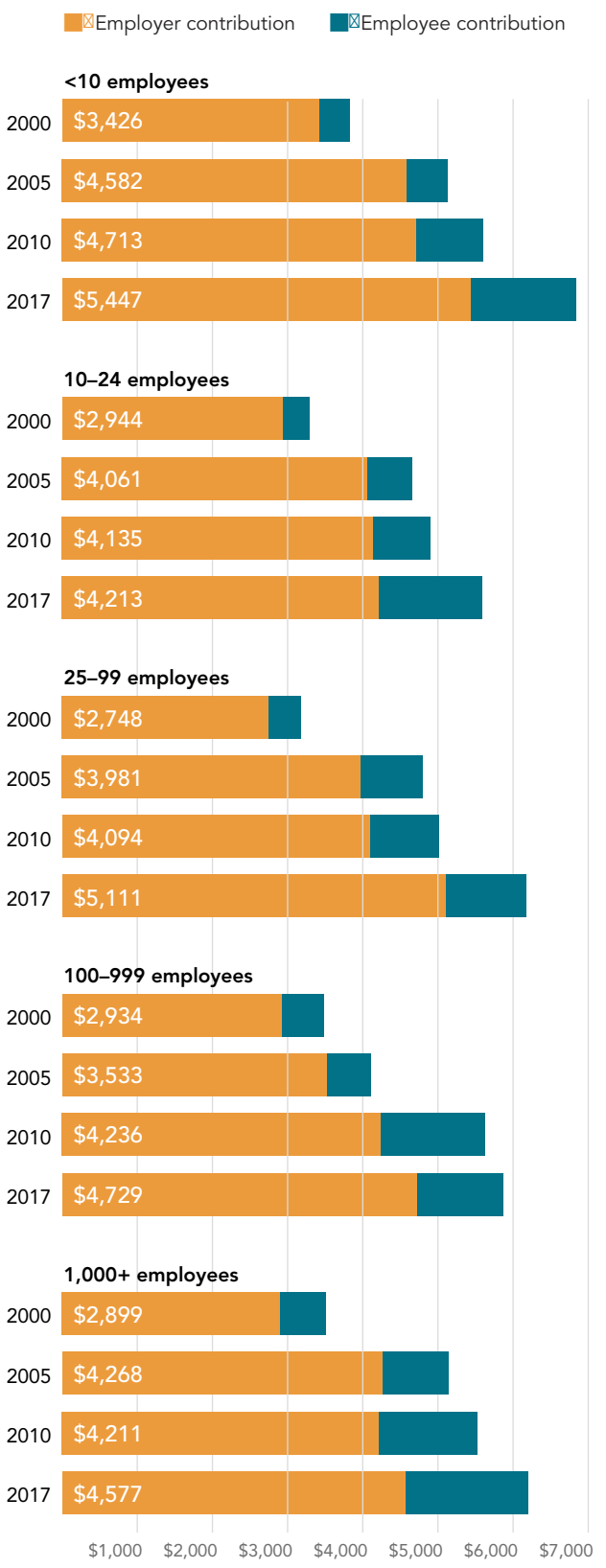
Figure 6. Share of the Employer-Sponsored Insurance Population, by Firm Size, California, 2000–17, Selected Years



Note: Totals may not sum due to rounding.

Source: Authors' calculations based on data from the MEPS-IC.

Figure 7. Employers' Share of Premium, by Firm Size, California, 2000–17, Selected Years



the share of the ESI population that works for a firm with 1,000 or more employees increased from 41% to 45%; while the share of the ESI population that works for a firm with 100 to 999 employees increased from 19% to 21%. The share of enrollees who worked at firms with fewer than 100 workers declined over the same time period.

Figure 7 shows differences in average total premiums in California for a single enrollee (that is, an enrollee in a plan that covers only a single person and does not cover dependents) by firm size. Premiums include employer and employee contributions. In 2017, the average total single-enrollee premium in California was nearly $7,000 for firms with fewer than 10 workers and roughly $6,000 for firms of other sizes. Although the smallest firms (those with fewer than 10 workers) consistently have the highest premiums, a consistent relationship between premiums and firm size does not appear in the data.

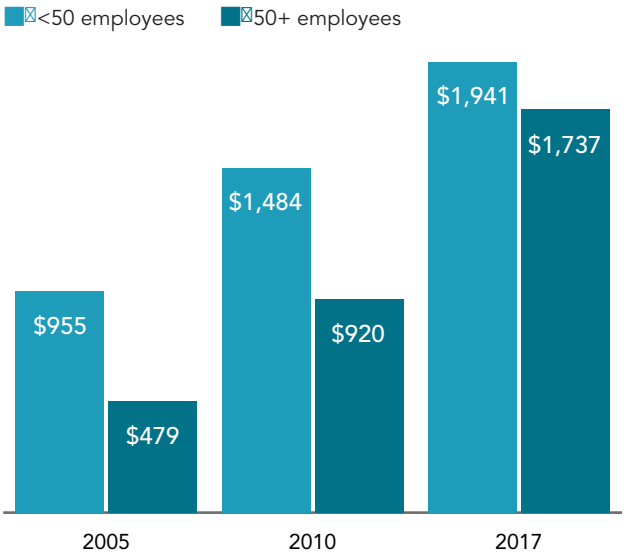
Worker contributions more than doubled from 2000 through 2017. Firms with fewer than 25 workers faced the largest increases in worker contributions, which more than tripled over the time period studied.

Since 2000, average total premiums increased by between 68% and 94% in absolute terms, with the largest increases at firms with 25 to 99 workers. Worker contributions more than doubled from 2000 through 2017. Firms with fewer than 25 workers faced the largest increases in worker contributions, which more than tripled over the time period studied.

Source (Figure 7): Authors' calculations based on data from the MEPS-IC.

Figure 8 examines trends in annual deductibles for ESIs. Deductibles represent the amount that patients are required to pay "out of pocket" before insurance coverage begins.[19] Although employees of smaller firms face consistently higher average deductibles than those of larger firms, the gap has narrowed over time. For example, while deductibles approximately doubled for firms with fewer than 50 employees between 2005 and 2017, deductibles for larger firms nearly quadrupled over the same time period.

Figure 8. Average Individual Employer-Sponsored Deductible, California, 2000–17, Selected Years



Source: Authors' calculations based on data from the MEPS-IC.

III. Disparities That Signal Wasteful Spending

As the preceding sections demonstrate, rapidly rising health care costs have a dramatic impact on Californians' lives, and these cost increases are not spread equally across the various types of insurance, sites of service, and sizes of businesses. Increases in health care costs are also not spread equally across the state. In addition, prices for the same medical treatment vary widely across California, and these differences do not necessarily reflect differences in the quality of care.

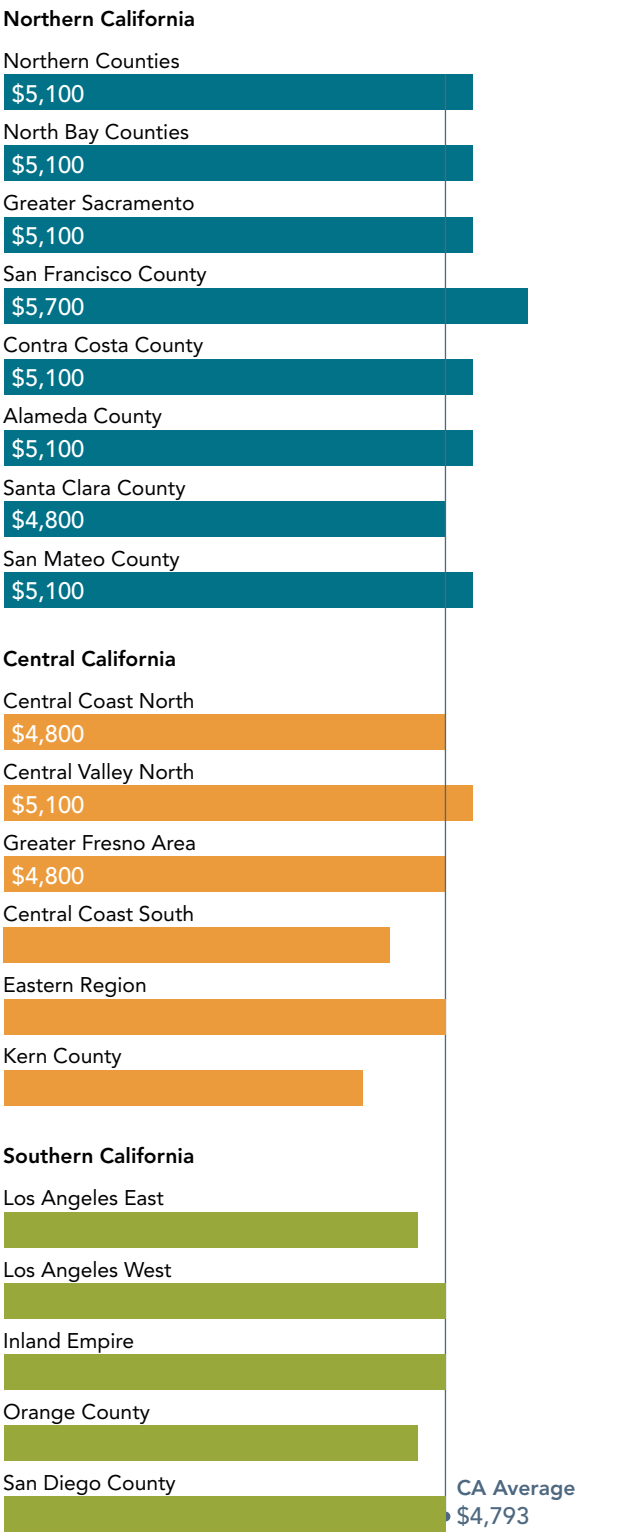
For example, the Integrated Healthcare Association estimated that if all Californians with commercial and Medicare insurance received care at the same cost as in San Diego — one of the least expensive major metropolitan areas in which to receive health care, and a city with high-quality care — total costs to the state would decrease by an estimated $11 billion annually.[20]

This section provides an overview of the considerable price and quality disparities across California, using publicly available sources. The disparities outlined below signal enormous areas of wasted spending, and they represent clear opportunities to reduce health care spending without compromising quality and outcomes.

Price Disparities by County and Region in California

According to the California Regional Health Care Cost & Quality Atlas (the Atlas) — a resource that analyzes clinical quality, hospital use, and the cost of care for three-fourths of the state's population — prices and quality vary widely across the state.[21,22] To illustrate the range of variation, Figure 9 provides a snapshot of the range of average total risk-adjusted costs of care per member per year for the commercially insured across the state.[23]

Figure 9. Average Total Cost of Care,* Commercially Insured Californians, by Region, 2017



*Geography and ACG risk adjusted.

Source: Integrated Healthcare Association. California Regional Health Care Cost & Quality Atlas: Total Cost of Care – Geography and ACG Risk Adjusted – Commercial. 2017. Accessed January 7, 2020.

Average annual costs range from a high of $5,700 in San Francisco County to a low of $3,900 in Kern County. Other components of the total cost of care show similar magnitudes of variation across the state. For example, pharmacy costs range from an average of $650 per member per year in several locations, including Alameda County, Central Valley North, Kern County, and much of the southeastern part of the state to $1,100 per member per year in San Francisco.

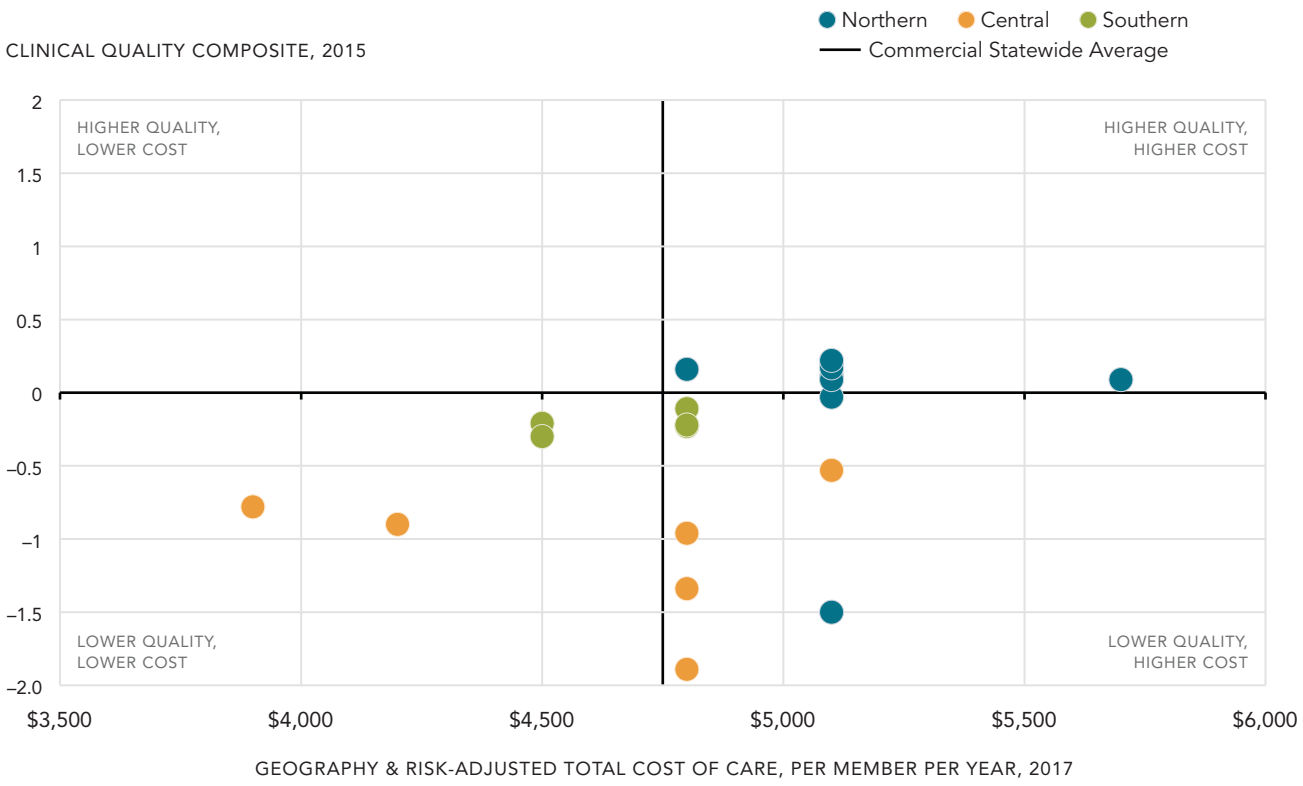
Figure 10 compares the clinical quality composite score (for the 10 clinical quality measures available for 2015) and the average total risk-adjusted cost of care for each region in California. Regions are grouped into three "super regions" of the state — Northern, Central, and Southern.

Northern California regions (in the upper-right quadrant) typically provide better clinical quality but have the highest costs. Exceptions are the northern rural counties (in the bottom-right quadrant), which have both poor quality and higher-than-average costs. Santa Clara County (the blue dot closest to the vertical axis) also stands out as having above average quality and relatively low costs. Southern California counties (in green) have relatively average costs and slightly below average quality, while Central California counties (in orange) tend to have worse quality scores than other regions, and wide variation in costs.

The analysis does not suggest the "right" spending level for any region. However, the Atlas shows the wide variation in risk-adjusted costs. Although imperfect risk adjustment could be the source of some of the variation, the differences in costs suggest that some residents could be receiving poor value for their health care investment.

If the quality of care from the top-performing region were provided to all Californians, "nearly 570,000 more people would have been screened for colorectal cancer and 166,000 more women would have been screened for breast cancer in 2015," according to the Atlas.[24]

Figure 10. Quality vs. Cost in Commercial Insurance, by Region, California



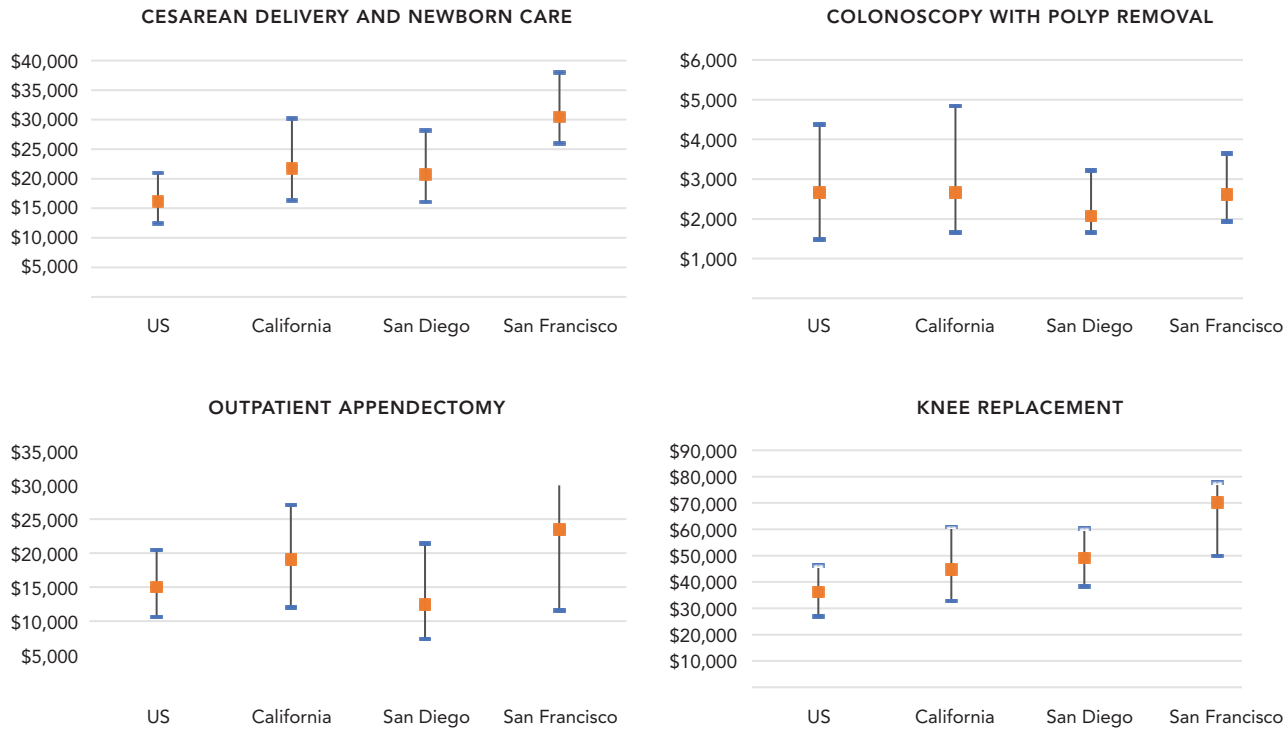
Source: Integrated Healthcare Association, California Regional Health Care Cost & Quality Atlas: Total Cost of Care - Geography and ACG Risk Adjusted - Commercial and Clinical Quality Composite - 2015 Measures - Commercial. 2017. Accessed January 10, 2020.

Price Disparities for the Same Procedures

The Atlas data above paint a disparate picture of health costs and quality statewide. The prices that private health plans pay for specific procedures also reveal wide disparities around the state. The Health Care Cost Institute (HCCI) has amassed more than 730 million claims from four insurers[25] and uses the data to assess variations in prices across the US. HCCI data for four common health care service bundles were assessed using the Guroo online price transparency tool, as seen in Figure 11.[26]

The substantial variation in prices for the same procedure shown in Figure 11 suggests that some consumers may be getting poor value for their dollars. For example, the average price of a cesarean delivery in San Diego was just over $20,000, compared with an average price of just over $30,000 in San Francisco. Even within a region, prices often vary substantially. For example, the minimum price for an outpatient appendectomy in San Diego is less than half the amount of the maximum price, according to the data. In general, average prices in California for these services are higher than average prices nationwide, although the wide range in prices indicates a high degree of overlap.

Figure 11. Price Ranges for Four Common Health Care Services, US, California, San Diego, and San Francisco



Note: Data are based on claims paid between July 1, 2014, and June 30, 2016, trended forward to 2018 price levels.

Source: Authors' calculations based on Guroo Price Transparency Tool. Accessed December 2019.

IV. Six Contributors to Wasteful Spending

The large price disparities among regions in California described above suggest substantial waste or inefficiency in the system. If health care policymakers addressed waste and inefficiency, they could significantly lower the cost of care.

In their 2019 update of a landmark report by the IOM, Shrank et al. estimated that between one-fifth and one-quarter of the nation's health care spending was the result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care.[27] Assuming that the proportion of wasteful and unnecessary spending is similar in California, the state could save between $58 and $73 billion per year by eliminating waste and improving efficiency.

This section explores six contributors to wasteful spending and examines their relevance to costs in California. Options for reducing health spending in a number of these areas are covered in the second report in this series.

Overtreatment

Nationwide, overtreatment accounts for up to $76 to $101 billion in health spending annually.[28] Factors that contribute to overtreatment include ordering duplicate tests, prescribing treatments that have little or no value, and ordering a high-cost treatment when a lower-cost treatment could have resulted in equivalent or superior quality of care. Some patients and doctors believe that more treatment is better. The availability (or supply) of health care treatments may also cause patients and doctors to use them more, regardless of their clinical benefit.[29,30] Further, excessive prices and overtreatment may be related: If providing services of little or no clinical value is profitable, some providers may continue to offer them despite the limited benefit.

The Choosing Wisely initiative, which the ABIM (American Board of Internal Medicine) Foundation launched in 2012 in partnership with *Consumer Reports*, seeks to identify commonly used tests and procedures that may be unnecessary. The initiative provides information about these services to help patients and providers make better decisions.[31,32] Based on recommendations from Choosing Wisely, stakeholders in California recently formed Smart Care California, a consortium of payers that includes CalPERS (the California Public Employees' Retirement System), Medi-Cal, and Covered California. The group promotes best practices for reducing overtreatment in three areas: inappropriate opioid prescribing, unnecessary cesarean sections, and unnecessary imaging for low back pain. According to Smart Care California data, the state saw sizable reductions in inappropriate opioid prescribing and small reductions in cesareans for low-risk, first-time mothers from 2015 through 2017.[33]

While the Smart Care initiative is a step toward reducing unnecessary care, additional opportunities to expand and build on this capacity exist. California's all-payer claims database (APCD), which is in development, may enable policymakers to identify patterns about low-value care and, ultimately, take action to address waste. For example, the Minnesota Department of Public Health used its APCD to show $55 million in spending on 18 low-value services in 2014. The most common low-value service was diagnostic imaging for uncomplicated headaches.[34] A similar study used Virginia's APCD to estimate that more than $586 million in spending went to 44 low-value services, including baseline lab tests for patients having low-risk surgery, annual cardiac screening for asymptomatic patients, and routine imaging for uncomplicated rhinosinusitis.[35]

Failures of Care Delivery and Inadequate Prevention

Shrank et al. estimated that the US spends $102 to $166 billion each year, or 14% to 18% of all avoidable health spending, treating conditions that are preventable, unnecessary, or avoidable.[36] These missed opportunities include primary prevention (avoiding an illness or injury), secondary prevention (screening to identify health issues at an early stage), tertiary prevention (managing diseases post-diagnosis), avoidable

conditions such as hospital-acquired infections, and excess costs stemming from clinical inefficiency.

While reducing hospital-acquired infections and clinical inefficiencies will both improve health care quality and reduce costs, prevention is something of a mixed bag in terms of cost containment. Prevention can save money in many important ways, such as by reducing the cost of treating diseases by detecting them earlier and avoiding treatment altogether. But in other ways, prevention can increase costs when poorly targeted.

While the IOM points to some specific opportunities to save money by expanding access to treatment, in general the literature shows that expanding access to preventive care increases spending.[37] Preventive services must typically be provided to a large share of the population, many of whom will not have the condition. Among those who screen positive, savings will only materialize if lower-cost treatments can stave off costlier treatments down the road. In a review of the literature, Cohen, Neumann, and Weinstein found that most preventive services both add value to the health system and increase total costs.[38] Similarly, a recent review of disease management programs found cost savings in only a minority of cases.[39]

Nevertheless, as both Shrank et al. and the IOM concluded, certain types of preventive services can save money, particularly if targeted to high-risk populations. For example, certain colorectal cancer screening approaches have been found to reduce total health spending for people in targeted age groups,[40] as have disease management programs for congestive heart failure.[41] In many cases, preventive services enable people to live longer, healthier lives, making the services a good investment even if they cause overall health care spending to increase.

According to the National Healthcare Quality and Disparities Reports, California scores average relative to other states in terms of providing preventive care, and weak relative to other states in terms of managing chronic conditions through preventive care.[42] Among the prevention measures considered, California scored poorly on influenza and pneumococcal vaccinations and cholesterol measurement. The state scores in the average range for many vaccines provided to children and adolescents, and for depression treatment among those who have experienced a major depressive episode. Areas of strength include preventive care measures related to colorectal and cervical cancer screening, and chronic care measures related to HIV management.

Failures of Care Coordination

Although some people disagree about the meaning of "care coordination," the Agency for Healthcare Research and Quality (AHRQ) defines it as a process in which a provider or other person in the health care system takes responsibility for managing a patient's course of care across multiple settings, including home, community, primary, inpatient, and other care.[43] Failures of care coordination occur when a patient's care is disjointed, such as when there is poor communication across multiple providers caring for a patient, potentially leading to lapses, oversights, or redundancies in treatment.[44] Individuals with complex chronic conditions, who use more services and may interact with many providers, are at particular risk for coordination failures. At a national level, failures of care coordination that may lead to avoidable or unnecessary medical complications and hospital admissions account for approximately $27 to $78 billion in excess spending. However, the California profile is a bit different, possibly due to the high adoption of managed care in the state, which may facilitate care coordination if patients are treated in an integrated delivery system with established protocols for sharing information. In the most recent version of the National Healthcare Quality and Disparities Report,[45] California's ratings in the priority area of care coordination were above average.[46]

Still, the state has room for improvement. For example, a recent assessment of the Cal MediConnect Program — which attempts to integrate and coordinate Medicare and Medi-Cal services for those eligible to participate in both programs — found that while enrollees said they were more satisfied with benefits and thought the quality of care was better because

of the program, there was no improvement in care coordination.[47]

Administrative Complexity

Shrank et al. estimate that high administrative expenses contribute to roughly $266 billion in overspending nationwide.[48] A comprehensive 2005 accounting of administrative costs for private insurers, physician groups, and hospitals in California found that commercial insurers in the state spend roughly 10% of revenue on administration, physician groups spend about 27% of revenue on administration, and hospitals spend about 21% of revenue on administration.[49] CALPIRG (the California Public Interest Research Group) estimated in 2008 that administrative activities consumed 5% of total health spending in California, although the data may be outdated.[50]

California has several unique features that may contribute to high administrative costs. First, a ban on the corporate practice of medicine, which aims to separate the "professional standards and obligations" of medical professionals and the "profit motive of the corporate employer," prohibits corporate entities from employing physicians or owning physician entities.[51] This may lead to inefficient behaviors, such as hospitals having to establish or contract with a medical foundation that can employ physicians.

In addition, California remains the only state in which two agencies regulate health insurance, which adds an additional layer of administrative complexity. The Department of Managed Health Care oversees most health maintenance organizations (HMOs), covering about 21.6 million Californians. The California Department of Insurance regulates most preferred provider organizations (PPOs) and traditional fee-for-service plans, covering about 2.4 million people. The dual structure has been described as confusing and inefficient, with the potential for regulatory inconsistencies.[52] Potential options for regulatory reform include consolidating the two agencies and institutionalizing coordination and consistency between them.[53] However, at present, both agencies continue to operate independently.

Finally, California's 13 million Medi-Cal beneficiaries receive their health care through six models of managed care.[54] This relatively complex approach to administering the Medi-Cal program has the potential to increase administrative costs.

Pricing and Market Inefficiencies

As noted in the discussion of data from HCCI above, prices for health care services are often higher in Northern California compared with the statewide average. Increased market concentration plays an important role. In March 2018, California Attorney General Xavier Becerra brought a civil antitrust action against Sutter Health and its affiliates for using their market power in Northern California to increase prices, and therefore costs, for its health care services.[55] The suit alleged that Sutter prevented insurers from using "steering and tiering," which can be important tactics for gaining bargaining leverage against health care providers that dominate local markets. In late 2019, Sutter agreed to pay $575 million to settle the lawsuit, and also agreed to restrictions on out-of-network charges and practices viewed by the state as anticompetitive, such as requiring insurers to include all Sutter hospitals in their networks as opposed to individual hospitals ("all or nothing" agreements).[56] At the time of this writing, it is too early to know how the settlement will affect the market for health care in California.

Despite health care market consolidation, average health spending in California is lower than in the rest of the country by some measures. According to statistics compiled by the Kaiser Family Foundation using data from the Office of the Actuary of the Centers for Medicare & Medicaid Services, per-capita health spending in California — $7,549 — was lower than the national average of $8,045 in 2014 (the most recent year for which data are available).[57] Similarly, 2017 employer premiums in California were slightly below the national average, according to an analysis conducted by the Kaiser Family Foundation using data from the Medical Expenditure Panel Survey (MEPS) Insurance Component.[58,59]

One factor that may contribute to lower per-capita spending is the dominance of managed care in the state. HMOs cover 59% of eligible Californians, the highest rate of any state.[60] Kaiser Permanente accounts for a particularly large share of the California market. A recent assessment of accountable care organization (ACO) partnerships in California underscores Kaiser's strong competitive pressure in a community: "The more dominant Kaiser's presence, the stronger the incentive for other plans to develop new products at lower prices to maintain market shares."[61] In addition, the California population is relatively young compared with the national population,[62] and Medi-Cal payment rates for physician services are low relative to the national average,[63] although not for hospital care.[64]

Fraud and Abuse

Across the nation, Shrank et al. put the cost of health care fraud at between $59 and $84 billion.[65] The Federal Bureau of Investigation, the primary agency tasked with investigating fraud in the health care system, estimates that health care fraud costs US taxpayers $80 billion per year.[66] The most common types of fraud include billing for services that were never rendered — such as using genuine patient information, sometimes obtained through identity theft, to fabricate entire claims, as well as padding claims with charges for procedures or services that did not take place.

Major fraud investigations have produced multiple criminal filings, which provide some sense of the magnitude of the problem in California. For example, prosecutors in Los Angeles filed cases in 2018 alleging $660 million in fraudulent bills. The 33 defendants included doctors, pharmacists, and an attorney accused of kickback schemes involving surgeries, drugs, home health services, Medicare Part D prescriptions, and hospice care.[67] Also in 2018, the South San Francisco–based drug manufacturer Actelion paid $360 million to resolve claims that it illegally paid the copays of thousands of Medicare patients who used the drugmaker's hypertension drugs, including Tracleer, Ventavis, Veletri, and Opsumit.[68]

These recent actions in California indicate that fraud is an ongoing, and very likely a costly, concern in the state.

Extrapolating to California

The national estimates of wasteful spending are challenging to extrapolate to California given several factors raised above, including the higher prevalence of managed care in the state, the relatively younger population, and unique market consolidation patterns, particularly in Northern California. Nevertheless, if we use the Shrank et al. estimates[69] as a rough guidepost, we can infer that roughly $58 to $73 billion of total health spending in California is wasteful, with the largest shares of waste stemming from excessive administrative complexity (28% to 35%) and pricing and market inefficiencies (26% to 30%). Table 3 shows estimates of the breakdown of wasteful spending in California by category, assuming that the Shrank et al. national estimates can be applied at the state level.

Table 3. Estimated Breakdown of Wasteful Health Spending, by Category, California, 2014

WASTE CATEGORY	LOWER BOUND (%)	UPPER BOUND (%)	LOWER BOUND (BILLIONS)	UPPER BOUND (BILLIONS)
Administrative complexity	34.9%	28.4%	$20.3	$20.7
Pricing and market inefficiencies	30.4%	25.7%	$17.6	$18.8
Failures of care delivery and inadequate prevention	13.5%	17.7%	$7.8	$12.9
Overtreatment	10.0%	10.8%	$5.8	$7.9
Fraud and abuse	7.7%	9.0%	$4.5	$6.5
Failures of care coordination	3.6%	8.4%	$2.1	$6.1
Totals	**100%**	**100%**	**$58**	**$73**

Notes: The lower bound estimates assume it is possible to eliminate 20% of health spending ($58 billion), and the upper bound estimates assume it is possible to eliminate 25% of health spending ($73 billion). Totals may not sum due to rounding.

Source: Estimated percentages come from Shrank WH, Rogstad TL, Parekh N. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA.* Oct 7, 2019; 322(15):1501–1509.

V. Conclusion

One of the three primary goals of 2010's Affordable Care Act was to stimulate efforts nationwide to contain health care costs. However, health spending continues to outpace inflation and remains a major challenge nationally and within California.

The high cost of care is a significant source of stress for Californians, particularly for the poor and those with chronic conditions, who often have to choose between paying for food and utilities and paying for doctor visits and prescription drugs. Businesses of all sizes struggle to afford the rapidly rising costs of providing health care to their employees. And prices themselves remain stubbornly high in many regions due to market consolidation and other factors.

Although many stakeholders agree that controlling health care spending should be a priority, little consensus exists about how to achieve that goal. In the next report in this series, we will take a step toward addressing that issue as we explore the policies that have the strongest potential to move the needle on cost containment.

California has always been a national leader in the development of health policy and in creating and scaling up innovative approaches to reducing health care costs. Governor Gavin Newsom's recent creation of the Office of Health Care Affordability provides a fresh opportunity to redouble our collective efforts to tame the inexorable rise in health spending.

Appendix A. Methodology

Background on the MEPS

The Medical Expenditure Panel Survey Household Component (MEPS-HC) is an annual panel survey of households that began in 1996 and is conducted by the Agency for Healthcare Research and Quality (AHRQ). Data from MEPS are widely used to examine health care costs and utilization. MEPS combines detailed survey information with spending and utilization data that are validated through the patient's insurer and provider. To produce estimates for California, the team used restricted-access state identifiers made available for this project through AHRQ project number 466 and Census Bureau project number 2169. The research for this report was conducted at the AHRQ's Center for Financing, Access and Cost Trends (CFACT) Data Center, and the support of AHRQ is acknowledged. The results and conclusions in this paper are those of the authors and do not indicate concurrence by AHRQ or the US Department of Health and Human Services.

The research team used MEPS data from 2000 through 2016, the last year for which we had access to the data. (Data from the MEPS Insurance Component, an employer survey, are released on a different schedule.)

An advantage of the MEPS relative to other data sources such as State Health Expenditure Accounts (SHEA) data from the Office of the Actuary (OACT) of the Centers for Medicare & Medicaid Services (CMS) is that it is disaggregated, allowing the user to analyze specific categories of health spending. However, while MEPS is designed to be nationally representative, the estimates are not necessarily representative of the population of California.

MEPS reports aggregated annual data files and medical event files for specific sites of care (such as hospital inpatient care, hospital outpatient care, office visits, and prescription drugs). For this report, the team used data from both the full-year consolidated files and the medical event files.

Health Spending Estimates

The MEPS data result in smaller spending estimates than those found in the CMS SHEA data due in part to an undercount of high spenders. The MEPS estimates were adjusted to address this undercount using the method described by Bernard et al.[70] After adjustment, California health spending in the MEPS was $213 billion in 2016. Even with these adjustments, the MEPS figures are lower than those reported by the National Health Expenditure Accounts (NHEA), because MEPS excludes certain categories of health care, including long-term care, public health spending, health-related investments and philanthropy, and over-the-counter medications. The approach used to adjust the MEPS data is described in detail below.

Weighting

To account for MEPS undercounting,[71] prior research upweights MEPS spending categories to better align with the CMS National Health Expenditure Accounts (NHEA). Bernard et al.[72] propose using the weights shown in Table A1 for specific sources of payments.

Table A1. MEPS Weights to Align with NHEA Benchmarks

PAYMENT SOURCE	WEIGHTS TO ALIGN WITH NHEA BENCHMARKS
Out of pocket	9.47%
Private health insurance	30.51%
Medicare	14.28%
Medicaid/Children's Health Insurance Program (CHIP)	38.84%
Department of Veterans Affairs	–9.94%
Workers' compensation insurance	112.40%
Other federal	0.00%
Other state and local	0.00%
Other sources	0.00%
All expenditures	**23.10%**

Source: Bernard D, Selden TM, Pylypchuk YO. Aligning the Medical Expenditure Panel Survey to Aggregate U.S. Benchmarks, 2010 (PDF); Working Paper No. 15002. 2015. Accessed April 5, 2019.

Spending estimates for the present analysis were reweighted by increasing the raw numbers by the percentage factors shown in Table A1. As an example, a private health insurance expenditure of $100 in the 2016 MEPS would be increased by a factor of 30.51%, to $130.51. Unlike the other spending estimates, VA spending is reduced, because this category of expenditure is overestimated in the MEPS relative to the NHEA. California-specific MEPS-HC spending estimates shown in this document are reported in 2016 dollars, weighted for MEPS undercounting. Medical spending is also reported by insurance plan.

Insurance Hierarchy

Because some individuals in MEPS report having insurance from more than one source, the following hierarchy was used to classify individuals into mutually exclusive groups: Medicaid, Medicare, employer-sponsored insurance, other government insurance (including TRICARE and other public plans), non-group plans (including those purchased through Covered California), and the uninsured. Individuals with miscellaneous private insurance who are not classified as having Medicare, Medicaid, or employer-sponsored plans are included in the non-group category.

Trends

In order to understand trends in medical spending in California, the team used the MEPS full-year consolidated data files for 2000–2016. The team's trend analysis differs from the expenditure analysis described above in two key ways. First, medical spending for years prior to 2016 was inflated to 2016 dollars using the California Consumer Price Index (CPI) for urban consumers. Second, since the distribution of medical spending is highly influenced by a small number of high-cost patients, observations in the top 1% of the spending distribution were replaced with the 99th-percentile expenditure in each category. While very high-cost individuals are an important feature of overall health spending in California, in finite survey samples they distort underlying trends. For that reason, we recategorized spending for these individuals in the trend analysis, although all observations were kept when reporting total spending. This accounts for discrepancies between total spending estimates and the trend estimates.

Gross State Product (GSP) Calculations

The team calculated total per-capita health care expenditures in California as the sum of personal expenditures ($7,549 in 2014[73]) and nonpersonal expenditures ($1,474 in 2014[74]). Nonpersonal expenditures include government health care administration, net costs of private health insurance, government public health activities, and investments in research, structures, and equipment. California per-person nonpersonal expenditures are assumed to equal the national average. Health expenditures as a share of GSP are then ($7,549 + $1,474) / $61,957 = 14.6%, where the denominator is California's GSP per capita as estimated by the US Bureau of Economic Analysis.[75]

Endnotes

1. The statistics reported in this paragraph were compiled based on California-specific data for 2018 reported by the Agency for Healthcare Research and Quality as part of the Medical Expenditure Panel Survey Insurance Component State and Metro Area Tables.
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9. Centers for Medicare & Medicaid Services. Health Expenditures by State of Residence, 1991–2014. 2017. Accessed April 5, 2019.
10. California accounted for 10.4% of total national health spending, although California accounted for 12.1% of the US population. In 2014, health expenditures were 14.6% of gross state product (GSP), compared with 17.3% of gross domestic product for the broader country. However, these differences are not direct comparisons, because California has a higher GSP than many other states. While the CMS data are the most comprehensive available estimates of total spending in the state, they are relatively outdated. See Appendix A for a discussion about the methodology.
11. To produce estimates for California, the team used restricted-access state identifiers made available for this project through AHRQ project number 466 and Census Bureau project number 2169. The research for this report was conducted at the AHRQ's Center for Financing, Access and Cost Trends (CFACT) Data Center, and the support of AHRQ is acknowledged. The results and conclusions reported here are those of the authors and do not indicate concurrence by AHRQ or the US Department of Health and Human Services.
12. To show trends, historical spending numbers have been adjusted to 2016 dollars using the California Consumer Price Index (CPI) for urban consumers. This adjustment eliminates changes in spending due to general inflation while preserving portions of the trends that are due to changes in utilization and increases in relative price levels.
13. Medi-Cal is California's Medicaid program.
14. Federal expenditures on Medi-Cal are determined by Medicaid's Federal Medical Assistance Percentage (FMAP). California receives the minimum FMAP payment, 50%, for those who were eligible for Medi-Cal prior to the enactment of the Affordable Care Act (ACA). However, the ACA increased federal payment for Medi-Cal enrollees who were made newly eligible for coverage under the law.
15. McConville S, Warren P, Danielson C. Funding the Medi-Cal Program. 2017. Accessed April 5, 2019.
16. To construct the trend charts, outliers were removed by replacing the top percentile of spending in each year and by each source of spending with the 99th-percentile expenditure in that category. This accounts for minor differences between estimates in Table 1 and the figures.
17. The MEPS-IC is a survey of employees fielded by AHRQ that collects information about health insurance premiums, employee contributions, and the type of health insurance employers offer. Because access to the restricted-use MEPS-IC was not available for this project, the analysis relied on aggregate tables reported on AHRQ's website.
18. Agency for Healthcare Research and Quality. Private-Sector Data by Firm Size and State, Table II.B.2.b.(1) Percent of Private-Sector Enrollees That Are Enrolled in Self-Insured Plans at Establishments That Offer Health Insurance by Firm Size and State: United States, 2017. 2017. Accessed April 5, 2019.
19. Historically, the MEPS-IC data only reported deductible data based on firms within two size categories (those with fewer than or greater than 50 workers). In addition, the MEPS-IC data do not contain deductible information for the year 2000.
20. Integrated Healthcare Association. California Regional Health Care Cost & Quality Atlas, Fact Sheet. 2018. Accessed March 16, 2019.
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25. The four insurers are Aetna, Humana, Kaiser Permanente, and UnitedHealthcare.

26. The HCCI/Guroo data represent claims incurred between July 1, 2014, and June 30, 2016, and have been projected to reflect prices for 2018.

27. Shrank WH, Rogstad TL, Parekh N. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA*. Oct 7, 2019; 322(15):1501–1509.

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Californians' Understanding of the Mandate to Have Health Coverage and the Awareness of Financial Help – December 2019 Survey

Research Conducted by GREENBERG

January 9, 2020

Key Findings

Penalty

- Many Californians reported being unaware of the requirement to have health insurance coverage in 2020 or else pay a penalty, including 38% of *insured* respondents and a majority of *uninsured* respondents *(56%).*

- Among *uninsured* respondents, once informed about the penalty, 64% say that the penalty makes them more likely to enroll in health insurance coverage for 2020. This compares to only 46% of *uninsured* respondents reporting that they planned to have health coverage in 2020 when asked at the beginning of the survey.

- Among the *insured* population, the vast majority of which (91%) report that they will keep health insurance coverage in 2020, 46% indicate the penalty motivated them to stay covered.

Financial Help

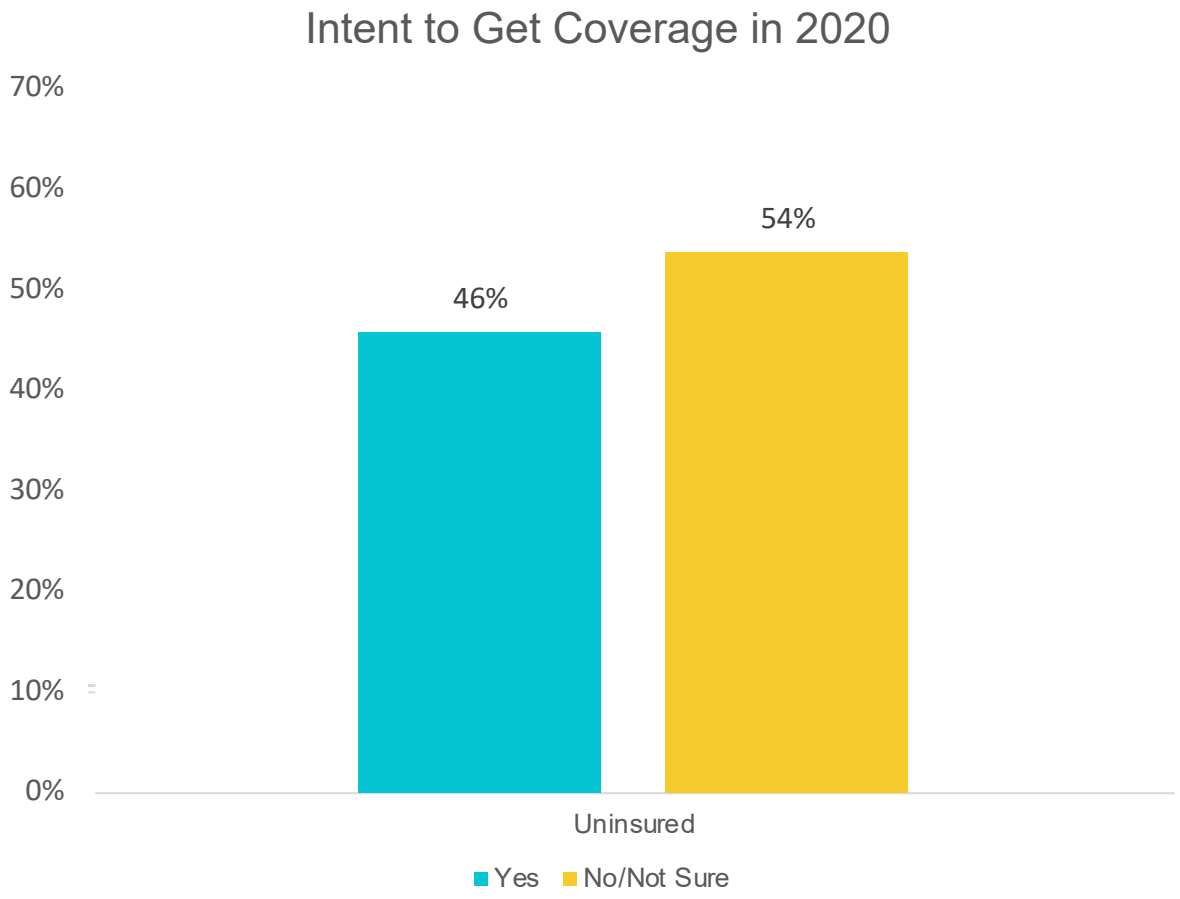
- The awareness that Covered California offers financial help to help pay for health insurance is low among the uninsured. Nearly two-thirds (62%) reported that they are not aware or unsure sure of the availability of financial help.

- Most uninsured respondents (62%) have not looked to see if they qualify for financial help.

- More than two-thirds of *uninsured* respondents stated that subsidies of $500 per month would make them likely to enroll in health care coverage.

See last slide for information on survey methodology.
Note that results shown throughout are unweighted responses among those Californians surveyed through a panel survey, and may not be fully representative of all Californians.

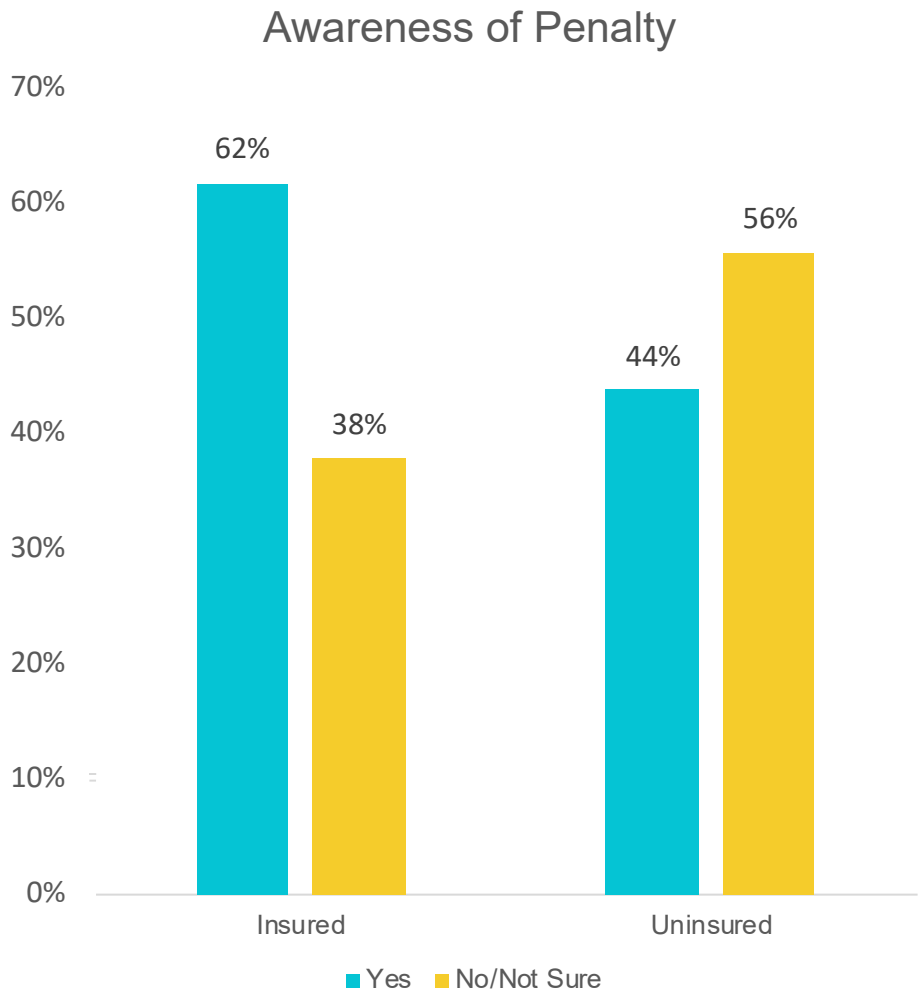
Most Uninsured Californians Do Not Intend to Get Health Insurance Coverage in 2020



- **Among the *uninsured*, a majority are not sure/do not plan to have health insurance coverage in 2020 (54%).**

Q: Do you plan to have health insurance in 2020?

Many Californians – Especially Uninsured – Are Unaware of State Penalty

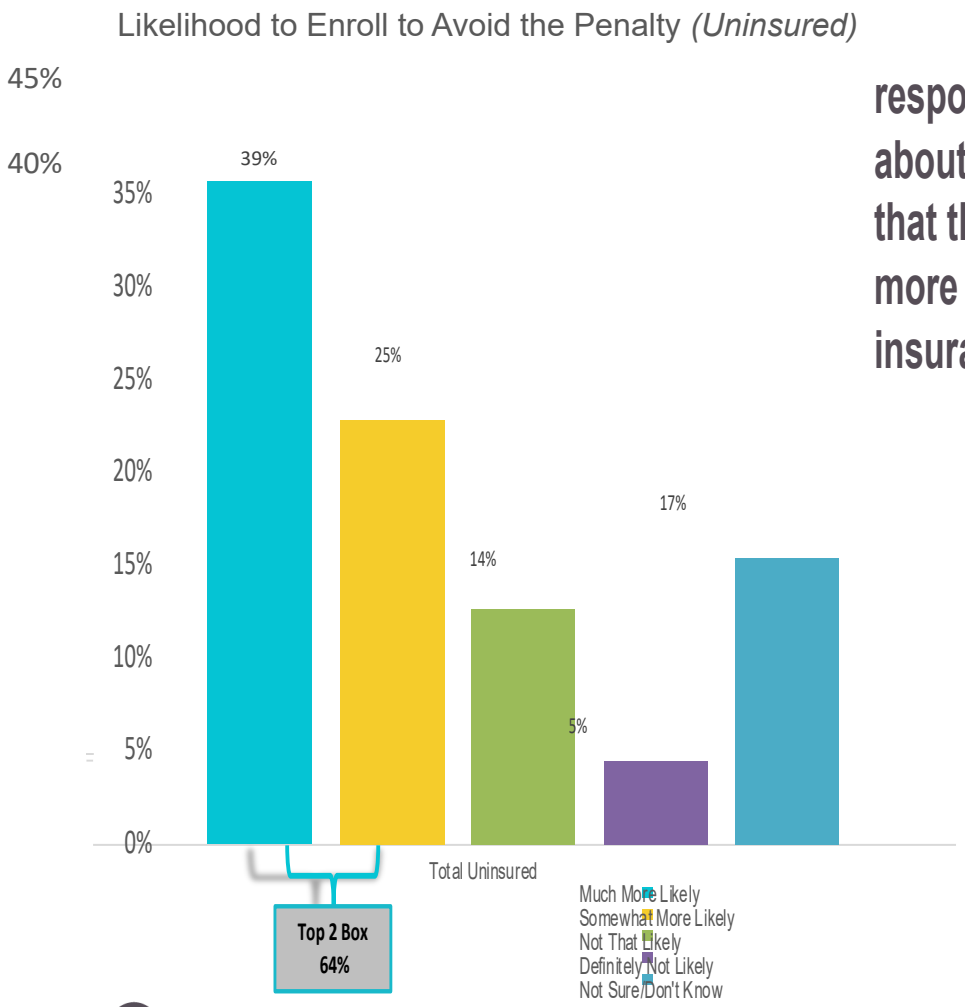


- **Many Californians reported being unaware of the requirement to have health insurance coverage in 2020 or else pay a penalty.**
- **38% of respondents with *insurance* are unaware of the state penalty.**
- **56% of *uninsured* respondents are unaware of the state penalty.**

COVERED CALIFORNIA™

Q: **As far as you know, are Californians required by law to have health insurance coverage in 2020 or else pay a penalty?**

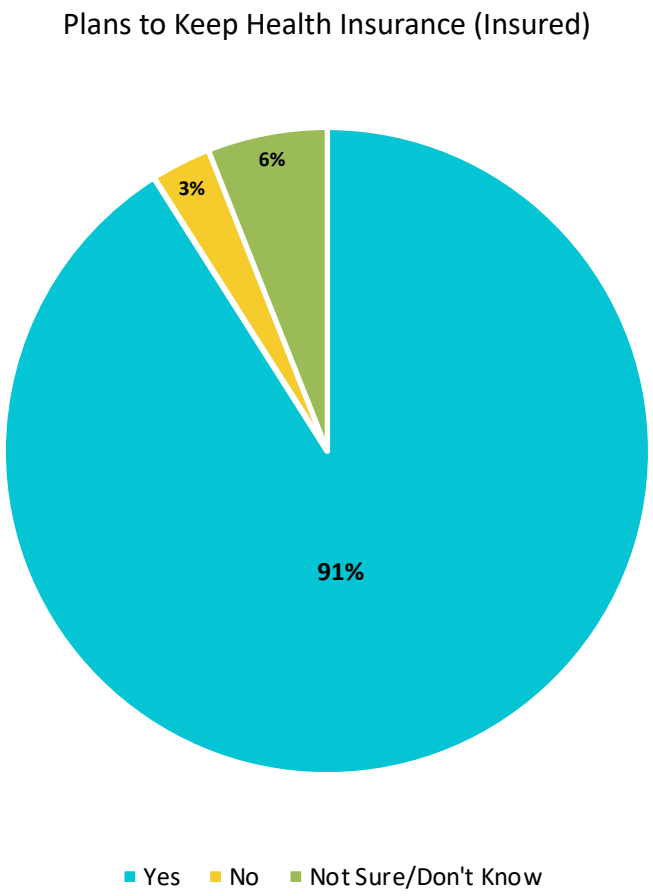
Uninsured Californians Are More Likely To Enroll in Coverage if Aware of the State Mandate



Among *uninsured* respondents once informed about the penalty, 64% say that the penalty makes them more likely to enroll in health insurance coverage for 2020.

Q: Starting in 2020, Californians are required to have health insurance coverage in 2020 or else pay a penalty of a minimum of $695 per taxpayer. How, if at all, does this information impact your likelihood to enroll in health insurance coverage in 2020?

State Mandate Encourages Already Insured Californians to Keep Their Coverage

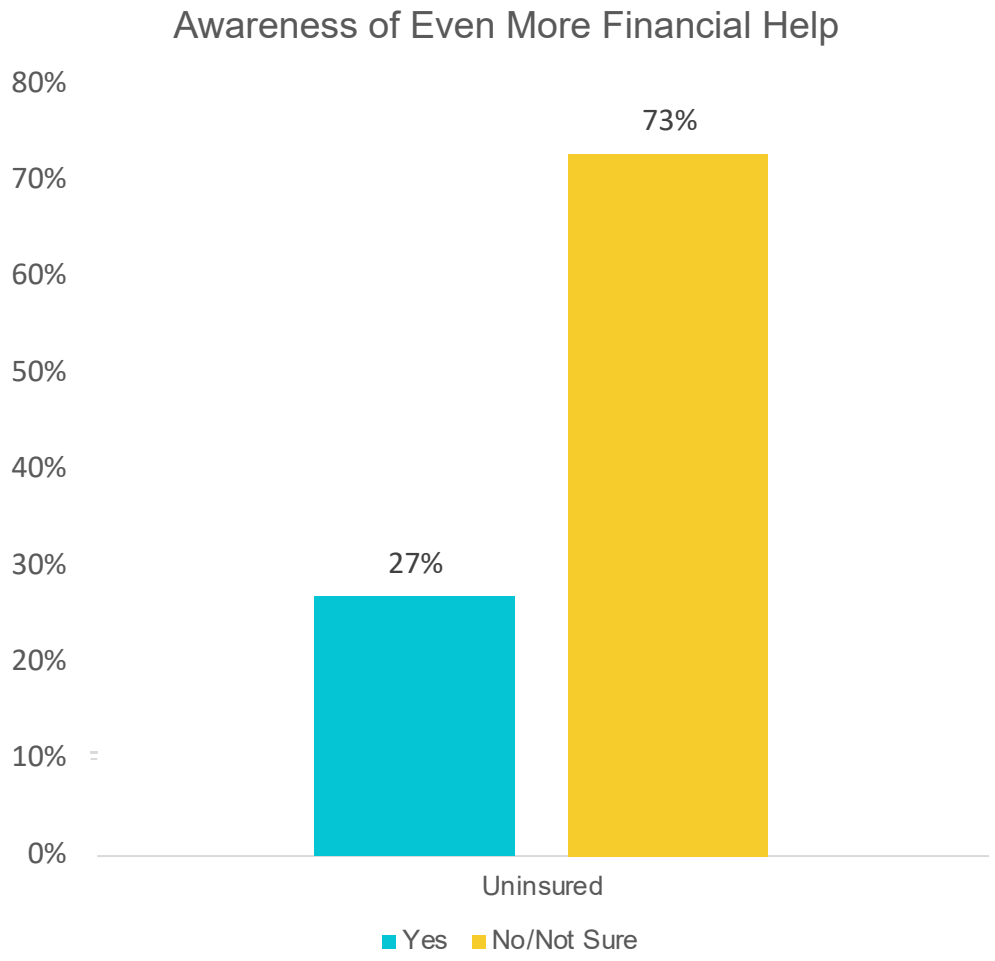


- **Among the *insured* population, the vast majority of which (91%) – with a range of sources of coverage (e.g., employer, individual and Medi-Cal) – report that they will keep health insurance coverage in 2020.**
- **46% of insured respondents indicate the penalty motivated them to stay covered.**

COVERED CALIFORNIA™

Q: Starting in 2020, Californians are required to have health insurance coverage in 2020 or else pay a penalty of a minimum of $695 per taxpayer. Knowing this, does this motivate you to keep health coverage in 2020?

Uninsured Are Even LESS Likely to Know About New Financial Assistance

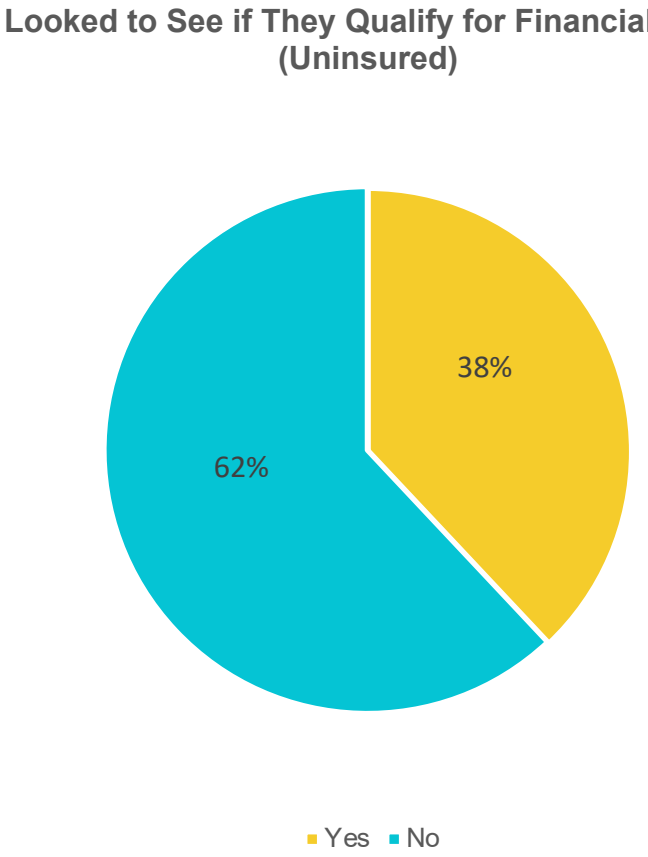


- **Among the *uninsured* respondents, only 27% are aware that Californians can receive even more financial help than ever before for health insurance coverage (compared to the 38% who generally know financial help is available).**

COVERED CALIFORNIA™

Q: To the best of your knowledge, have you heard that in 2020 Californians can receive even more financial help than ever before for health insurance coverage?

Many Uninsured Californians Who Could Get Financial Help Are Not Checking if They Are Eligible

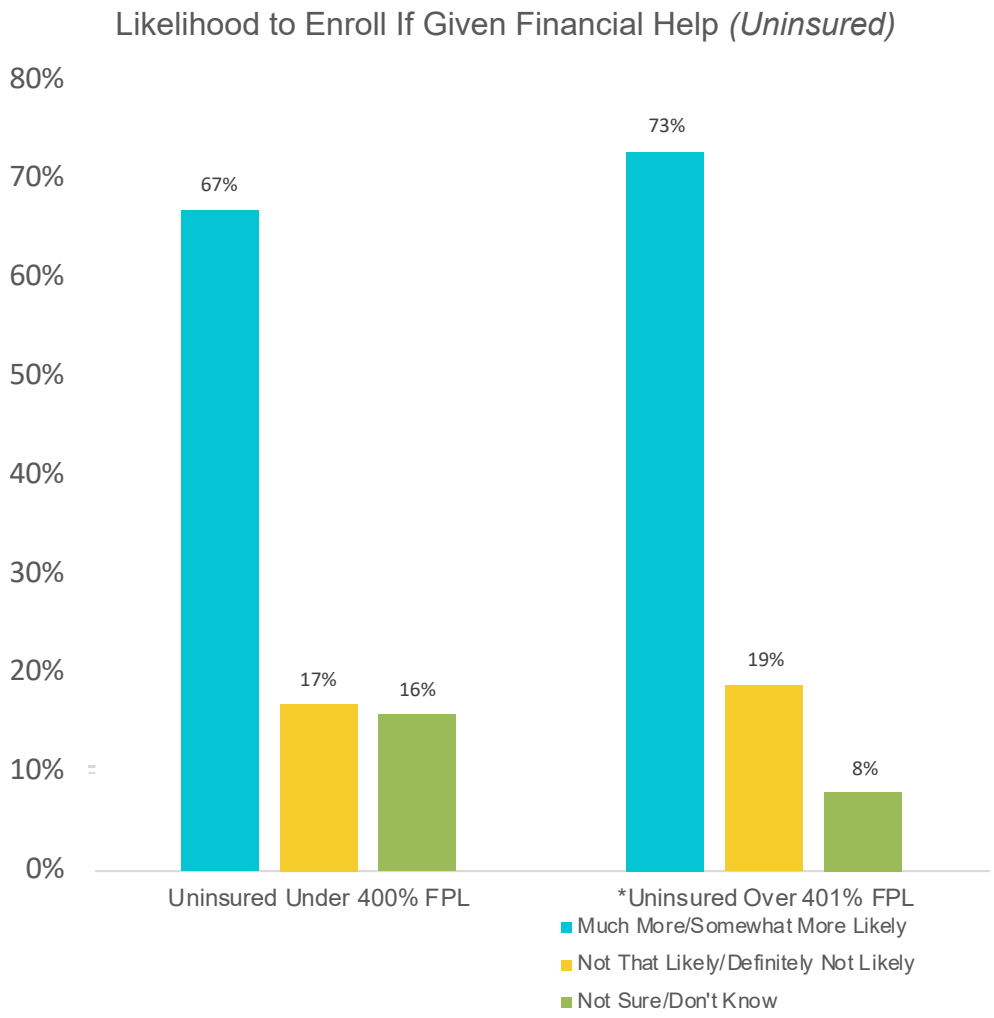


- **Nearly ALL of the *uninsured* respondents surveyed (93%) could qualify for financial help.**
- **Most *uninsured* respondents (62%) have not looked to see if they qualify for financial help.**

COVERED CALIFORNIA™

Q: When was the last time you looked to see if you qualify for this financial help through Covered California?

Uninsured Californians Are Far More Likely to Enroll in Coverage if Given Financial Help



*Sample size is small and is not representative of the total population (n=64). This can affect the precision and interpretation of this data point.

- **More than two-thirds of *uninsured* respondents stated that subsidies of $500 per month would make them likely to enroll in health care coverage.**
- ***Uninsured* middle class Californians (making between 401-600% FPL) are even more likely to enroll in coverage if they knew they were eligible for a $500 per month subsidy.**
- **The average subsidy for eligible consumers earning less than 400% FPL is $590 per month per household; the average state subsidy per household for eligible middle-income consumers (between 401-600% FPL) is $460 per month.**

COVERED CALIFORNIA™

Q: Starting in 2020, there will be additional financial help offered by the State of California that will help lower the cost of health insurance for middle-income Californians. They could receive about $500 per month, per household in financial help. How, if at all, does this information impact your likelihood to enroll in health insurance coverage?

Methodology: Californians' Understanding of the Mandate to Have Health Coverage and the Awareness of Financial Help – December 2019 Survey

How

- Online survey provided to respondents in English
- Independently conducted by LRWGreenberg, an external research and strategy consultancy firm, is comprised of the top data analytics, consumer insights, and marketing services with headquarters in the San Francisco Bay Area

Who

- Population: California residents
- Mix of insured and uninsured with over sampling of uninsured compared to the population
- Mix of gender, age (18-64), race, household income sizes, and geographical locations

Sample

- Total Completes n= 1,000 (Insured n= 534, Uninsured n=466)
- Subsidy Eligible (SE) 401-600% Federal Poverty Level (FPL) n=164 (Insured n=100, Uninsured n=64)

When

- Fielding dates: December 6, 2019 – December 18, 2019

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Issue Brief

California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits

An Update and Overview of New Federal Regulations

January 8, 2020

Prepared by
California Health Benefits Review Program

www.chbrp.org

Suggested Citation: *California Health Benefits Review Program (CHBRP). (2020). Issue Brief: California State Benefit Mandates and the Affordable Care Act's Essential Health Benefits. Berkeley, CA*

KEY FINDINGS

Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) of 2010 required some (but not all) forms of health insurance to cover a set of Essential Health Benefits (EHBs). For 2020, the California Health Benefits Review Program (CHBRP) estimated that 12.9% of Californians are enrolled in commercial health insurance that must cover EHBs.[1] EHBs are 10 statutory categories of tests, treatments, and services required by federal regulation based on a state plan benchmark.[2] This issue brief provides background on EHBs in California and how they interact with current and proposed state benefit mandates. This brief also describes recent changes to federal EHB regulations and discusses California's options for modifying the selected set of EHBs for 2022.

Essential Health Benefits: Overview

In California, commercial health insurance required to cover EHBs include non-grandfathered commercial plans and policies sold in the individual and small-group markets, the majority of which are sold through Covered California, California's health insurance marketplace.[3]

According to the ACA, EHBs must include the following broad categories of benefits: (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services and devices, (8) Laboratory services, (9) Preventive and wellness services and chronic disease management and (10) Pediatric services, including oral and vision care.[4]

However, to comply with the ACA and federal guidance by 2014, states were required to define a state's EHBs based on one of ten possible benchmark plan options already offered in the state, and add any EHB category not included in the chosen option but now required by federal law, such as pediatric vision care. California selected the "largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market," the Kaiser Foundation Health Plan Small Group HMO 30 plan and supplemented with additional benefits.[5]

State benefit mandates that exceed essential health benefits

The ACA allows a state to require benefits in addition to the EHBs for plans and policies subject to EHBs, but if the state does so, the state must make payments to the enrollee of a qualified health plan or their insurer to defray the cost of those additionally mandated benefits. However, state benefit mandates enacted before December 31, 2011 are considered part of the EHBs and the requirement that the state defray the costs of these mandated benefits is waived.[6]

For a state benefit mandate to exceed EHBs in California, the following must be true: (1) the state benefit mandate applies to qualified health plans (which are the subset of plans that are non-grandfathered, sold in the individual or small-group market by Covered California, or their off-exchange mirror equivalent); (2) the state benefit mandate is not covered in the Kaiser Foundation Health Plan Small Group HMO 30 plan that defines the current EHB benchmark package in California or in the additional specified benefits; (3) the state benefit mandate is not covered under basic health care services, as required by the Knox-Keene

[1] See CHBRP's *Estimates of Sources of Health Insurance in California in 2020*, available at: http://chbrp.org/other_publications/index.php#revize_document_center_rz44.
[2] Refer to CHBRP's full report below for full citations and references.
[3] Medi-Cal, California's Medicaid program is also required by the ACA to cover a set of benefits referred to as EHBs, but, as discussed in Appendix B, Medi-Cal EHBs are separate from and function independently from the EHBs commercial health insurance is required to cover.
[4] 42 U.S.C. §18022
[5] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on December 16, 2019 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb
[6] 42 U.S.C. §18031(d)(3)(B) and 45 CFR §155.170(b).

Health Care Service Plan Act of 1975;[7] and (4) the state benefit mandate is specific to care, treatment, and/or services, thus meeting the federal definition of a benefit mandate that could exceed EHBs. Changes to service delivery method, provider types, cost sharing, or reimbursement methods do not fall under category (4) and therefore would not trigger the requirement for the state to defray the cost.

Federal regulations state the "State" is responsible for determining whether a benefit exceeds EHBs, subject to federal oversight. However, the regulations do not designate this responsibility to a specific agency or individual and California has not officially determined who or which agency would be responsible.

Essential Health Benefits Regulation Changes

Essential Health Benefits changes: overview

The Department of Health and Human Services (HHS) issued a final rule in 2018 (and a similar final rule in 2019) which provided new flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the option of retaining the current EHB benchmark plan, beginning with the 2020 plan year.[8] States could: (1) select an EHB benchmark plan used by another state for the 2017 plan year, (2) replace one or more of the 10 EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan, or (3) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of 10 previous 2017 benchmark comparison plan options.

Essential Health Benefits: Insights from Other States

Two states elected to utilize the new options for defining EHB benchmark plans, with both choosing the third option, "otherwise selecting a set of benefits that would become the State's EHB-benchmark plan."[9] Both states maintained their current EHB base-benchmark plan while supplementing EHBs with an additional benefit. Starting in the 2020 plan year, Illinois was approved to modify the prescription drug category and mental health substance use disorder services category by altering pain treatment options and expanding access to mental health services. Starting in the 2021 plan year, South Dakota was approved to supplement its habilitation services category with Applied Behavioral Analysis treatment for Autism Spectrum Disorder. Illinois and South Dakota submitted actuarial analyses demonstrating that these EHB additions would not exceed the most generous comparison plan, thus satisfying the generosity test.

2022 Essential Health Benefits: California Options

California has until **May 8, 2020** to submit documents to HHS supporting an application for a new or modified EHB benchmark plan for 2022 Plan Year. By selecting some or all categories from another state's EHB benchmark plan or otherwise selecting a set of benefits, California has the ability of include new services that are not currently in the California benchmark plan. CHBRP is aware of three specific benefits that are covered by the majority of other state EHB benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan. Chiropractic care services, hearing

[7] The Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.

[8] 83 FR 16930 and 84 FR 17454

[9] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on December 16, 2019 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb

aids, and infertility services and treatments are included in the majority of states' EHB benchmark plans, though most incorporate utilization management and other limits to these benefits.[10]

Conclusion

HHS's recent regulations provide an opportunity for states to modify or select a new EHB benchmark plan. Though the regulations allow for considerable flexibility, HHS maintains a minimum scope of benefits floor as well as a "generosity test" ceiling. Within these confines, California could use one of the three new EHB benchmark plan options to supplement its set of benefits. The two states which have already done so both chose to keep their current benchmark plan while adding a specific set of benefits within one or two EHB categories. California can look to these two states and the new regulations as it considers any potential changes to its EHB benchmark plan.

[10] As the 2017 EHB benchmark plan remained for years 2018 and 2019, this analysis of 2017 EHB benchmark plan covered benefits is still accurate for the 2019 plan year: https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf

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CALIFORNIA STATE BENEFIT MANDATES AND THE AFFORDABLE CARE ACT'S ESSENTIAL HEALTH BENEFITS

Beginning in 2014, the federal Patient Protection and Affordable Care Act (ACA) of 2010 required some (but not all) forms of health insurance to cover a set of Essential Health Benefits (EHBs).[11] The EHB coverage requirement interacts with California's existing laws and may interact with proposed health insurance benefit mandate (or repeal) legislation. The California Health Benefits Review Program (CHBRP)[12] produced this issue brief to provide background on EHBs in California and recent federal changes in EHB benchmark plan selection options. Specifically, this brief provides:

- A description of state benefit mandates and enrollees with health insurance subject to state benefit mandates in California;
- An overview of how EHBs are defined at the federal level and in California, including how new federal Department of Health and Human Services regulations have changed these definitions; and
- A summary of California's options for 2022 EHB selections.

What Are State Health Insurance Benefit Mandates?

As defined by CHBRP's authorizing statute,[13] California's health insurance benefit mandate laws can require health insurance products to provide coverage or offer coverage for any of the following: (1) coverage for screening, diagnosis, or treatment of a specific disease or condition; (2) coverage for specific types of health care treatments or services; (3) coverage for services by specific types of health care providers; and/or (4) the provision of coverage with specified terms that may affect cost sharing, prior authorization requirements, or other aspects of benefit coverage. CHBRP is aware of 79 health insurance benefit mandate laws in California.[14]

Health Insurance Subject to State Benefit Mandates in California

State benefit mandates only apply to a subset of enrollees with health insurance in California: enrollees with health insurance regulated by either the California Department of Managed Health Care (DMHC), which regulates *health care service plans*, or the California Department of Insurance (CDI), which regulates *health insurance policies*.[15] This accounts for approximately 62% of Californians (24.5 million) in 2020.[16]

[11] 42 U.S.C. § 18022

[12] The California Health Benefits Review Program (CHBRP), established in 2002, responds to requests from the California State Legislature for independent, evidence-based analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Additional information about the program is available on CHBRP's website at: www.chbrp.org.

[13] Available at: http://chbrp.com/about_chbrp/index.php.

[14] Annually updated, the CHBRP document *Health Insurance Benefit Mandates in California State Law* lists state and federal benefit mandate laws applicable to health insurance in California. It is available at: www.chbrp.org/other_publications/index.php.

[15] California has a bifurcated system of regulation for health insurance. DMHC regulates health care service plans, which offer benefit coverage to their enrollees through health plan contracts. The California Department of Insurance (CDI) regulates health insurers, which offer benefit coverage to their enrollees through health insurance policies.

[16] CHBRP, *Estimates of Sources of Health Insurance*, 2019. Available at: http://chbrp.org/other_publications/index.php

State benefit mandates in Covered California

The ACA requires the establishment of health insurance marketplaces that sell health insurance in the small-group and individual markets.[17] California chose to set-up its own state-run marketplace, but states also have the option of allowing the federal government to run the state marketplace or selecting a hybrid partnership alternative with the federal government. Plans and policies certified and sold through the marketplace are called qualified health plans (QHPs). QHPs sold through Covered California, California's insurance marketplace,[18] are regulated by DMHC or CDI, and thus are subject to the state's benefit mandates.

Federal Benefit Mandates

In addition to state benefit mandates, there are also federal benefit mandates, some of which interact with state benefit mandates and EHB coverage requirements (discussed below). Like state benefit mandates, federal benefit mandates generally apply to both the individual and group market, unless a market is specifically excluded. However, federal benefit mandates may also apply to Medicare or to self-insured plans, which are not subject to state benefit mandates. (For more detailed information on current federal benefit mandates, see *Appendix A: Federal Benefit Mandates*, as well as CHBRP's documents *Federal Preventive Services Mandate and California Mandates* and *Health Insurance Benefit Mandates in California State Law*.[19])

Essential Health Benefits: Overview

Essential Health Benefits Defined: Federal Requirements and Guidance

The ACA requires the Secretary of the U.S. Health and Human Services (HHS) to define EHBs through regulation, but requires that at least some items and services within 10 specific categories of benefits be included.[20] See Exhibit 1 for the full list.

When defining EHBs within the 10 EHB categories, the Secretary of HHS must ensure that the EHB floor "is equal to the scope of benefits provided under a typical employer plan."[21] The Secretary of HHS is required to take into account: the need for balance between the 10 ACA-specified EHB categories; the needs of diverse segments of the population; and the need to not discriminate against individuals because of age, disability, or expected length of life.

In plan years 2014 through 2019, EHBs for nongrandfathered plans and policies in the small-group and individual markets were defined in a manner that allows for

Exhibit 1: The 10 Essential Health Benefit Categories

1) Ambulatory patient services;
2) Emergency services;
3) Hospitalization;
4) Maternity and newborn care;
5) Mental health substance use disorder services, including behavioral health treatment;
6) Prescription drugs;
7) Rehabilitative and habilitative services and devices;
8) Laboratory services;
9) Preventive and wellness services and chronic disease management; and
10) Pediatric services, including oral and vision care.

[17] 42 U.S.C. § 18031
[18] The California Health Benefits Exchange, Covered California, Authorizing Statute is available here: http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.html and here: http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100930_chaptered.html
[19] These documents are available at: www.chbrp.org/other_publications/index.php.
[20] 42 U.S.C. §18022(b).
[21] 42 U.S.C. §18021(b)(2)(A).

state flexibility.[22] States selected from four benchmark plan options that reflect the scope of services offered by a typical employer plan. The benchmark plan then must be supplemented to ensure it includes all 10 EHB categories and meets the other ACA requirements (e.g., balance between the 10 EHB categories, nondiscrimination). A health plan or policy is required to offer benefits that are "substantially equal" to the benefits of the selected benchmark plan. Plans or policies can substitute coverage within a benefit category, with the exception of the prescription drug benefits category, so long as they do not reduce the value of coverage; the substituted benefits must be actuarially equivalent to the benefits being replaced. States can enforce stricter requirements on benefit substitution or prohibit it entirely.[23] Regulatory changes that impacted the EHB benchmark options for plan years 2020-2021 and 2022 are discussed below.

Exhibit 2. Choosing the Initial "EHB-Benchmark Plan" for Plan Year 2014

To begin to define EHBs, states selected a benchmark plan sold in 2012 from one of several options that reflected the scope of services offered by a typical employer plan.

- The largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employee Health Benefits Plan (FEHBP) options by enrollment; or
- The largest insured commercial non-Medicaid HMO operating in the state.

If a state did not select a benchmark plan, the default benchmark plan was the largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market. Enrollment for selection of a benchmark plan was based on the first quarter of calendar year 2012. The benchmark plan selected by a state, or the federal government for a state, is known as the "base-benchmark plan." The initial base-benchmark plan chosen in 45 states and the District of Columbia is the largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market. (a)

As needed, the base-benchmark plan must be supplemented to ensure it includes all 10 EHB categories. If a base-benchmark plan does not provide services within a specific EHB category, it has to be supplemented "by adding that particular category in its entirety from another base-benchmark plan option." Further, the base-benchmark plan must be assessed to ensure it has a balance between the 10 EHB categories and meets the standards for nondiscrimination, as required by the ACA. The resulting supplemented package is known as the "EHB-benchmark plan."

Notes: (a) Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. Federal Register, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accessed August 28, 2019.

Health Insurance Subject to the Essential Health Benefits Coverage Requirement

As of January 1, 2014, the ACA required most health insurance products in individual and small-group markets to cover EHBs.[24] The ACA requires coverage of EHBs for almost all enrollees in the individual

[22] Department of Health and Human Services, Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule. *Federal Register*, Vol. 78, No. 37. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. Accessed August 27, 2019.
[23] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[24] 42 U.S.C. §300gg-6.

and small-group markets, both inside and outside Covered California (Table 1).[25] Inside Covered California, all QHPs are required to provide coverage of EHBs,[26] while outside Covered California, nongrandfathered plans and policies in the individual and small-group market are required to cover EHBs.[27] Large group, self-insured and grandfathered plans and policies are exempt from the EHB requirements.[28] Approximately 5.1 million Californinans (12.9%) have health insurance subject to EHBs in 2020.

In addition, in accordance with the ACA, Medi-Cal is required to provide coverage of EHBs.[29] See Appendix B for further information on Medicaid EHBs.

Exhibit 3. Additional Guidance on the "EHB-Benchmark Plan"

For defining and meeting the requirements for the EHB-benchmark plan for the 10 EHB categories, HHS provided the following additional guidance:

- **Pediatric services, including oral and vision care:** HHS defined pediatric care as up to age 19, but allowed state flexibility to extend pediatric coverage beyond this age limit. In regards to the benefits covered, HHS found that pediatric oral and vision services were generally not covered in the benchmark plan options. Therefore, HHS guidance identified two options states could use to supplement their base-benchmark plan to meet this coverage requirement: (1) the Federal Employees Dental and Vision Insurance Program (FEDVIP) plan with the largest enrollment; or (2) the state's separate Children's Health Insurance Program (CHIP). (a)
- **Habilitative services:** Habilitative services was another area HHS found was not covered as a distinct group of services by insurers. If the base-benchmark plan needed to be supplemented to meet the habilitative services EHB coverage requirement, HHS guidance allowed for one of the following to define habilitative services: (1) states could define the benefits that should be included in this category; or (2) if a state does not define habilitative services, a health insurance issuer must either provide coverage for habilitative services in parity with rehabilitative services or decide what habilitative services to cover.
- **Mental health and substance use disorder services:** Coverage within this EHB category must meet the Mental Health Parity and Addiction Equity Act (MHPAEA), which previously did not apply to the individual market and small group market in California. (b)
- **Preventive and wellness services:** The ACA requires nongrandfathered group and individual market plans and policies to cover certain preventative services without cost sharing. (c) The guidance on EHBs requires coverage of these services to be included to meet the definition of EHBs.

Notes: (a) For more detail, CHBRP has a Policy Brief focused on pediatric oral and vision care component of EHBs, available here: www.chbrp.org/other_publications/index.php.
(b) The MHPAEA previously only applied to group plans and policies with more than 50 employees (www.dol.gov/ebsa/newsroom/fsmhpaea.html). California defines the small group as 50 or fewer employees.
(c) ACA Section 1001, modifying Section 2713 of the Public Health Service Act. CHBRP has a Resource looking at the preventive services coverage requirement in the ACA, available here: www.chbrp.org/other_publications/index.php. Also, see Appendix A: Federal Benefit Mandates.

[25] 42 U.S.C. §18022.
[26] 42 U.S.C. §18021.
[27] 42 U.S.C. §300gg-6.
[28] A grandfathered health plan is defined as: "A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers" (www.healthcare.gov/glossary/grandfathered-health-plan/).
[29] 42 U.S.C. §1396u-7(b)(5)

Table 1. Required Coverage of Essential Health Benefits (EHBs) in California for Privately Purchased Health Insurance

	Inside Covered California	Outside Covered California
Individual Market		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes
Small-Group Market(b)		
Grandfathered	N/A (a)	No
Nongrandfathered	Yes	Yes

Notes: (a) Qualified health plans cannot be grandfathered plans or policies, therefore there are not grandfathered plans or policies sold through Covered California.
(b) The large-group market is not a part of Covered California. Per 42 U.S.C. §18042, states had the option starting in 2017 to include the large-group market in the state's marketplace, but California did not chose to do so.

Essential Health Benefits Defined: California

The base-benchmark plan California selected for 2014 (Kaiser Foundation Health Plan Small Group HMO 30 plan) was the largest plan by enrollment in one of the three largest small-group insurance products in the state's small-group market.[30] California chose to supplement this plan with the pediatric oral benefit from its separate CHIP program,[31] and the pediatric vision benefits from the FEDVIP plan.[32] If the selected benchmark plan did not include habilitative services, states or insurers must supplement the benchmark plan to cover this EHB category. California chose to define habilitative services[33] and required that these services be provided "under the same terms and conditions applied to rehabilitative services."[34]

In addition, the Kaiser Foundation Health Plan Small Group HMO 30 plan is a DMHC-regulated plan and, as such, is subject to the Knox-Keene Health Care Service Plan Act of 1975 that requires coverage of medically necessary basic health care services. Therefore, medically necessary basic health care services are a part of the EHB coverage requirement in California.[35]

[30] H&SC Section 1367.005; IC Section 10112.27.
[31] In 2014, California completed transitioning enrollees in Healthy Families, its Separate Children's Health Insurance Program (CHIP) program, into Medi-Cal, becoming a Medi-Cal Expansion CHIP program. The EHB pediatric oral benefits are based on the benefits covered in the Healthy Families Program in 2011–2012, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. (H&SC Section 1367.005; IC Section 10112.27)
[32] H&SC Section 1367.005; IC Section 10112.27.
[33] California defined habilitative services as: "Habilitative services means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment." (H&SC Section 1367.005; IC Section 10112.27)
[34] H&SC Section 1367.005; IC Section 10112.27.
[35] Starting in 2014, CDI-regulated policies subject to the EHB coverage requirement—nongrandfathered small-group and individual market policies—are required to cover basic health care services.

Exhibit 4. California's EHB Benchmark Plan, Plan Years 2014-2019

In plan years 2014, 2015 and 2016, the EHB benchmark plan was a plan that was sold in 2012, while in plan years 2017, 2018 and 2019, the benchmark EHB plan was a plan that was sold in 2014. California chose the Kaiser Foundation Health Plan Small Group HMO 30 HMO, the largest plan by enrollment of the three largest small-group plans. This plan did not include the full scope of pediatric benefits, so California selected the pediatric oral benefit from the state CHIP plan and the pediatric vision benefit from the FEDVIP plan. (a)

The EHB benchmark plan for plan years 2020-2021 is discussed below.

Notes: (a) Details can be found here: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-California-Benchmark-Summary.pdf and here: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP_CA.zip .

State Benefit Mandates That Exceed Essential Health Benefits

The ACA allows a state to require health plans and policies subject to EHBs to cover additional benefits.[36] If the state does so, the state must make payments to defray the cost of the additionally mandated benefits, either by paying the enrollee directly or by paying the QHP. Health plans and policies sold outside of the marketplace are not subject to this requirement to defray the costs. However, state benefit mandates enacted by December 31, 2011 are considered part of the state's EHBs, eliminating the requirement that the state defray the costs of those additionally mandated benefits. State benefit mandates enacted after December 31, 2011 that meet the federal definition of a state benefit mandate would be subject to the requirement that a state defray the costs. The federal definition of a state benefit mandate that can exceed EHBs is "specific to the care, treatment, and services that a state requires issuers to offer to its enrollees."[37] State rules around service delivery method (e.g., telemedicine), provider types, cost sharing, or reimbursement methods are not considered state benefit mandates that would trigger the requirement for the state to defray the costs even though plans and policies in a state must comply with these requirements.

Exhibit 5. Key Points: State Benefit Mandates That Would Exceed Essential Health Benefits

- Enacted after December 31, 2011;
- Apply to the nongrandfathered small-group and individual markets inside a state's health insurance marketplace; and
- Are specific to care, treatment, and services.

It is unclear which entity within the state would be responsible for this determination. Federal guidance established the "State" as the entity that would identify when a state benefit mandate exceeds EHBs, however the state entity would be subject to federal oversight.[38] There are no federal guidelines that specifically designate this responsibility. Additionally, California has not officially determined who or which agency would be the responsible party for determining whether a benefit exceeds EHBs. For mandates that do exceed, federal guidance established QHPs as the responsible entity for calculating the marginal cost that must be defrayed. However, federal guidance left state flexibility in how this would be calculated;

[36] 42 U.S.C. §18031(d)(3)(B).
[37] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[38] Frequently Asked Questions on Defrayal of State Additional Required Benefits. *Centers for Medicare and Medicaid Services*. October 23, 2018. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.

it could be based on "either a statewide average or each QHP issuer's actual cost."[39] CHBRP is not aware of any states with state benefit mandates that have been determined to exceed EHBs.

As this brief will discuss later, states recently gained additional flexibility with regard to EHB benchmark plan options. Despite the increased flexibility, the election of alternative EHB benchmark plans will not alleviate a state of defrayal requirements for state benefit mandates that exceed EHBs. Benefits mandated via state legislative or regulatory action after December 31, 2011 will continue to require defrayal if they are included in a new EHB benchmark plan. However, if a new EHB benchmark plan includes additional benefits beyond a previous EHB benchmark plan, these additional benefits would not require defrayal unless the benefits were mandated via state legislative or regulatory action after December 31, 2011.[40]

How a state benefit mandate could exceed essential health benefits in California

For a state benefit mandate to exceed the definition of EHBs in California, thus triggering the requirement that the state defray the costs, the following must be true:

- The state benefit mandate would apply to QHPs sold through Covered California;
- The state benefit mandate is not covered in the Kaiser Foundation Health Plan Small Group HMO 30 plan that defines the EHB benchmark package in California;
- The state benefit mandate is not covered under basic health care services, as required by the Knox-Keene Health Care Service Plan Act of 1975; and
- The state benefit mandate is specific to care, treatment, and/or services, thus meeting the definition of a benefit mandate that would exceed EHBs.[41]

Between 2013 and 2019, California enacted multiple health insurance benefit mandates, none of which appear to exceed EHBs. However, multiple bills have been introduced that if passed, would likely exceed EHBs.

Inclusion of whether a bill exceeds EHBs in CHBRP Reports

The Legislature has requested CHBRP include whether a bill is likely to exceed EHBs within each CHBRP report. Because federal and state regulations are unclear as to who would make the final determination, CHBRP queries both state regulators (DMHC and CDI) and reports their conclusions. CHBRP also examines the EHB benchmark plan, but because not all benefits are explicitly defined in the Explanation of Benefits or Scope of Benefits, CHBRP relies heavily on the regulators.

[39] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[40] Frequently Asked Questions on Defrayal of State Additional Required Benefits. *Centers for Medicare and Medicaid Services*. October 23, 2018. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf.
[41] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

Exhibit 6. Example of a State Benefit Mandate Exceeding Essential Health Benefits

In 2019, CHBRP analyzed Assembly Bill 767 (Wicks), which would have required DMHC-regulated plans and CDI-regulated policies in the large and small group markets to cover infertility treatments (including in vitro fertilization) and mature oocyte cryopreservation. As analyzed by CHBRP, AB 767 likely would have exceeded EHBs because infertility treatment and mature oocyte cyropreservation:

- Are not included in the Kaiser Foundation Health Plan Small Group HMO 30 plan;
- Are not required coverage under (state) basic health care services; and
- Meet the federal definition of a state benefit mandate that would exceed EHBs.

CHBRP estimated the marginal change in the per member per month (PMPM) premium that would result from AB 767 and that the state would be responsible for defraying for each enrollee in a small-group QHP in Covered California would have been $3.72. For further information, see CHBRP's 2019 report on AB 767 available here: www.chbrp.org/completed_analyses/index.php.

Essential Health Benefits and Cost Sharing

Annual out-of-pocket maximums

The ACA places an annual limitation, or annual out-of-pocket maximum, on plans and policies required to provide coverage for EHBs.[42] The annual out-of-pocket maximum for 2020, as set by the federal government, is $8,150 for self-only coverage or $16,300 for family coverage, and includes deductibles, copayments, and other forms of cost sharing but does not include the cost of premiums.[43,44] In California, the annual out-of-pocket maximum may be lower depending on an enrollee's income and on the metal coverage level or the plan or policy.[45] Important to note is that the ACA allows the pediatric dental benefit to be covered either through a stand-alone dental insurance carrier or through an enrollee's health insurance carrier.[46] Final guidance from HHS has allowed stand-alone pediatric dental insurance to have a separate annual limit from the annual limit for health insurance.[47,48]

The ACA further requires that "group health plans" adhere to this annual out-of-pocket maximum.[49] Although the large-group market is not subject to EHB coverage requirements, federal guidance clarified that the annual out-of-pocket maximum applies to the large group.[50] In California, statute also requires nongrandfathered large group plans and policies that cover EHBs to maintain an annual out-of-pocket maximum that only applies to EHBs.[51]

[42] 42 U.S.C. §18022(c) references Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, which defines maximum annual out-of-pocket expenses for high deductible health plans (HDHPs). The dollar values provided here are the limits set by the Department of Health and Human Services for 2020.
[43] Available at: https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.
[44] [42 U.S.C. §18022 (c)]
[45] More information is available at: www.healthexchange.ca.gov/Pages/Default.aspx.
[46] 42 U.S.C. §18022 (d)(2)(B)(ii).
[47] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[48] For more information on the EHB pediatric oral and vision coverage requirement, standalone dental plans, and the annual limit requirements for these plans, see CHBRP's Policy Brief on this issue, available here: www.chbrp.org/other_publications/index.php.
[49] 42 U.S.C. §300gg-6.
[50] Essential Health Benefits Final Rule. *Federal Register*, Vol. 87, No. 27. February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.
[51] H&SC Section 1367.006(2) ; IC Section 10112.28(2).

Deductibles

While the ACA initially included limits on the deductible for plans offered through the small group market, a law signed in 2014 removed these limits.

Essential Health Benefits Regulation Changes

Essential Health Benefits: Regulatory Updates

HHS issued a *Notice of Benefit and Payment Parameters* final rule on April 9, 2018, which contained a number of changes and updates, including some pertaining to EHB benchmark plan selection.[52] This final rule marked the first substantial changes within the EHB realm since the enabling rules were promulgated in the aftermath of the ACA enabling legislation earlier in the decade. This rule provided for new flexibility for states by allowing three new options for selecting an EHB base-benchmark plan, in addition to the option of retaining the current EHB benchmark plan, beginning with the 2020 plan year. These new options maintain a minimum scope of benefits standard and established a generosity ceiling to limit the range and cost of benefits that could be considered.

Essential Health Benefits: Scope of Benefits

Regardless of the option chosen by a state, the EHB benchmark plan must provide coverage for items and services within all 10 categories of benefits.[53] The EHB benchmark plan is also subject to the scope of benefits requirements that provide both a floor and ceiling. The five scope of benefits requirements include:

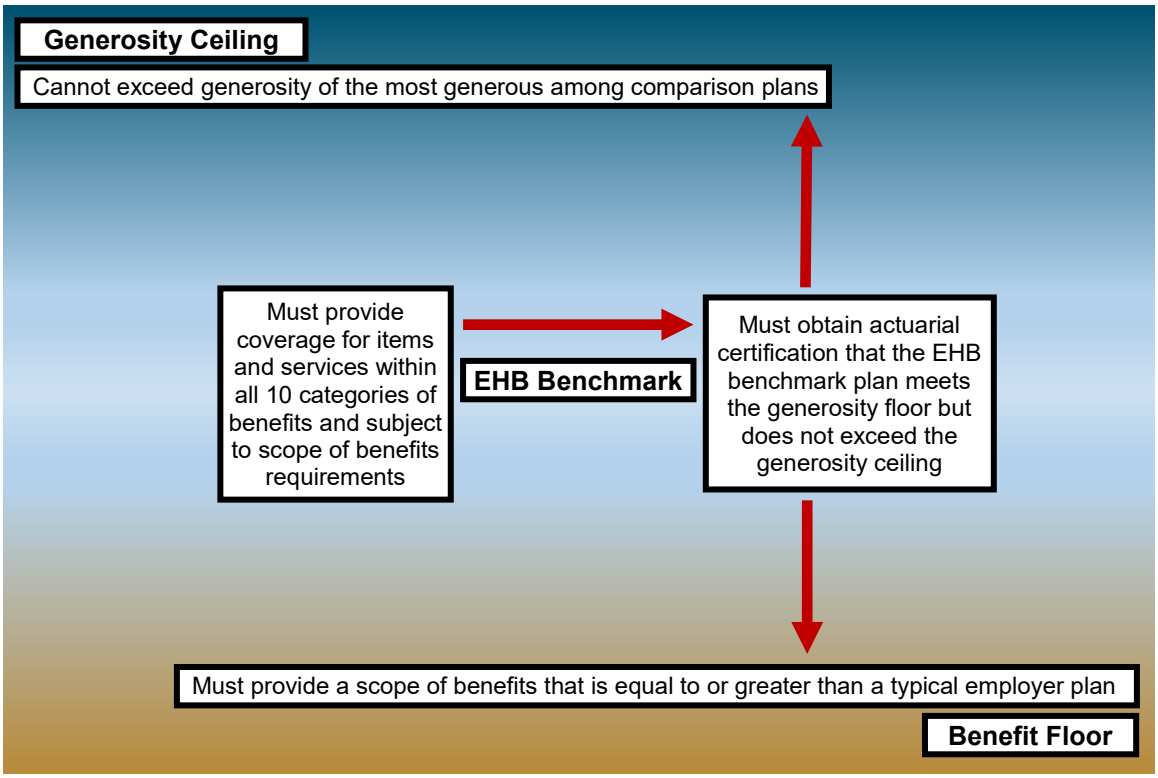
1) Scope of benefits equal to or greater than the scope of benefits provided under a typical employer plan, which is defined as either:
    a) One of the state's 10 benchmark plan options described previously, as sold in 2017
    b) The largest health insurance plan by enrollment within one of the five largest group health insurance products in the state, provided that: (1) the product has at least 10% of the total enrollment of the 5 largest large group health insurance products in the state, (2) the plan provides a minimum value of 60% of total allowed cost of benefits, (3) the benefits are not excepted benefits (such as workers' compensation, disability income, liability and travel insurances) and (4) the benefits are from a plan year beginning in 2014 or thereafter
2) Cannot exceed the generosity of the most generous among a set of comparison plans, including:
    a) The state's EHB benchmark plan utilized for the 2017 plan year
    b) Any of the state's benchmark plan options for the 2017 plan year
3) Cannot have benefits unduly weighted towards any of the 10 categories of benefits
4) Must provide benefits for diverse segments of the population, including women, children, persons with disabilities and other groups
5) Cannot include discriminatory benefit designs that violate the non-discrimination standards (age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions)

[52] 83 FR 16930

[53] As explained previously and in 45 CFR § 156.110(a), these include (1) Ambulatory patient services, (2) Emergency services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance use disorder services, including behavioral health treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services and devices, (8) Laboratory services, (9) Preventive and wellness services and chronic disease management and (10) Pediatric services, including oral and vision care.

While a state will confirm in writing that a selected EHB benchmark plan option fulfills the above scope of benefits requirements, the state also must obtain actuarial certification that the EHB benchmark plan meets the generosity floor but does not exceed the generosity ceiling. A certified actuarial report is necessary that affirms that the EHB benchmark plan provides a scope of benefits equal to or greater than the typical employee plan (described in item 1 above) without exceeding the generosity of the most generous among the plans listed in item 2 above (Figure A).

Figure A. Essential Health Benefits Benchmark Scope of Benefits Requirements



Though the new EHB benchmark plan options may provide a means for California to add additional services or treatments to EHB categories, there are important limitations in the rules. The chosen EHB benchmark plan must provide a scope of benefits that is equal to or greater than a typical employer plan, as explained above.[54] In addition to meeting this benefit floor, the EHB benchmark plan cannot exceed a generosity ceiling, as shown in Figure A.

As discussed in Exhibit 7, South Dakota chose to enhance their existing EHB benchmark plan starting in 2021 by adding Applied Behavior Analysis Habilitative Services for enrollees with Autism Spectrum Disorder. As required by statute, South Dakota commissioned an actuarial analysis of this additional benefit in the context of the new generosity test.[55] The actuarial analysis revealed that this new benefit would increase the relative EHB benefit value by 0.3% annually, however several comparison benchmark EHB benchmark plans also had +0.3% relative benefit value, as compared to the existing EHB benchmark plan. As such, this actuarial analysis determined that the additional EHB benefit would not exceed the most generous comparison plan, thus satisfying the generosity test.

[54] 45 CFR 156.111(a)
[55] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SD-Plan-Documents.zip

Exhibit 7. State Examples of 2020 and 2021 EHB Changes

Two states submitted a request to change their EHB benchmark plan in 2020 and/or 2021, both of which were approved by HHS. Both of these states utilized the third option of "selecting a set of benefits that would become the state's EHB benchmark plan." Using this third option, both states maintained their current EHB benchmark plan while supplementing their EHBs with an additional set of benefits.

- **Illinois: 2020-2021**(a): Within the prescription drug category and mental health substance use disorder services category, instituted a new Access to Care and Treatment (ACT) Plan to reduce opioid addiction and expand access to mental health services:
  - Cover alternative therapies for pain like topic anti-inflammatories
  - Limit opioid prescriptions for acute pain to 7 days maximum
  - Remove barriers to obtaining Buprenorphine products for medically assisted treatment (MAT) of opioid use disorder
  - Cover prescriptions for naloxone when high opioid doses are prescribed
  - Cover tele-psychiatry care by both a prescriber and a licensed therapist
- **South Dakota 2021**: Within the "Habilitation Services" category of the 10 EHB categories:
  - Treatment for Autism Spectrum Disorder with Applied Behavioral Analysis (ABA) is covered with the following limits: up to 1300 hours/year through age 6, up to 900 hours/year for ages 7-13, up to 450 hours/year for ages 14-18

Notes: (a) https://www2.illinois.gov/IISNews/18098-DOI_Essential_Health_Benefit-benchmark_plan_Release.pdf
(b) https://dlr.sd.gov/insurance/documents/SD_proposed_EHB_benchmark_summary_04292019.pdf

Essential Health Benefits Benchmark Plan Selection for 2020 and 2021

States had until July 2, 2018 to submit a new EHB benchmark plan for the 2020 plan year. In addition to submitting required documents to HHS, states were required to provide public notice and an opportunity for public comment on the potential EHB benchmark plan change. One state, Illinois, elected to change its EHB benchmark plan for the 2020 plan year (and onwards) by utilizing the third option of "selecting a set of benefits that would become the state's EHB benchmark plan." The Illinois EHB benchmark plan was subsequently approved by HHS. More details discussing the Illinois change can be found in Exhibit 7.

HHS issued a subsequent Notice of Benefit and Payment Parameters final rule on April 25, 2019.[56] Unlike the final rule issued in 2018, 2019's final rule did not lead to any changes in EHB benchmark plan selection. Instead, this rule maintained the previous changes and issued a deadline of May 6, 2019 for states to submit a new EHB benchmark plan for the 2021 plan year. This year, a single state, South Dakota, proposed a change to its EHB benchmark plan for the 2021 plan year (and onwards) by choosing the third option of "selecting a set of benefits that would become the state's EHB benchmark plan." The change to South Dakota's benchmark plan, was approved by HHS (Exhibit 7).

States that did not choose to exercise the new flexibility continue to use the same EHB benchmark plan from plan years 2017-2019.[57]

[56] 84 FR 17454
[57] Information on Essential Health Benefits (EHB) Benchmark Plans. *Centers for Medicare and Medicaid Services.* 2019. Accessed on December 16, 2019 at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb

Exhibit 8. California's EHB Benchmark Plan for Plan Years 2020-2021

California did not actively make a new selection for the EHB Benchmark plan for plan years 2020 and 2021 and therefore the existing benchmark plan (Kaiser Foundation Health Plan Small Group HMO 30 plan) continues as the identified plan.

Essential Health Benefits for Plan Year 2022

In the April 25, 2019 *Notice of Benefit and Payment Parameters* final rule,[58] HHS advised states of the deadline to select an EHB benchmark plan for the 2022 plan year. States have until **May 8, 2020** to submit the required documentation to HHS. The 2019 final rule continues to allow states to select from the three EHB benchmark plan option alternatives, in addition to the option of maintaining the current EHB benchmark plan.

The final rule emphasized the statutory prohibition on EHB discrimination contained in 45 CFR 156.125, which is also summarized in item 5 of *Essential Health Benefits: Scope of Benefits*. This means that any reduction in the generosity of an EHB for subsets of individuals that is not based on clinically indicated, reasonable medical management practices is potentially discriminatory and is thus prohibited.[59] The final rule explained this by discussing the example of an EHB plan inappropriately excluding a particular treatment for an opioid use disorder when the same treatment is covered for other medically necessary purposes. This example and other mentions of the opioid use disorder demonstrate that HHS is particularly concerned by continued discrimination with regard to treatment of this specific disorder. Noting that not all QHPs cover all forms of Medication-Assisted Treatment (MAT) for opioid use disorder, HHS encourages "…every health insurance plan to provide comprehensive coverage of MAT, even if the applicable EHB-benchmark plan does not require the inclusion of all four MAT drugs…"[60]

If a state does not make an active EHB selection by May 8, 2020, the state's EHB benchmark plan for the applicable year will be the state's EHB benchmark plan from the prior year.[61] For California, if a new plan is not chosen, the Kaiser Foundation Health Plan Small Group HMO 30 plan will continue to serve as the EHB benchmark plan.

2022 Essential Health Benefits: California Options

In accordance with the previously mentioned final rule, California has until May 8, 2020 to submit documents to HHS. While California can choose to continue to utilize the current EHB benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, California can also choose to utilize one of the 3 original options outlined in Exhibit 2, or select one of the new options as described above. By selecting some or all categories from another state's EHB benchmark plan, California has the ability to include new services that are not currently in the California benchmark plan. CHBRP is aware of three specific benefits that are covered by many other state EHB benchmark plans but that are not included in the current Kaiser Foundation Health Plan Small Group HMO 30 plan.

Chiropractic care services are not currently covered in California's EHB benchmark plan. Among the 50 state and District of Columbia EHB benchmark plans for the 2019 plan year, 46 of these 51 plans covered chiropractic care services to some extent.[62] Many of these plans incorporated utilization management, such as referrals, prior authorizations or annual visit maximums (i.e. 10 or 25 chiropractic visits per year) to limit the benefit. Chiropractic care services are typically included under the Rehabilitative and Habilitative Services category of EHBs.

[58] 84 FR 17454
[59] Ibid.
[60] ibid
[61] 45 CFR 156.111
[62] As the 2017 EHB benchmark plan remained for years 2018 and 2019, this analysis of 2017 EHB benchmark plan covered benefits is still accurate for the 2019 plan year: https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf

Hearing aids, aside from cochlear implants, are not currently covered in California's EHB benchmark plan. As of the 2019 plan year, 25 states and the District of Columbia include hearing aids in their current EHB benchmark plan.[63] Nearly all of these plans include age limits, typically covering hearing aids only among enrollees under age 18 or 21. While all of these 25 state plans and the District of Columbia's cover removable hearing aids, several other plans only cover bone-anchored hearing aids. Hearing aids are included under the Rehabilitative and Habilitative Services category of EHBs.

Infertility services and treatments, including in-vitro fertilization (IVF), are not currently covered in California's EHB benchmark plan. As of the 2019 plan year, 25 states and the District of Columbia include some level of infertility services in their current benchmark plan.[64] However, the covered infertility services are almost always limited to diagnostic services and a select few infertility treatment medications. Only a few states, such as Connecticut, Hawaii and Illinois, are known to cover IVF. Among the states that cover IVF, enrollees are limited in the number of covered IVF cycles, often two cycles. When covered, infertility services and treatments are typically incorporated among one or more EHB categories, including Ambulatory Patient Services, Prescription Drugs and Maternity and Newborn Care.

Should California desire to include any of these above benefits, the state can select another state's EHB benchmark plan in whole or in part. California can replace its plan entirely with another state or only replace one category, such as Rehabilitative and Habilitative Services. California can also choose a third option of "selecting a set of benefits that would become the State's EHB-benchmark plan."[65] Illinois and South Dakota, which altered their EHB benchmark plans in 2020 and 2021, respectively, both chose to use this third option to supplement their existing EHB benchmark plans with additional benefits.

Conclusion

HHS's recent regulations provide an option for states to modify or select a new EHB benchmark plan. Though the regulations allow for considerable flexibility, HHS maintains a minimum scope of benefits floor as well as a Generosity Test ceiling. Within these confines, California could use one of the three new EHB benchmark plan options to supplement its set of benefits. The two states which have already done so both chose to keep their current benchmark plan while adding a specific set of benefits within one or two EHB categories. California can look to these two states and the new regulations as it decides whether to change its EHB benchmark plan.

[63] ibid
[64] ibid
[65] 45 CFR 156.111(a)

APPENDIX A FEDERAL BENEFIT MANDATES

Federal benefit mandates, like state benefit mandates, generally apply to both the individual and group markets, unless a market is specifically excluded from the federal benefit mandate coverage requirement. However, federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. There were federal benefit mandates in place prior to the passage of the ACA, and the ACA added federal benefit mandates that apply to many, but not all, DMHC-regulated plans and CDI-regulated policies in the individual and group markets in California. CHBRP's document *Health Insurance Benefit Mandates in California State and Federal Law*[66] lists the federal benefit mandates currently known to CHBRP.

Federal Benefit Mandates Prior to the Affordable Care Act

CHBRP is aware of four federal benefit mandates that were in effect prior to the ACA:[67]

- The Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act (Pregnancy Discrimination Act);
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act);
- The Women's Health and Cancer Rights Act (WHCRA); and
- The Mental Health Parity and Addiction Equity Act (MHPAEA).

For these federal benefit mandates, the mandate applies to the group market,[68] and only applies *if* coverage for the service or treatment is part of the health plan or policy. For example, the Newborns' Act does not require that a group plan or policy cover maternity, but, if maternity is covered, coverage for a minimum length of stay in a hospital following childbirth is required.

Federal Benefit Mandates in the Affordable Care Act

The passage of the ACA added additional federal benefit mandates to products in the individual and group market, with the exception in some cases of grandfathered health plans.[69] These new federal benefit mandates include:

- Prohibitions on lifetime and annual limits on the dollar value of benefits for any individual.[70]
- Where emergency services are provided, requirements that the services are provided: regardless of whether the provider is in or out of network; with the same cost-sharing levels in network as out of network; and without prior authorization.[71]
- Prohibition on requiring prior authorization or referral before covering services from a health care professional who specializes in obstetrics or gynecology.[72]
- Prohibition on denying coverage for children with preexisting conditions.
- Prohibition on denying coverage to anyone with a preexisting condition.[73]

[66] Available at: www.chbrp.org/other_publications/index.php.
[67] There may be other federal benefit mandates that are not included in this list. The federal health insurance benefit mandates discussed in this Issue Brief most closely align with the definition of benefit mandates in CHBRP's authorizing statute.
[68] How the group market is defined for federal benefit mandates does not always align with how the group market is defined for state benefit mandates. For example, the Newborns' Act applies to group plans with 15 or more people.
[69] Some of the new federal benefit mandates in the ACA do not apply to grandfathered health plans (ACA Section 1251).
[70] ACA Section 1001 modifying Section 2711 of the PHSA.
[71] ACA Section 1001 modifying Section 2719A of the PHSA.
[72] Ibid.
[73] ACA Section 1201 modifying Section 2704 of the PHSA.

- Requirements for coverage of specified preventive health services without cost sharing, including:[74,75]
  - Evidence-based items or services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF)[76];
  - Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[77];
  - Infants, children, and adolescents of evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);[78] and
  - Preventive care and screenings for women provided for in comprehensive guidelines supported by HRSA.[79]

In addition to these new federal benefit mandates in the ACA, the ACA also expands the Mental Health Parity and Addiction Equity Act by applying it to QHPs offered in a state's exchange "in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."[80] The ACA further expands MHPAEA to include the individual market and the small-group market, which were previously excluded from this parity requirement.[81]

The Interaction of Federal and State Benefit Mandates

Just as state benefit mandates vary and may overlap with each other, federal benefit mandates and state benefit mandates also vary and may overlap across products and markets, as well as the conditions and disorders addressed by the benefit mandates. For example, the federal Newborns' Act requiring a minimum length of stay in a hospital following childbirth, if maternity services are covered, is very similar to a California state benefit mandate. Both the federal and state benefit mandates affect group DMHC-regulated plans and CDI-regulated policies, however, the state benefit mandate affects individual-market DMHC-regulated plans and CDI-regulated policies, whereas the federal benefit mandate does not. It is important to note that plans and policies subject to both state and federal benefit mandates must meet or exceed the more demanding benefit mandate, whether that is the state benefit mandate or the federal benefit mandate.

[74] ACA Section 1001 modifying Section 2713 of the PHSA.
[75] CHBRP has a Resource looking at the preventive services coverage requirement in the ACA, available at: www.chbrp.org/other_publications/index.php.
[76] A list of the USPSTF A and B recommendations is available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ .
[77] A list of the immunizations recommended by the ACIP is available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
[78] Comprehensive guidelines for infants, children, and adolescents supported by HRSA appear in two charts: the periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at http://https://www.aap.org/en-us/documents/periodicity_schedule.pdf, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at: https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/rusp-uniform-screening-panel.pdf.
[79] A list of the guidelines supported by HRSA for women's preventive care and screening is available at: https://www.hrsa.gov/womens-guidelines/index.html.
[80] ACA Section 1311(j).
[81] ACA Section 1563(c)(4) modifying Section 2726 of the PHSA.

APPENDIX B MEDICAID AND ESSENTIAL HEALTH BENEFITS

Since 2006, states have had the option to identify Medicaid benchmark plans for certain groups of enrollees under section 1937 of the Social Security Act.[82] The ACA renamed Section 1937 Medicaid benchmark or benchmark-equivalent plans "Alternative Benefit Plans" (ABPs), and specified that they must cover the 10 Essential Health Benefits (as defined in section 1302 of the ACA) to which some commercial health insurance, as specified earlier in this brief, is subject.[83] Adults in the Medicaid Expansion population (i.e. individuals eligible under the "modified adjusted gross income standard") must be covered under ABPs, and states may use an ABP for coverage of any other groups of individuals eligible for Medi-Cal.[84]

Section 1937 of the Social Security Act provides the following options for selection of ABPs:[85]

- The benefit package provided by the Federal Employees Health Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option;
- State employee health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- (Federal Health and Human Services) Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage.

The benefits included in California's ABP (currently Blue Cross Blue Shield/CareFirst Preferred Option 1) are the same benefits as full-scope Medi-Cal benefits, discussed in Attachment 3.1-A and 3.1-B of California's State Plan.[86]

If state or federal law adds or changes a benefit, Medi-Cal would either need to cover the benefit or list an actuarially equivalent benefit.[87] In that case, the Department of Health Care Services would submit a State Plan Amendment to draw down federal funding for providing these services to beneficiaries.[88]

It is important to note that while Medi-Cal is also required to cover the 10 EHB categories, the specific benefits included in the chosen Medi-Cal benchmark plan may be different from the specific benefits included in the commercial benchmark plan because the EHB benchmark plan is different from the ABP in California.

[82] 42 U.S.C. §1396u-7.
[83] Like the State Plan, the ABP is a contract between the Department of Health Care Services and the Center for Medicare and Medicaid Services for Title XIX funding for Medicaid Services.
[84] Alternative Benefit Plan Final Rule. *Federal Register*, Vol. 78, No. 135. July 14, 2013. Available at: https://www.govinfo.gov/content/pkg/FR-2013-07-15/pdf/2013-16271.pdf.
[85] 42 U.S.C. §1396u-7, as described by the Alternative Benefit Plan Final Rule, cited above.
[86] California's state plan can be found online at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx. This is also consistent with WIC § 14132.02.
[87] As required by 42 U.S.C. §18022(d).
[88] Communication between CHBRP and the Department of Health Care Services. October 14, 2019.

ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

Garen Corbett, MS
Director

Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org

116TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
116–414

STATE HEALTH CARE PREMIUM REDUCTION ACT

MARCH 9, 2020.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PALLONE, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1425]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1425) to amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

The amendment is as follows:

99–006

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "State Health Care Premium Reduction Act".

SEC. 2. IMPROVE HEALTH INSURANCE AFFORDABILITY FUND.

Subtitle D of title I of the Patient Protection and Affordable Care Act is amended by inserting after part 5 (42 U.S.C. 18061 et seq.) the following new part:

"PART 6—IMPROVE HEALTH INSURANCE AFFORDABILITY FUND

"SEC. 1351. ESTABLISHMENT OF PROGRAM.

"There is hereby established the 'Improve Health Insurance Affordability Fund' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide funding, in accordance with this part, to the 50 States and the District of Columbia (each referred to in this section as a 'State') beginning on January 1, 2020, for the purposes described in section 1352.

"SEC. 1352. USE OF FUNDS.

"(a) IN GENERAL.—A State shall use the funds allocated to the State under this part for one of the following purposes:

"(1) To provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage (other than through a plan described in subsection (b)) offered by such issuers.

"(2) To provide assistance (other than through payments described in paragraph (1)) to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled under qualified health plans offered on the individual market through an Exchange.

"(b) EXCLUSION OF CERTAIN GRANDFATHERED AND TRANSITIONAL PLANS.—For purposes of subsection (a), a plan described in this subsection is the following:

"(1) A grandfathered health plan (as defined in section 1251).

"(2) A plan (commonly referred to as a 'transitional plan') continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, February 13, 2017, April 9, 2018, and March 25, 2019, or under any subsequent extensions thereof.

"(3) Student health insurance coverage (as defined in section 147.145 of title 45, Code of Federal Regulations).

"SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

"(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

"(1) IN GENERAL.—To be eligible for an allocation of funds under this part for a year (beginning with 2020), a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2020, not later than 90 days after the date of the enactment of this part and, in the case of allocations for a subsequent year, not later than March 1 of the previous year) and in such form and manner as specified by the Administrator containing—

"(A) a description of how the funds will be used; and

"(B) such other information as the Administrator may require.

"(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this part and of the reason for such denial.

"(3) 5-YEAR APPLICATION APPROVAL.—If an application of a State is approved for a purpose described in section 1352 for a year, such application shall be treated as approved for such purpose for each of the subsequent 4 years.

"(4) REVOCATION OF APPROVAL.—The approval of an application of a State, with respect to a purpose described in section 1352, may be revoked if the State fails to use funds provided to the State under this section for such purpose or otherwise fails to comply with the requirements of this section.

"(b) DEFAULT FEDERAL SAFEGUARD.—

"(1) 2020.—For 2020, in the case of a State that does not submit an application under subsection (a) by the 90-day submission date applicable to such year under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

"(2) 2021 AND SUBSEQUENT YEARS.—For 2021 or a subsequent year, in the case of a State that does not have in effect an approved application under this section for such year, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

"(3) SPECIFIED USE.—The amount described in paragraph (4), with respect to 2020 or a subsequent year, shall be used to carry out the purpose described in section 1352(a)(1) in each State described in paragraph (1) or (2) for such year, as applicable, by providing reinsurance payments to health insurance issuers with respect to attachment range claims (as defined in section 1354(b)(2)), using the dollar amounts specified in subparagraph (B) of such section for such year) in an amount equal to, subject to paragraph (5), the percentage (specified for such year by the Secretary under such subparagraph) of the amount of such claims.

"(4) AMOUNT DESCRIBED.—The amount described in this paragraph, with respect to 2020 or a subsequent year, is the amount equal to the total sum of amounts that the Secretary would otherwise estimate under section 1354(b)(2)(A)(i) for such year for each State described in paragraph (1) or (2) for such year, as applicable, if each such State were not so described for such year.

"(5) ADJUSTMENT.—For purposes of this subsection, the Secretary may apply a percentage under paragraph (3) with respect to a year that is less than the percentage otherwise specified in section 1354(b)(2)(B) for such year, if the cost of paying the total eligible attachment range claims for States described in this subsection for such year at such percentage otherwise specified would exceed the amount calculated under paragraph (4) for such year.

"SEC. 1354. ALLOCATIONS.

"(a) APPROPRIATION.—For the purpose of providing allocations for States under subsection (b) and payments under section 1353(b) there is appropriated, out of any money in the Treasury not otherwise appropriated, $10,000,000,000 for 2020 and each subsequent year.

"(b) ALLOCATIONS.—

"(1) PAYMENT.—

"(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Secretary shall, with respect to a State not described in section 1353(b) for such year and not later than the date specified under subparagraph (B) for such year, allocate for such State the amount determined for such State and year under paragraph (2).

"(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this subparagraph is—

"(i) for 2020, the date that is 45 days after the date of the enactment of this part; and

"(ii) for 2021 or a subsequent year, January 1 of the respective year.

"(C) NOTIFICATIONS OF ALLOCATION AMOUNTS.—For 2021 and each subsequent year, the Secretary shall notify each State of the amount determined for such State under paragraph (2) for such year by not later than January 1 of the previous year.

"(2) ALLOCATION AMOUNT DETERMINATIONS.—

"(A) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State described in paragraph (1)(A) for such year is the amount equal to—

"(i) the amount that the Secretary estimates would be expended under this part for such year on attachment range claims of individuals residing in such State if such State used such funds only for the purpose described in paragraph (1) of section 1352(a) at the dollar amounts and percentage specified under subparagraph (B) for such year; minus

"(ii) the amount, if any, by which the Secretary determines—

"(I) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attrib-

utable to individuals residing in such State for such year without application of this part; exceeds

"(II) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for such year if such State were a State described in section 1353(b) for such year.

For purposes of the previous sentence and section 1353(b)(3), the term 'attachment range claims' means, with respect to an individual, the claims for such individual that exceed a dollar amount specified by the Secretary for a year, but do not exceed a ceiling dollar amount specified by the Secretary for such year, under subparagraph (B).

"(B) SPECIFICATIONS.—For purposes of subparagraph (A) and section 1353(b)(3), the Secretary shall determine the dollar amounts and the percentage to be specified under this subparagraph for a year in a manner to ensure that the total amount of expenditures under this part for such year is estimated to equal the total amount appropriated for such year under subsection (a) if such expenditures were used solely for the purpose described in paragraph (1) of section 1352(a) for attachment range claims at the dollar amounts and percentage so specified for such year.

"(3) AVAILABILITY.—Funds allocated to a State under this subsection for a year shall remain available through the end of the subsequent year.".

I. PURPOSE AND SUMMARY

H.R. 1425, the "State Health Care Premium Reduction Act," was introduced on February 28, 2019, by Reps. Craig (D–MN) and Peters (D–CA) and referred to the Committee on Energy and Commerce.

The goal of H.R. 1425 is to provide $10 billion annually to States, with the option for States to establish a state reinsurance program or use the funds to provide financial assistance to reduce premium costs and out-of-pocket costs for individuals enrolled in qualified health plans. The legislation further requires the Centers for Medicare and Medicaid Services (CMS) to establish and implement a reinsurance program in States that do not apply for federal funding. The legislation sets a State's allocation amount based on the State's share of claims of high-cost enrollees.

II. BACKGROUND AND NEED FOR LEGISLATION

The Affordable Care Act (ACA) established a transitional reinsurance program that provided payments to individual market health plans for high-cost enrollees with significant medical needs. The reinsurance program, which sunset in 2016, helped reduce premiums for all enrollees in the individual market.

The Administration has issued several regulations and implemented policy changes that have resulted in an increase in premiums.[1] A study by the Kaiser Family Foundation estimates that 2019 premiums are 16 percent higher than they otherwise would be due to the Administration's actions to eliminate the law's cost-sharing subsidies, expand the availability of short-term limited duration insurance (STLDI), and the repeal of the individual mandate.[2]

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[1] The Brookings Institution, *How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?* (Aug. 2018) (www.brookings.edu/wp-content/uploads/2018/08/Individual-Market-Premium-Outlook-20191.pdf).

[2] Henry J Kaiser Family Foundation, *How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums* (Oct. 26, 2018) (www.kff.org/health-reform/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/?utm_campaign=KFF-2018-October-Health-Costs-ACA-Premiums-Marketplaces).

The Administration's regulatory and policy changes have contributed to an increase in health care costs for individuals who are not eligible for the ACA's tax subsidies and has caused a significant decrease in enrollment among this population.[3] Premiums in the individual market increased approximately 17 percent in 2018 versus 2017, and unsubsidized enrollment outside the ACA marketplaces decreased by 2.3 million.[4]

H.R. 1425 would provide $10 billion annually to States to reinstitute the ACA's reinsurance program and reduce health care costs for enrollees in the individual market.

III. Committee Hearings

For the purposes of section 103(i) of H. Res. 6 of the 116th Congress, the following hearing was used to develop or consider H.R. 1425:

On March 6, 2019, the Subcommittee on Health held a hearing on H.R. 1425 entitled, "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access." The Subcommittee received testimony from the following witnesses:

- Peter Lee, Executive Director, Covered California;
- Audrey Morse Gasteier, Chief of Policy, Massachusetts Health Connector; and
- J.P. Wieske, Vice President, State Affairs, Council for Affordable Health Coverage.

IV. Committee Consideration

H.R. 1425, the "State Health Care Premium Reduction Act," was introduced on February 28, 2019, by Reps. Craig (D–MN) and Peters (D–CA) and referred to the Committee on Energy and Commerce. The bill was then referred to the Subcommittee on Health on March 1, 2019. Following a legislative hearing, the Subcommittee met, pursuant to notice, in open markup session to consider H.R. 1425. Mr. Pallone offered an amendment in the nature of a substitute (AINS) to the bill. Mr. Burgess offered an amendment to the Pallone AINS, which was defeated by a roll call vote of 12 yeas to 17 nays (roll call # HE—3). A vote occurred on the Pallone AINS, which was agreed to by a roll call vote of 18 yeas to 12 nays (roll call # HE—4). The Subcommittee on Health then agreed to a motion by Ms. Eshoo, chairwoman of the subcommittee, to forward favorably H.R. 1425, amended, to the full Committee by a record vote of 18 yeas to 13 nays (roll call #HE—5).

On April 3, 2019, the full Committee on Energy and Commerce met, pursuant to notice, in open markup session to consider H.R. 1425, as amended by the Subcommittee on Health. Mr. Burgess offered an amendment, which was subsequently withdrawn. Mr. Pallone offered an amendment that was agreed to by a voice vote. Mrs. Rodgers offered an amendment that was defeated by a voice vote. The full Committee then agreed to a motion by Mr. Pallone, chairman of the committee, to order H.R. 1425 favorably reported to the

[3] Centers for Medicare & Medicaid Services, *Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment* (July 2, 2018) (www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf).

[4] Kaiser Family Foundation, *Data Note: Changes in Enrollment in the Individual Health Insurance Market* (July 31, 2018) (www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market).

House, amended, by a record vote of 30 yeas to 22 nays, a quorum being present (roll call # 20)—Final Passage.

V. COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list each record vote on the motion to report legislation and amendments thereto. The Committee advises that there were 5 record votes taken on H.R. 1425, including three record votes taken during subcommittee markup, and a motion by Mr. Pallone during full Committee markup ordering H.R. 1425 reported favorably to the House, amended. The motion on final passage of the bill was approved by a record vote of 30 yeas to 22 nays. The following are the record votes taken during Committee consideration, including the names of those members voting for and against:

COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
116th CONGRESS
ROLL CALL VOTE # 3 (HE)

BILL: H.R. 1425, the "State Health Care Premium Reduction Act"

AMENDMENT: An amendment to the Pallone AINS offered by Mr. Burgess, No. 1a, to limit the receipt of funds allocated to States under the part 6 of Subtitle D of title 1 in the Patient Protection and Affordable Care Act that would not be permitted under section 2105 of the Social Security Act.

DISPOSITION: NOT AGREED TO by a roll call vote of 12 yeas to 17 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Rep. Eshoo		X		Rep. Burgess	X		
Rep. Engel				Rep. Upton	X		
Rep. Butterfield		X		Rep. Shimkus	X		
Rep. Matsui		X		Rep. Guthrie	X		
Rep. Castor		X		Rep. Griffith	X		
Rep. Sarbanes				Rep. Bilirakis	X		
Rep. Luján		X		Rep. Long	X		
Rep. Schrader		X		Rep. Bucshon	X		
Rep. Kennedy		X		Rep. Brooks			
Rep. Cárdenas		X		Rep. Mullin	X		
Rep. Welch		X		Rep. Hudson	X		
Rep. Ruiz		X		Rep. Carter	X		
Rep. Dingell		X		Rep. Gianforte			
Rep. Kuster		X		Rep. Walden	X		
Rep. Kelly		X					
Rep. Barragán		X					
Rep. Blunt Rochester		X					
Rep. Rush		X					
Rep. Pallone		X					

03/27/2019

COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
116th CONGRESS
ROLL CALL VOTE # 4 (HE)

BILL: H.R. 1425, the "State Health Care Premium Reduction Act"

AMENDMENT: An Amendment in the Nature of a Substitute to H.R. 1425, offered by Mr. Pallone, No. 1, to amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market.

DISPOSITION: AGREED TO by a roll call vote of 18 yeas to 12 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Rep. Eshoo	X			Rep. Burgess		X	
Rep. Engel	X			Rep. Upton		X	
Rep. Butterfield	X			Rep. Shimkus		X	
Rep. Matsui	X			Rep. Guthrie		X	
Rep. Castor	X			Rep. Griffith		X	
Rep. Sarbanes	X			Rep. Bilirakis		X	
Rep. Luján				Rep. Long		X	
Rep. Schrader	X			Rep. Bucshon		X	
Rep. Kennedy	X			Rep. Brooks		X	
Rep. Cárdenas	X			Rep. Mullin		X	
Rep. Welch	X			Rep. Hudson			
Rep. Ruiz	X			Rep. Carter		X	
Rep. Dingell	X			Rep. Gianforte		X	
Rep. Kuster	X			Rep. Walden		X	
Rep. Kelly	X						
Rep. Barragán	X						
Rep. Blunt Rochester	X						
Rep. Rush	X						
Rep. Pallone	X						

03/27/2019

COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
116th CONGRESS
ROLL CALL VOTE # 5 (HE)

BILL: H.R. 1425, the "State Health Care Premium Reduction Act"

MOTION: A motion by Ms. Eshoo to forward favorably **H.R. 1425,** amended, to the full Committee.

DISPOSITION: AGREED TO by a roll call vote of 18 yeas to 13 nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Rep. Eshoo	X			Rep. Burgess	X		
Rep. Engel	X			Rep. Upton	X		
Rep. Butterfield	X			Rep. Shimkus	X		
Rep. Matsui	X			Rep. Guthrie	X		
Rep. Castor	X			Rep. Griffith	X		
Rep. Sarbanes	X			Rep. Bilirakis	X		
Rep. Luján				Rep. Long	X		
Rep. Schrader	X			Rep. Bucshon	X		
Rep. Kennedy	X			Rep. Brooks	X		
Rep. Cárdenas	X			Rep. Mullin	X		
Rep. Welch	X			Rep. Hudson	X		
Rep. Ruiz	X			Rep. Carter	X		
Rep. Dingell	X			Rep. Gianforte			
Rep. Kuster	X			Rep. Walden	X		
Rep. Kelly	X						
Rep. Barragán	X						
Rep. Blunt Rochester	X						
Rep. Rush	X						
Rep. Pallone	X						

03/27/2019

COMMITTEE ON ENERGY AND COMMERCE – 116th CONGRESS
ROLL CALL VOTE # 20

BILL: **H.R. 1425**, the "State Health Care Premium Reduction Act"

MOTION: A motion by Mr. Pallone to order H.R. 1425 reported favorably to the House, amended. (Final Passage)

DISPOSITION: AGREED TO by a roll call vote of 30 yeas to 22 nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Rep. Pallone	X			Rep. Walden		X	
Rep. Rush	X			Rep. Upton		X	
Rep. Eshoo	X			Rep. Shimkus		X	
Rep. Engel	X			Rep. Burgess		X	
Rep. DeGette	X			Rep. Scalise		X	
Rep. Doyle	X			Rep. Latta		X	
Rep. Schakowsky	X			Rep. Rodgers		X	
Rep. Butterfield	X			Rep. Guthrie		X	
Rep. Matsui	X			Rep. Olson		X	
Rep. Castor	X			Rep. McKinley		X	
Rep. Sarbanes	X			Rep. Kinzinger			
Rep. McNerney	X			Rep. Griffith		X	
Rep. Welch	X			Rep. Bilirakis		X	
Rep. Lujan	X			Rep. Johnson		X	
Rep. Tonko	X			Rep. Long			
Rep. Clarke	X			Rep. Buschon		X	
Rep. Loebsack	X			Rep. Flores		X	
Rep. Schrader	X			Rep. Brooks		X	
Rep. Kennedy	X			Rep. Mullin		X	
Rep. Cardenas	X			Rep. Hudson		X	
Rep. Ruiz	X			Rep. Walberg		X	
Rep. Peters	X			Rep. Carter		X	
Rep. Dingell	X			Rep. Duncan		X	
Rep. Veasey	X			Rep. Gianforte		X	
Rep. Kuster	X						
Rep. Kelly	X						
Rep. Barragan	X						
Rep. McEachin							
Rep. Blunt Rochester	X						
Rep. Soto	X						
Rep. O'Halleran	X						

04/04/2019 – 12:06 a.m.

VI. Oversight Findings

Pursuant to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portion of the report.

VII. New Budget Authority, Entitlement Authority, and Tax Expenditures

Pursuant to 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

VIII. Federal Mandates Statement

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

IX. Statement of General Performance Goals and Objectives

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to provide $10 billion annually to states, with the option for states to establish a state reinsurance program or use the funds to provide financial assistance to reduce costs for individuals enrolled in qualified health plans. The bill further requires CMS to establish and implement a reinsurance program in states that do not apply for federal funding.

X. Duplication of Federal Programs

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 1425 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111–139 or the most recent Catalog of Federal Domestic Assistance.

XI. Committee Cost Estimate

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

XII. Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 1425 contains no earmarks, limited tax benefits, or limited tariff benefits.

XIII. Advisory Committee Statement

No advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act was created by this legislation.

XIV. Applicability to Legislative Branch

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

XV. Section-by-Section Analysis of the Legislation

Section 1. Short title

Section 1 designates that the short title may be cited as the "State Health Care Premium Reduction Act".

Sec. 2. Improve Health Insurance Affordability Fund

Section 2 amends Subtitle D of title I of the Affordable Care Act (ACA) by inserting a new subdivision, Part 6—Improve Health Insurance Affordability Fund. As part of the new subdivision, section 2 adds the following new sections to the ACA, sec. 1351, sec. 1352, sec. 1353, and sec. 1354. The new subdivision and the new sections are as follows:

PART 6—IMPROVE HEALTH INSURANCE AFFORDABILITY FUND

Sec. 1351. Establishment of program

Section 1351 establishes the "Improve Health Insurance Affordability Fund" to be administered by the Secretary of Health and Human Services (HHS) to provide funding to States and the District of Columbia beginning on January 1, 2020.

Sec. 1352. Use of funds

Section 1352 establishes the purpose for the use of funds. This section allows states to use the funds to establish a state reinsurance program and provide payment to insurers for high-cost individuals enrolled in health insurance coverage in the individual market. States may also use the funds to provide financial assistance to reduce costs for individuals enrolled in qualified health plans. The section excludes the use of funds for grandfathered plans, transitional plans, and student health insurance coverage.

Sec. 1353. State eligibility and approval; Default safeguard

Section 1353 establishes the application process and timeline for States to apply for the funds. This section requires States to apply to the CMS Administrator and allows States to receive automatic approval for a period of five years. For 2020, States are required to apply no later than 90 days after the date of enactment, and for subsequent years, no later than March 1 of the previous year. This section requires CMS to implement a default federal reinsurance program in states that do not apply for federal funding. This section allows for state funds to be revoked if a state fails to use the funds for the intended purpose described in the legislation. The section also allows the HHS Secretary to make an adjustment to

the allocation formula if total eligible claims for states exceed the amount calculated for a year.

Sec. 1354. Allocations

Section 1354 appropriates $10 billion annually and establishes the allocation methodology. This section requires the HHS Secretary to allocate funds to a State based on the estimated expenditure on attachment range claims for individuals in that state if such State used the funds for the purposes of administering a reinsurance program. For 2020, the HHS Secretary is required to notify States of the allocation amount 45 days after the date of enactment, and for subsequent years, no later than January 1 of the previous year. This section provides the HHS Secretary the authority to establish the attachment range claims and requires the Secretary to set the attachment range claims in a manner to ensure that the amount of expenditures equals the amount appropriated for such year. The section also allows the funds allocated to a State for a year to remain available through the end of the subsequent year.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * * * *

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * * * *

Subtitle D—Available Coverage Choices for All Americans

* * * * * * *

PART 6—IMPROVE HEALTH INSURANCE AFFORDABILITY FUND

SEC. 1351. ESTABLISHMENT OF PROGRAM.

There is hereby established the "Improve Health Insurance Affordability Fund" to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the "Administrator"), to provide funding, in accordance with this part, to the 50 States and the District of Columbia (each referred to in

this section as a "State") beginning on January 1, 2020, for the purposes described in section 1352.

SEC. 1352. USE OF FUNDS.

(a) IN GENERAL.—A State shall use the funds allocated to the State under this part for one of the following purposes:

(1) To provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage (other than through a plan described in subsection (b)) offered by such issuers.

(2) To provide assistance (other than through payments described in paragraph (1)) to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled under qualified health plans offered on the individual market through an Exchange.

(b) EXCLUSION OF CERTAIN GRANDFATHERED AND TRANSITIONAL PLANS.—For purposes of subsection (a), a plan described in this subsection is the following:

(1) A grandfathered health plan (as defined in section 1251).

(2) A plan (commonly referred to as a "transitional plan") continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, February 13, 2017, April 9, 2018, and March 25, 2019, or under any subsequent extensions thereof.

(3) Student health insurance coverage (as defined in section 147.145 of title 45, Code of Federal Regulations).

SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

(1) IN GENERAL.—To be eligible for an allocation of funds under this part for a year (beginning with 2020), a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2020, not later than 90 days after the date of the enactment of this part and, in the case of allocations for a subsequent year, not later than March 1 of the previous year) and in such form and manner as specified by the Administrator containing—

(A) a description of how the funds will be used; and

(B) such other information as the Administrator may require.

(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this part and of the reason for such denial.

(3) 5-YEAR APPLICATION APPROVAL.—If an application of a State is approved for a purpose described in section 1352 for a year, such application shall be treated as approved for such purpose for each of the subsequent 4 years.

(4) REVOCATION OF APPROVAL.—The approval of an application of a State, with respect to a purpose described in section 1352, may be revoked if the State fails to use funds provided to the State under this section for such purpose or otherwise fails to comply with the requirements of this section.

(b) DEFAULT FEDERAL SAFEGUARD.—

(1) 2020.—For 2020, in the case of a State that does not submit an application under subsection (a) by the 90-day submission date applicable to such year under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

(2) 2021 AND SUBSEQUENT YEARS.—For 2021 or a subsequent year, in the case of a State that does not have in effect an approved application under this section for such year, the Administrator, in consultation with the State insurance commissioner, shall, from the amount calculated under paragraph (4) for such year, carry out the purpose described in paragraph (3) in such State for such year.

(3) SPECIFIED USE.—The amount described in paragraph (4), with respect to 2020 or a subsequent year, shall be used to carry out the purpose described in section 1352(a)(1) in each State described in paragraph (1) or (2) for such year, as applicable, by providing reinsurance payments to health insurance issuers with respect to attachment range claims (as defined in section 1354(b)(2)), using the dollar amounts specified in subparagraph (B) of such section for such year) in an amount equal to, subject to paragraph (5), the percentage (specified for such year by the Secretary under such subparagraph) of the amount of such claims.

(4) AMOUNT DESCRIBED.—The amount described in this paragraph, with respect to 2020 or a subsequent year, is the amount equal to the total sum of amounts that the Secretary would otherwise estimate under section 1354(b)(2)(A)(i) for such year for each State described in paragraph (1) or (2) for such year, as applicable, if each such State were not so described for such year.

(5) ADJUSTMENT.—For purposes of this subsection, the Secretary may apply a percentage under paragraph (3) with respect to a year that is less than the percentage otherwise specified in section 1354(b)(2)(B) for such year, if the cost of paying the total eligible attachment range claims for States described in this subsection for such year at such percentage otherwise specified would exceed the amount calculated under paragraph (4) for such year.

SEC. 1354. ALLOCATIONS.

(a) APPROPRIATION.—For the purpose of providing allocations for States under subsection (b) and payments under section 1353(b) there is appropriated, out of any money in the Treasury not otherwise appropriated, $10,000,000,000 for 2020 and each subsequent year.

(b) ALLOCATIONS.—

(1) PAYMENT.—

(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Secretary shall, with respect to a State not described in section 1353(b) for such year and not later than the date specified under subparagraph (B) for such year, allocate for such State the amount determined for such State and year under paragraph (2).

(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this subparagraph is—

(i) for 2020, the date that is 45 days after the date of the enactment of this part; and

(ii) for 2021 or a subsequent year, January 1 of the respective year.

(C) NOTIFICATIONS OF ALLOCATION AMOUNTS.—For 2021 and each subsequent year, the Secretary shall notify each State of the amount determined for such State under paragraph (2) for such year by not later than January 1 of the previous year.

(2) ALLOCATION AMOUNT DETERMINATIONS.—

(A) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State described in paragraph (1)(A) for such year is the amount equal to—

(i) the amount that the Secretary estimates would be expended under this part for such year on attachment range claims of individuals residing in such State if such State used such funds only for the purpose described in paragraph (1) of section 1352(a) at the dollar amounts and percentage specified under subparagraph (B) for such year; minus

(ii) the amount, if any, by which the Secretary determines—

(I) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for such year without application of this part; exceeds

(II) the estimated amount of premium tax credits under section 36B of the Internal Revenue Code of 1986 that would be attributable to individuals residing in such State for such year if such State were a State described in section 1353(b) for such year.

For purposes of the previous sentence and section 1353(b)(3), the term "attachment range claims" means, with respect to an individual, the claims for such individual that exceed a dollar amount specified by the Secretary for a year, but do not exceed a ceiling dollar amount specified by the Secretary for such year, under subparagraph (B).

(B) SPECIFICATIONS.—For purposes of subparagraph (A) and section 1353(b)(3), the Secretary shall determine the dollar amounts and the percentage to be specified under this subparagraph for a year in a manner to ensure that the total amount of expenditures under this part for such year is estimated to equal the total amount appropriated for such year under subsection (a) if such expenditures were

used solely for the purpose described in paragraph (1) of section 1352(a) for attachment range claims at the dollar amounts and percentage so specified for such year.

(3) AVAILABILITY.—Funds allocated to a State under this subsection for a year shall remain available through the end of the subsequent year.

* * * * * * *

XVII. DISSENTING VIEWS

This bill provides $100 billion over 10 years for States to establish reinsurance programs strictly for individuals enrolled in the Patient Protection and Affordable Care Act's (PPACA) qualified health plans (QHPs). The bill is not paid for, nor does it contain a State match or State allocation formula, delegating the latter to the Secretary of the Department of Health and Human Services (HHS) like the transitional reinsurance program did. Finally, the bill does not include language affirming the long-standing consensus that Federal dollars should not pay for abortion services.

Congress has taken recent steps to provide States with reinsurance opportunities. In the 115th Congress, the House-passed H.R. 1628, the American Health Care Act of 2017, included the Patient and State Stability Fund. This provision would have provided States with the flexibility and resources to cut out-of-pocket costs like premiums and deductibles, promote access to health care services, and repair insurance markets. For States that chose not to access the available funding, the Federal government would have established and implemented a reinsurance program. In addition to reinsurance, the Patient and State Stability Fund's uses of funds included: helping high-risk individuals enroll in health insurance coverage; promoting participation in the individual market and small group market; and providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles. The fund included a modestly phased-in State match, as well as a State allocation formula based on each State's previously incurred claims. The Patient and State Stability Fund was fully paid for and included language affirming the long-standing consensus that Federal dollars should not pay for abortion services.

GREG WALDEN,
Republican Leader, Committee on Energy and Commerce.
MICHAEL C. BURGESS, M.D.,
Republican Leader, Subcommittee on Health, Committee on Energy and Commerce.

Suit Challenging ACA Legally Suspect But Threatens Loss of Coverage for Millions

Center on Budget and Policy Priorities

The Trump Administration and 18 Republican state attorneys general are asking the courts to strike down the entire Affordable Care Act (ACA) as unconstitutional. On March 2, 2020, the Supreme Court agreed to hear the case, with oral arguments expected to take place this fall and a decision likely next spring. The ACA remains the law of the land for now, and legal experts across the political spectrum view the case against it as extremely weak. But if the Administration and Republican states prevail, 20 million people would become uninsured and millions more could be charged more or denied coverage altogether because they have a pre-existing condition or would lose other important protections.

Lawsuit Background and Trump Administration's Position

The state attorneys general filed their lawsuit with a Texas district court in February 2018. The crux of their argument is that the Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* upheld the ACA's individual coverage requirement under Congress's taxing power, and the 2017 tax law zeroed out that tax penalty. Without the tax in place, they claim, the coverage requirement is unconstitutional, making the rest of the ACA also unlawful — an argument that ignores Congress's choice to leave the ACA intact when it zeroed out the tax penalty.

From the start the Trump Administration has refused to defend the ACA, an unprecedented move that seems to have led three senior career attorneys to withdraw from the case and one to resign. But the government's specific position on the case has changed. In June 2018 the Department of Justice (DOJ) largely agreed with the plaintiffs' reasoning, but it asked the court to strike down not the entire law but two critical consumer protections that it said were inextricably linked to the mandate: the prohibitions on insurers denying coverage to people with pre-existing conditions (guaranteed issue) and on charging people higher premiums because of their health status (community rating). It has since endorsed striking down the entire ACA, in line with its many legislative and executive attempts to repeal or undermine it.

District Court Judge Reed O'Connor ruled in favor of the plaintiff states and invalidated the entire ACA in December 2018 but stayed the decision. In December 2019 the Fifth Circuit concurred that the individual mandate was unconstitutional but sent the case back to Judge O'Connor to determine which, if any, portions of the ACA could remain.

A group of Democratic attorneys general led by California intervened to defend the law in court following the Trump Administration's refusal to do so. Following the Fifth Circuit decision, these attorneys general appealed to the Supreme Court, which has agreed to hear the case, now called *California v. Texas.*

What Happens if Trump Administration Prevails?

Striking down the ACA would increase the number of uninsured people by 20 million, or 65 percent, the Urban Institute estimates. (Urban also provides estimates by state and demographic group.) It would end not only the ACA's major coverage expansions — such as Medicaid expansion, premium tax credits, and the health insurance marketplaces — but other important protections as well, harming tens of millions of people who would remain insured.

- Insurers could once again put annual and lifetime limits on coverage, including for people with employer plans.
- Young adults would no longer be able to stay on their parents' plans up to age 26.
- Insurers could reimpose cost sharing for preventive services, including under employer plans and Medicare.
- Reversing the ACA's changes to how Medicare pays plans and providers and how state Medicaid programs determine eligibility would cause massive disruption.
- Medicare beneficiaries would face higher prescription drug costs due to the Medicare "donut hole" reopening.

Higher-income households, meanwhile, would reap $45 billion in tax cuts each year, with an average $46,000 per year for those with incomes over $1 million.

If the courts threw out only parts of the law, the result would be nearly as devastating. For example, allowing insurers to again discriminate based on health status would jeopardize coverage for millions who could be charged more, denied coverage for certain diagnoses, or blocked from individual market coverage altogether. Eliminating ACA protections could also let insurers charge higher premiums to women and people in certain occupations, reimpose pre-existing condition exclusions in employer coverage, and make premium tax credits nearly impossible to administer.

Legal Experts Across Political Spectrum Call Case "Absurd," "Ludicrous"

Legal experts, including experts opposed to the ACA and who supported other legal challenges to the law, almost uniformly agree that the arguments in this case are "absurd" or "ludicrous." Two Republican state attorneys general (from Montana and Ohio) submitted an *amicus* brief stating that "to describe [the plaintiffs' position] is to refute it." Fifth Circuit Judge Carolyn King's dissent called the district court opinion striking down the ACA "textbook judicial overreach." And Republican Senator Lamar Alexander has called the Administration's position that the 2017 tax bill effectively repealed the ACA "as far-fetched as any I've ever heard."

Chief among the many problems with the plaintiffs' argument is that it ignores Congress's unambiguous decision to zero out the individual mandate but leave the rest of the ACA intact. The plaintiffs argue that the mandate is so central to the ACA or its pre-existing condition exclusion that, without it, some or all of the law must be struck down. But while the Congress that passed the ACA said the mandate was important for the reformed insurance market to function, the Congress that zeroed out the penalty decided to keep the other provisions in place. Longstanding legal principles say that Congress, not the court, gets to make that decision — as even a brief from past litigants against the ACA noted.

Major Stakeholders Have Highlighted Catastrophic Effects on the Health System

A diverse group of stakeholders have weighed in to strongly oppose the plaintiffs' arguments. Briefs were filed by:

- **Health care providers and insurers:** American Hospital Association and Federation of American Hospitals; the American Medical Association, American Academy of Family Physicians, American College of Physicians, and American Academy of Pediatrics; and America's Health Insurance Plans (AHIP).
- **Patient and non-profit groups:** American Cancer Society, American Diabetes Association, American Lung Association, and March of Dimes; AARP; and Families USA, Community Catalyst, National Health Law Program, Center on Budget and Policy Priorities, and SEIU.
- **Economists and small business representatives**, including Small Business Majority.

States Suing for Immediate End to ACA		States Defending ACA	
Alabama	Nebraska	California	Minnesota
Arkansas	North Dakota	*Colorado*	*Nevada*
Arizona	South Carolina	Connecticut	New Jersey
Florida	South Dakota	District of Columbia	New York
Georgia	Tennessee	Delaware	North Carolina
Indiana	Texas	Hawaii	Oregon
Kansas	Utah	Illinois	Rhode Island
Louisiana	West Virginia	*Iowa*	Vermont
~~Maine~~	~~Wisconsin~~	Kentucky	Virginia
Mississippi		Massachusetts	Washington
Missouri		*Michigan*	

Note: Strikethrough indicates states that have removed themselves from the lawsuit. Italics indicate states joining after the initial filing. Republican attorneys general from Montana and Ohio filed an *amicus* brief arguing that the mandate is unconstitutional but severable.

The Commonwealth Fund

What Are Americans' Views on the Coronavirus Pandemic?

NBC News/Commonwealth Fund Health Care Poll

March 20, 2020

| Sara R. Collins, Munira Z. Gunja, David Blumenthal, M.D., Christopher Hollander, and Jennifer Wilson

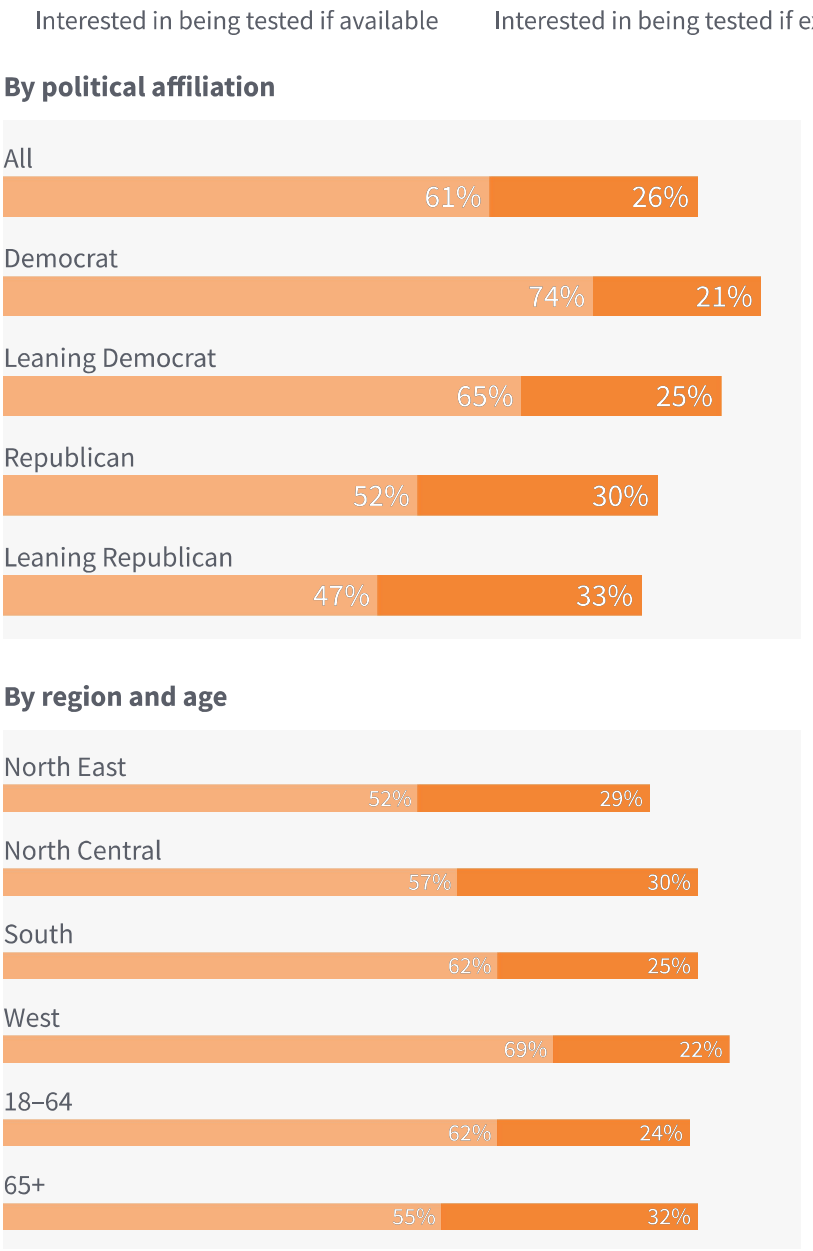
To understand how Americans are viewing the fast-moving coronavirus crisis, NBC News and the Commonwealth Fund took the pulse of U.S. adults over the last week. Between March 10 and March 15, the survey firm SSRS polled 1,006 people age 18 and older about their desire to get tested for the virus, the affordability of treatments and vaccines, and whom they trusted most to provide information about the pandemic. Here's what the poll found.

Findings

Nearly all U.S. adults (87%) want to get tested for the coronavirus, including most Democrats and most Republicans. Six in 10 said they want to get tested if the test is available, while one in four want to get tested if they think they might have been exposed to the virus. A larger percentage of Democrats than Republicans said they want to be screened if the test is available. As of last week, people living in the West were more likely to want to get tested compared to adults living in other regions of the country, regardless of whether they thought they were exposed. However, this geographic disparity is likely diminishing as more cases are identified across the U.S.

Would you want to get tested or not for the coronavirus?

Base: Adults age 18+



Data: NBC News/Commonwealth Fund Health Care Poll: Coronavirus, Mar. 2020 • Note: Adults who considered themselves an "Independent," "Other," or reported "Don't know/refused" were then asked if they lean more toward the Democratic or Republican Party. "Independent," "Other," and "Don't know/refused" categories are not listed.

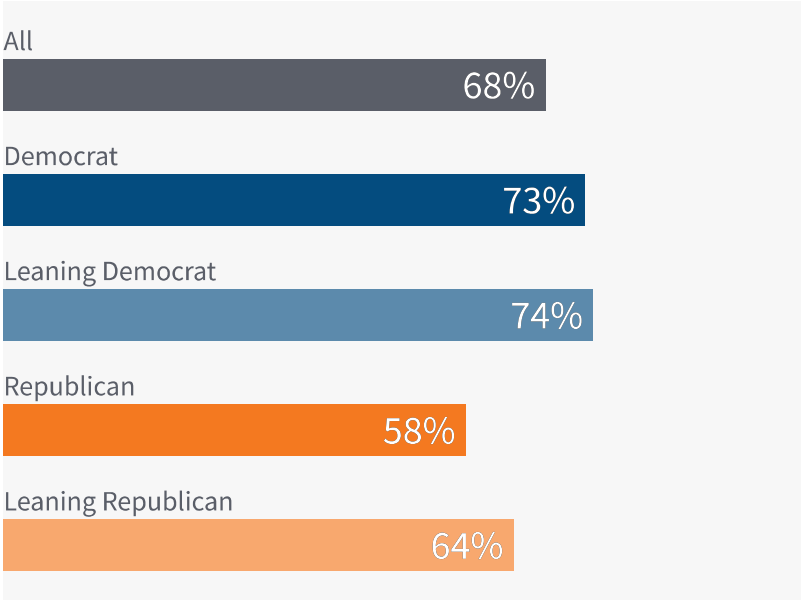
About 30 million people are uninsured in the U.S., while another 44 million have coverage but are underinsured because of the high deductibles and out-of-pocket costs they face. Concerns about the affordability of both health insurance and health care are a major reason why health issues have dominated the 2020 election so far. In our poll, 68 percent of adults said the out-of-pocket costs they might have to pay would be very or somewhat important in their decision to get care if they had symptoms of the coronavirus.

Democrats were substantially more likely than Republicans to say cost would be a factor in their decision to get care. Still, a majority of Republicans reported the same. Similarly, while people with incomes under $50,000 were more likely than those with higher incomes to say cost would factor into their decision to seek care, six of 10 adults with higher incomes also said this. In responses to this question, there was no statistically significant difference between people with insurance and people without it — a sobering reflection of the health care costs Americans face even when they have coverage.

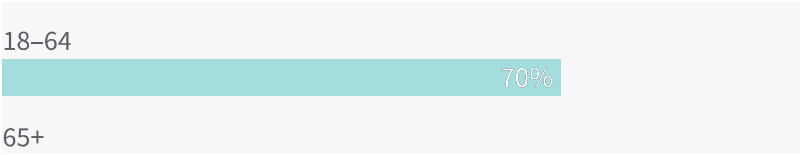
How important would the potential out-of-pocket costs be in your decision to seek care if you experienced any symptoms of the coronavirus?

Base: Adults age 18+

By political affiliation



By age, income, and insurance status

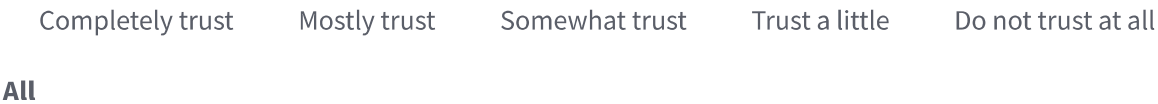


When it comes to whom the public trusts most to provide them with information about the coronavirus pandemic, "personal doctors or other health care providers" led the way, followed by leaders of federal public health agencies, like the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), and leaders of state and local governments. President Trump and Vice President Pence are the least trusted.

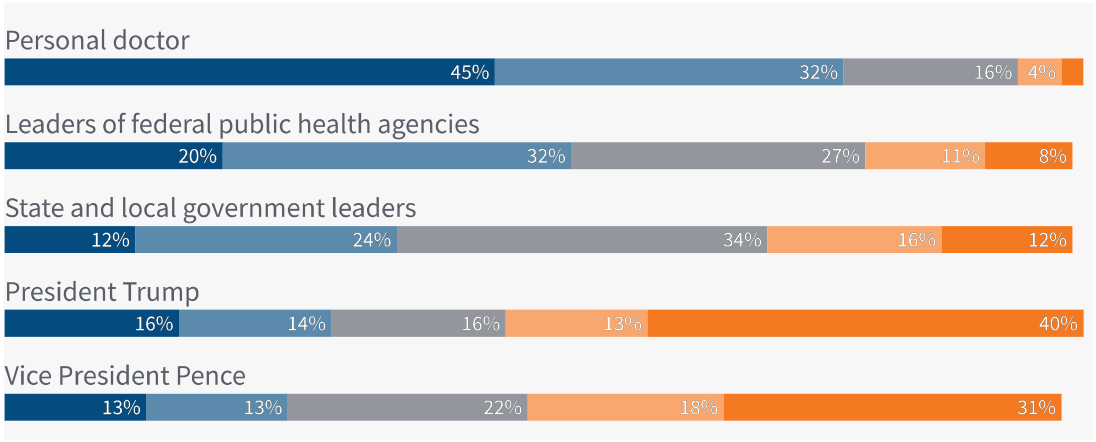
Democrats and Republicans are the most aligned in their trust of federal public health agencies, their state and local leaders, and their doctors. But there is a deep partisan divide in trust in President Trump and Vice President Pence. Only 20 percent of Democrats said they trusted the president, compared to 83 percent of Republicans.

How much do you trust the following to provide information about the coronavirus epidemic?

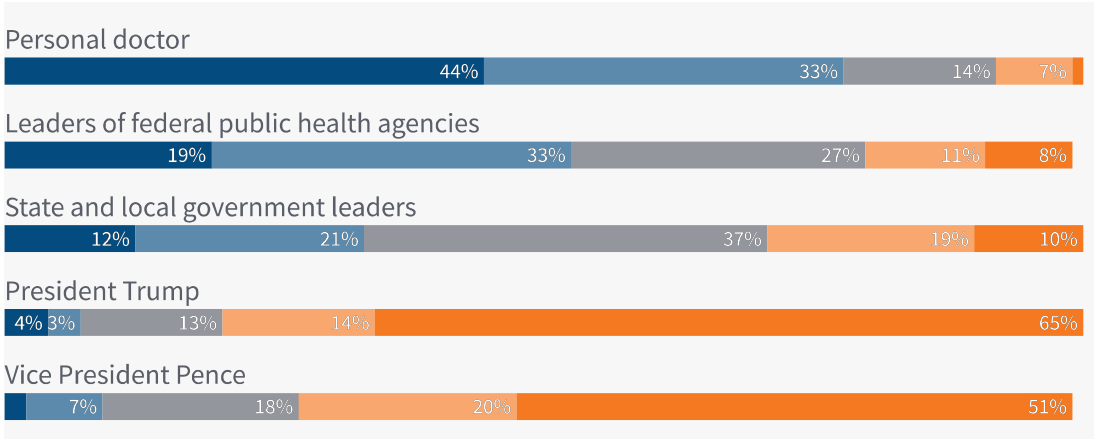
Base: Adults age 18+



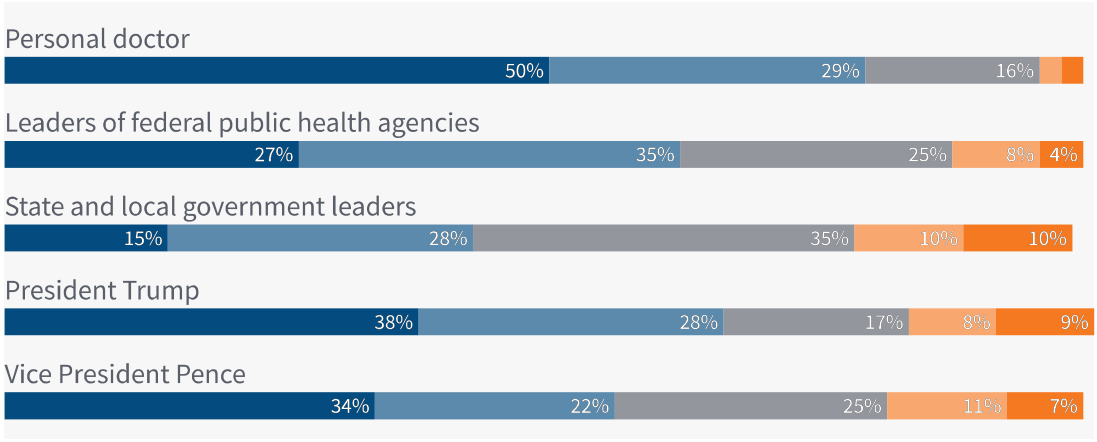
All



Democrats



Republicans



Data: NBC News/Commonwealth Fund Health Care Poll: Coronavirus, Mar. 2020

It could be a year before a vaccine for COVID-19 becomes available to the public. We asked respondents how confident they are, based on what they have heard from the 2020 presidential candidates, that a vaccine will be made available to everyone at little or no cost. More than six in 10 adults reported they are confident that if a Democrat is elected president later this year, a coronavirus vaccine would become available to the American public at little or no cost. Somewhat fewer — half — said they are confident that if President Trump is reelected the vaccine would be offered at little or no cost.

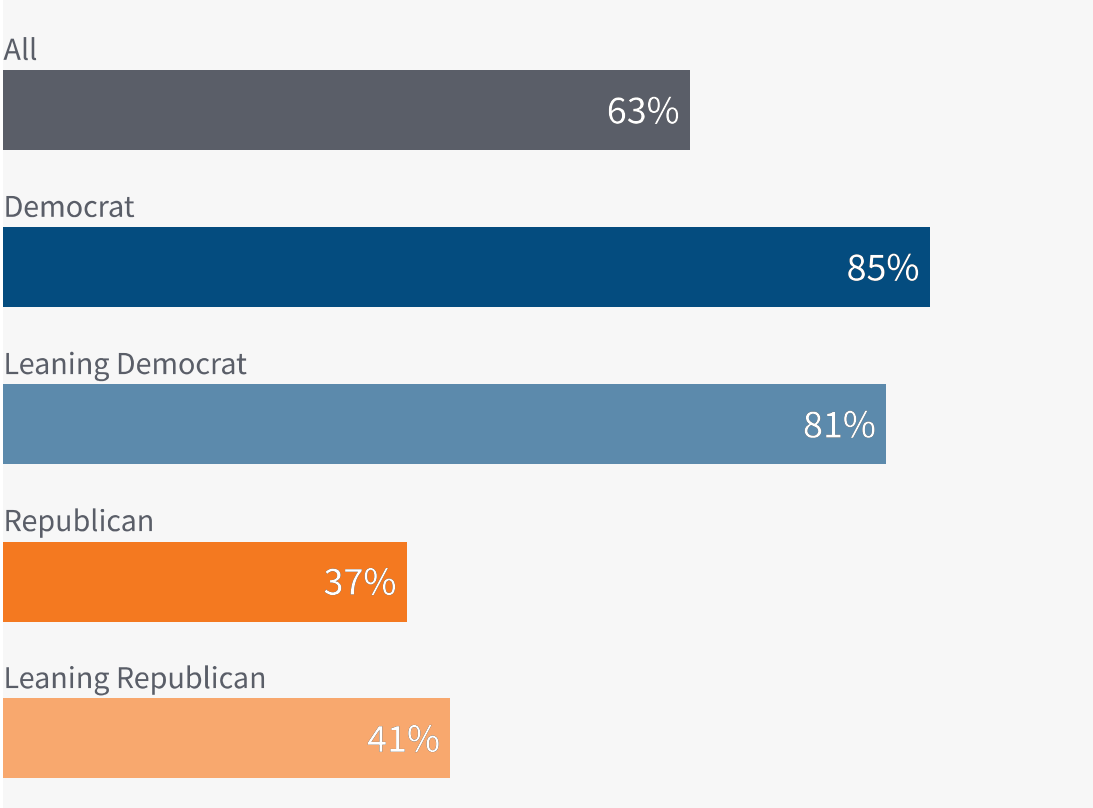
There was a considerable partisan divide in the level of confidence in a Democratic president versus President Trump: Republicans have more confidence in President Trump, while Democrats have greater confidence in a candidate from their own party. Women and adults under age 50 were more confident that a Democrat would offer the vaccine at little or no cost compared to President Trump.

Scientists are now working on a vaccine for the coronavirus, but it could be a year or more before it becomes available to the public. Based on what you are hearing from candidates running for president in 2020, how confident are you that the vaccine will be available to the American public at little or no cost...

By political affiliation

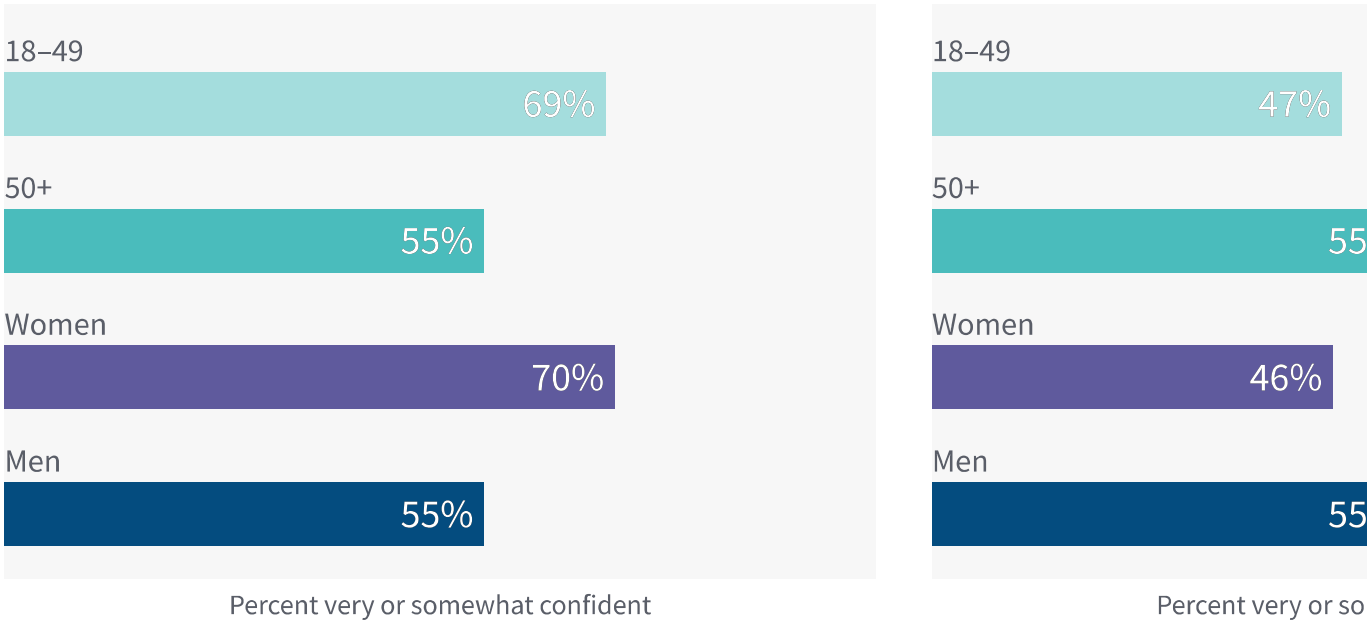
Base: Adults age 18+

If a Democrat is the next president



By age and gender

Base: Adults age 18+



Data: NBC News/Commonwealth Fund Health Care Poll: Coronavirus, Mar. 2020

How We Conducted This Study

The NBC News/Commonwealth Fund Health Care Poll: Coronavirus was conducted by SSRS from March 10 through March 15, 2020. The survey consisted of telephone interviews conducted among a random, nationally representative sample of 1,006 adults, age 18 and older, living in the United States. Overall, 304 interviews were completed via landline and 702 were conducted via mobile phone.

This is the second poll in a series to track public sentiment on a range of health care issues during the 2020 presidential election season. Data were collected through the SSRS Omnibus. The SSRS Omnibus uses a fully replicated, stratified, single-stage, random-digit-dialing (RDD) sample of telephone households, and randomly generated cell phones.

Each SSRS Omnibus insert was weighted to provide nationally representative and projectable estimates of the adult population 18 years of age and older. The weighting process took into account the disproportionate probabilities of household and respondent selection because of the number of separate telephone landlines and cell phones answered by respondents and their households, as well as the probability associated with the random selection of an individual household member. The sample was poststratified and balanced by key demographics such as age, race, sex, region, and education. The sample was also weighted to reflect the distribution of phone usage in the general population, meaning the proportion of those who are cell phone only, landline only, and mixed users.

The margin of error is +/– 3.5 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 3.9 percent response rate and the cellular phone component achieved a 2.8 percent response rate. The overall response rate was 3.1 percent.

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INITIATIVE FOR HEALTH POLICY

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February 27, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington DC, 20201

Re: CMS-9916-P, Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2021

Submitted electronically via Regulations.gov

Dear Secretary Azar:

Thank you for the opportunity to comment on the February 6, 2020 proposed rule, HHS Notice of Benefit and Payment Parameters for 2021 (CMS-9916-P).

We write to express our view that certain potential policy changes on which the agency seeks comment in this proposed rule are unlawful and exceed the authority committed to the agency. In particular, the agency has invited comment on two potential proposals to change long-standing rules regarding the provision of APTC in cases of auto-reenrollment. Under the potential changes, consumers would not receive the APTC to which they are entitled under sections 1411 and 1412 of the Affordable Care Act. This is not permissible. Section 1411 is the sole source of authority for an Exchange to make an eligibility determination for APTC, and section 1412 is the sole source of authority to pay (or not pay) APTC. The statute provides no pathway by which an Exchange can lawfully provide a different (or zero) amount of APTC.

Policies related to auto-reenrollment and eligibility determinations for APTC are governed under ACA sections 1311, 1411, and 1412 and section 36B of the Internal Revenue Code.

Auto-reenrollment is the process by which a consumer from the prior year who has not actively submitted an application and enrolled in coverage for the upcoming benefit year is enrolled in a plan for the upcoming year. Under longstanding regulations and guidance, individuals are reenrolled under similar terms to the prior year – in the same or similar plan and with APTC updated only for changes in the benchmark plan, the federal poverty level, and certain newly available income information. Section 608 of the Further Consolidated Appropriations Act of 2020, enacted in December 2019, amended section 1311(c) of the Affordable Care Act to require the agency to continue auto-reenrollment for plan year 2021. Specifically, it requires CMS to "establish a process under which an individual [enrolled in the Federally-Facilitated Exchanpge] is reenrolled for plan year 2021 in a qualified health plan." In determining eligibility for APTC during that mandated reenrollment process, agency action is governed by other sections of the ACA.

Section 36B of the Internal Revenue Code (as added by the ACA) specifies a series of criteria and calculations used in determining premium tax credit amounts. ACA section 1411 directs the Secretary of HHS to "establish a program… for determining… in the case of an individual claiming a premium tax credit or reduced cost-sharing under Section 36B of such Code or section 1402 whether the individual meets the income and coverage

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requirements of such sections." Section 1412(a) directs the Secretary to "establish a program under which… advanced determinations are made under section 1411." And section 1412(c) directs that the federal government "shall make the advanced payment under this section of any premium tax credit allowed under section 36B."

In other words, section 36B is the sole statutory instruction in how to calculate a premium tax credit amount. The program established under section 1411 must determine eligibility under section 36B. And once an individual has been determined eligible under section 1411, the federal government "shall make" payments in the amount "allowed under section 36B," as required under section 1412.

The agency may not alter an eligibility determination made under these statutes.

The proposed rule seeks comment on two potential policies that would violate these statutory requirements. The agency has expressed a policy concern about consumers for whom the APTC "covers the entire plan premium." The agency thus invites comment on whether individuals for whom this would be true should be enrolled "without APTC" or with APTC "reduced to a level that would result in an enrollee premium that is greater than zero dollars." Neither is permissible.

The policies on which the agency seeks comment would require the agency to conduct an eligibility determination under section 1411, calculate the amount of assistance that would be paid under section 36B, but then decide *not* to apply that amount of APTC to the enrollment. Section 1412 forecloses such options. A decision to apply no APTC at all for consumers determined eligible under section 1411 violates the requirement that the federal government "shall make the advanced payment." If an individual has been determined eligible, APTC must be paid. Nor may the agency invent a new and reduced amount of APTC that is different from the amount allowed under section 36B. Section 1412(c) requires payment of the amount "allowed under section 36B," not some other figure invented by the agency. Whatever policy concerns the agency may have, the text of the statute is clear and provides no discretion to the agency to make the changes suggested.

The policies proposed here are not analogous to other circumstances where the FFE does not apply APTC at reenrollment.

Certainly, there are other circumstances where in the course of automatically reenrolling a consumer, the FFE has historically not applied APTC to their enrollment. However, in those cases the denial is precisely because the agency is making a determination *pursuant to section 1411* that the individual does not "meet[] the income and coverage requirements" of section 36B.

Specifically, the FFE does not apply APTC at reenrollment when tax information shows a household has had income above 500% of the federal poverty level in a recent year. In doing so, the agency is using the authority committed to the Secretary under section 1411 to evaluate available information and determine that an individual is not eligible for APTC. Similarly, the FFE does not apply APTC when it has not been provided information from the applicant or from tax data sources for multiple years; the agency has concluded that it lacks sufficient information to determine that the individual is eligible under section 1411 and therefore it may not pay APTC under section 1412.

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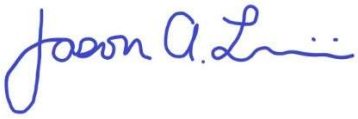
The procedures suggested here are entirely different. The agency is seeking comment on proposals where it would make a determination under section 1411 that a person is eligible and calculate an amount under section 36B, and then reject or alter that determination and apply a different amount of APTC or no APTC at all. It may not do so. Section 1412 requires the payment of APTC in the amount for which the consumer has been determined eligible.

There is no authority to modify or remove APTC for those eligible for assistance that covers their entire premium.

Internal Revenue Code section 36B specifies how APTC is to be calculated. Section 1411 of the ACA requires eligibility be determined in accordance with Code section 36B. ACA section 1412 requires that the federal government "shall" pay APTC for those determined eligible under section 1411 in the amount for which the consumer is eligible under section 36B. The agency may not violate those directives and apply some other amount of APTC or decline to apply APTC for which the consumer has been determined eligible.

Thank you again for the opportunity to comment. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,



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ANALYSIS

Health Insurance Coverage: What Comes After The ACA?

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ABSTRACT The Affordable Care Act (ACA) led to the largest expansion of health insurance in the US in fifty years, bringing the uninsurance rate to its lowest recorded level in 2016. But even at that point, nearly thirty million people lacked health insurance, and millions more still struggled to afford needed medical care. Recent studies also indicate a partial erosion of the ACA's coverage gains since 2017. This article identifies the underlying causes of these problems and evaluates potential policy remedies. Topics include the slow but steady growth of state expansions of eligibility for Medicaid; new waiver approaches in Medicaid, including work requirements; high cost sharing and premium growth in both the Marketplaces and employer coverage; and proposed systemic overhauls such as Medicare for All.

At its tenth anniversary, the Affordable Care Act (ACA) has fundamentally transformed health insurance in the US and has brought the uninsurance rate to its lowest level. Even so, the future of the ACA and the durability of its accomplishments remain uncertain. Furthermore, major challenges remain in the realm of coverage and affordability of health care.

When the ACA was signed into law in 2010, 16.3 percent of the US population was uninsured, corresponding to approximately 49.9 million people lacking coverage.[1] By 2016 the rate had fallen to 8.8 percent, or 28.1 million people.[2] While some of this decline may have been attributable to an improving economy, research indicates that the vast majority of the coverage gain (approximately twenty million people) was due to the ACA.[3,4] Medicaid accounted for an estimated 60 percent of the ACA's effects, through a combination of expanded eligibility and the "welcome-mat" or "woodwork" effect—which occurred when previously eligible but unenrolled people signed up under the ACA, likely as a result of a combination of factors that included greater outreach and media coverage, a simplified application process, and the individual mandate. Smaller gains were due to the availability of subsidized Marketplace coverage and the provision for young adult dependent coverage.[4,5]

All told, the ACA represented the largest expansion of health insurance since the creation of Medicare and Medicaid in 1965. Yet tens of millions of people remained without coverage. Even as numerous studies demonstrated major improvements in access to care and financial security as a result of the ACA,[6–8] cost-related concerns remain common. This article examines the gaps in coverage and affordability of care that remain in the US after implementation of the ACA and evaluates potential policy remedies.

Remaining Gaps And Root Causes

At the risk of oversimplification, the challenges facing the US in terms of making health care affordable can be summarized as a function of two problems: uninsurance and underinsurance. *Uninsurance* refers to the share of US residents who lack any insurance coverage. This is not a static population, but rather a changing group of people who move in and out of coverage

over time, with only some being uninsured for long periods.[9,10] *Underinsurance* refers to the share of people who have health insurance but whose coverage is inadequate to protect them against the risk of high out-of-pocket spending and cost-related delays in obtaining care.[11]

THE REMAINING UNINSURED Of the approximately thirty million people in the US who are uninsured, roughly half have a pathway to subsidized coverage under the ACA (exhibit 1). These people are already eligible for subsidized coverage via Medicaid or the Marketplaces but have yet to enroll or have lost coverage over time.[12]

In the Marketplaces, two main challenges have been the perceived lack of affordable options (cited by 57 percent of people who visited a Marketplace online but did not sign up) and confusion about applying (cited by 38 percent).[13] Despite frequent discussions of premium increases, more than 80 percent of Marketplace enrollees receive premium tax credits that effectively insulate them from the effects of premium increases (since the tax credits cap enrollees' premium contributions at a fixed percentage of income, based on the premium of the second-lowest-cost silver plan).[14] But affordability remains a barrier for some, especially those at the higher end of the income range for subsidy eligibility (that is, people with incomes just under 400 percent of the federal poverty level)—where a family would have to pay 9.5 percent of income for coverage, or nearly $10,000 annually for a family of four.

Moreover, another two to three million uninsured US residents are not eligible for Marketplace subsidies because they have an "affordable" offer of employer coverage, as defined by the ACA (9 percent of the remaining uninsured). These people are unlikely to be able to afford Marketplace coverage without a subsidy (or do not view health insurance as worth the cost), since they have already declined their employer's offer. Notably, the ACA's definition of "affordability" includes the "family glitch": If a worker's employer-sponsored insurance satisfies the affordability threshold (less than 9.8 percent of income for 2020), the entire family becomes ineligible for Marketplace subsidies—even if a family plan through the employer would cost much more than the "affordability" threshold. This policy affects nearly six million Americans, many of whom nonetheless obtain coverage but at a far greater cost without subsidies.[15]

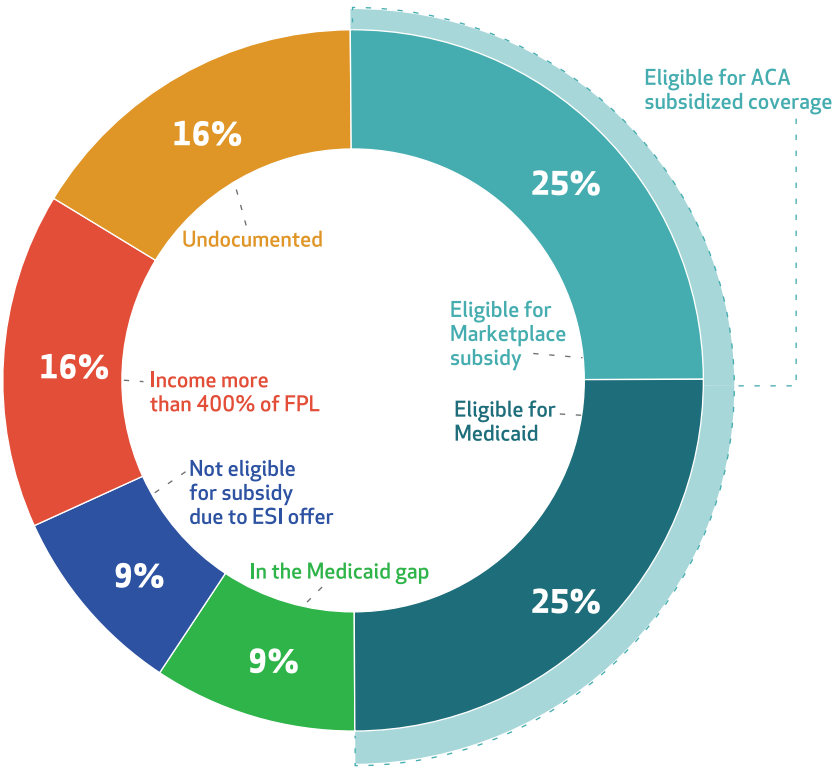
Meanwhile, among those who would have to pay full price for Marketplace plans (people with incomes above 400 percent of poverty), high premiums and premium increases are a likely deterrent to enrollment, and nearly five million people in this income range lack coverage (16 percent of the remaining uninsured).[12] In part, premium increases can be tied to plan exits from the Marketplace, which have left some counties with only one or two participating insurers and, in turn, higher premium growth.[16]

Another challenge for Marketplace enrollment is that many people remain unsure whether they are eligible. One 2017 study reported that 40 percent of uninsured adults said that they had not even heard of the ACA's Marketplaces.[17] Among those who are eligible, mistrust of the system and underinvestment in navigator and other assistance programs designed to help people enroll can contribute to lower enrollment rates.[18,19] All told, more than seven million uninsured Americans—25 percent of the remaining uninsured—likely would qualify for Marketplace tax credits.[12]

Meanwhile, another 7.5 million uninsured people—25 percent of the remaining uninsured—are eligible for Medicaid but not enrolled in it.[12] Problems with take-up rates in Medicaid are not new, as many states experienced low enrollment and high dropout rates before the

EXHIBIT 1

The US uninsured population, by subgroup, 2018



SOURCE Adapted from estimates from Blumberg LJ, et al., Characteristics of the remaining uninsured: an update (see note 12 in text). **NOTES** The group not eligible for subsidies because of offers of employer-sponsored insurance (ESI) are those with incomes of 100–400 percent of the federal poverty level (FPL) who are not eligible for Medicaid and could otherwise receive Advance Premium Tax Credits, were it not for their ESI offer. The group of adults in nonexpansion states in the Medicaid gap is explained in the text.

ACA.[20,21] While some ACA provisions streamlined enrollment and produced the welcome-mat effect discussed above, other policies cut in the opposite direction. State approaches in Medicaid—including those related to premiums; higher cost sharing; complex features such as health savings accounts; and, most recently, work requirements—have all been linked to confusion among beneficiaries and losses of coverage.[22–24] Other less salient program features, such as eligibility redetermination processes and outreach efforts, can also influence Medicaid participation rates.

One of the remaining uninsured populations that has received substantial attention consists of low-income nonelderly adults in the "Medicaid gap." These people live in states that did not expand Medicaid and have incomes too low for them to qualify for the ACA's Marketplace subsidies (which become available when people's income reaches 100 percent of poverty in nonexpansion states). This group of approximately 2.5 million people (9 percent of the remaining uninsured) consists of poor parents with incomes above their state's Medicaid eligibility threshold (the median threshold in nonexpansion states is 43 percent of poverty) and nearly all nondisabled childless adults with incomes below the poverty level.[25] By virtue of their very low incomes and high burden of chronic conditions, this is the population of uninsured people at highest risk for adverse economic and health outcomes resulting from the lack of coverage.[26]

Finally, there are approximately five million uninsured immigrants (16 percent of the remaining uninsured) who are not eligible for any subsidized coverage because of their undocumented status. In the absence of comprehensive immigration reform, it is unlikely that this population will experience large coverage gains—though some major cities and states (including New York City and California) are using their own funds to extend coverage to this group.[27]

THE UNDERINSURED Even among people with insurance, financial barriers to care remain common. Researchers often define *underinsurance* as spending more than 10 percent of income in the past year on health care costs (including premiums), or more than 5 percent for lower-income families; facing a deductible of more than 5 percent of household income; or putting off needed care in the past year because of cost.[11,28] One study estimated that 28 percent of nonelderly US adults with insurance coverage (or forty-one million people) were underinsured in 2016. Among low-income adults, the numbers are even higher: 38 percent of poor adults with private insurance were underinsured.[28]

High deductibles in the Marketplaces have received considerable attention, with the average silver plan featuring a deductible of nearly $3,000 and the average bronze plan $5,800 in 2016 (though enrollees with incomes of less than 250 percent of poverty receive additional cost-sharing subsidies).[29] But this phenomenon is not limited to ACA-related plans. More than 80 percent of workers with employer coverage face deductibles, which averaged $1,655 in 2018—a $400 increase since 2014.[30] Moreover, health care costs have become particularly onerous for lower-income people with employer coverage: The average share of family income going to premiums and out-of-pocket spending now tops 13 percent.[31] These trends cast some doubt on the conventional wisdom that employer coverage is still the most desirable form of insurance for most Americans—particularly for lower-income families that may be better off with the comprehensive financial protection of Medicaid.

Underlying these challenges are the nation's broader pressures related to health care costs. As long as health care in the US remains so expensive, these pressures will affect all aspects of health care financing, including federal and state budgets for Medicare and Medicaid, employers' trade-offs between wages and health benefits, and out-of-pocket spending among the general public. In part, the increasing use of high-deductible plans reflects the evidence that cost sharing reduces utilization and health care spending.[32] But evidence also shows that cost sharing leads patients to cut back on both necessary and unnecessary care—with potentially adverse health outcomes, particularly among low-income adults with chronic conditions.[32–34]

RECENT INCREASE IN THE UNINSURED POPULATION While the ACA brought the US's uninsurance rate to its lowest point in 2016, recent evidence indicates that the policy's effects have started to erode since then. Multiple data sources—including Medicaid administrative statistics, Marketplace enrollment reports, and population surveys—show coverage declines in 2017–18.[35–38] The most reliable estimate comes from the Census Bureau, which reported an increase of roughly 1.9 million US residents without coverage in 2018 and reductions in both Medicaid and private coverage.[37] While some media reports have noted a much larger coverage loss reported by Gallup, this estimate coincided with a dramatic change in the survey's methodology and might not be reliable.[39]

What's driving these changes? In one sense, the coverage losses are surprising, since they come at a time of very low unemployment and no major legislative changes to the ACA (the individual mandate repeal did not take effect until 2019). However, other policy factors are

There is no obvious market-based remedy for the increasing financial burden experienced by many people with private insurance.

likely to blame. Premium growth in the Marketplaces—which peaked in 2017–18—was one contributing factor, especially since the Marketplace enrollment decline in 2018 was entirely due to a drop in the number of unsubsidized enrollees (from 5.0 million to 3.8 million).[40] More broadly, changes in the executive oversight of the ACA in the administration of President Donald Trump likely played a large role, with shorter open enrollment periods; less advertising outreach; attempts to introduce lower-cost and less comprehensive plans; and the president's use of the bully pulpit during the ACA repeal debate, which left many Americans unsure whether the law was still in effect.[41]

In addition, states have been implementing a range of policies in Medicaid that have made it harder for eligible people to enroll and stay in the program. These include eliminating retrospective eligibility (which enables people to sign up for the program at the time of or shortly after an illness or injury); subjecting more Medicaid beneficiaries to premiums; and, most recently, work requirements, which led to 18,000 adults being removed from Arkansas Medicaid before a federal judge halted the requirements.[42]

Policy Remedies For Coverage Expansion

In terms of health equity and public health, the highest-priority population to cover is low-income adults in nonexpansion states' coverage gap. Covering these people could occur via several pathways. The most obvious would be to induce more states to expand Medicaid, which copious evidence has shown produces substantial benefits to low-income adults.[7,8,43] The trajectory on this front has been one of gradual movement toward expansions: Thirty-four states had expanded Medicaid as of 2019, compared to twenty-six states as of 2014. In three additional states, ballot initiatives to expand have passed, and expansions are slated for implementation in Utah and Idaho in 2020.[44] The success of these ballot initiatives in 2018 may offer a potential template for other states, given the popularity of Medicaid expansion even in red states.[45] However, not all states allow for binding voter initiatives, and even in Nebraska, which passed an initiative to expand Medicaid, state legislators have yet to fully implement the expansion.[43] A clearer path to Medicaid expansion is evident in the recent elections of governors who implemented the two newest expansions—in Virginia and Maine.

In states where the political climate remains hostile to expansion, compromises in the form of Section 1115 waivers for features such as health savings accounts, healthy behavior incentive programs, and work requirements can sometimes pave the way for expansion. This approach, piloted by the administration of President Barack Obama in states including Arkansas and Indiana, must contend with important legal and policy questions as to how far the waiver authority can and should be stretched. The nation's first experiment with Medicaid work requirements produced significant coverage losses and did not achieve its goal of increased employment.[42] However, the resulting increase in the uninsurance rate was much smaller than the overall effect of expansion versus nonexpansion. Specifically, Arkansas's uninsurance rate went from 10.5 percent to 14.5 percent among the group of low-income people ages 30–49 that was targeted by work requirements. But even after this increase, the uninsurance rate remains far lower than the state's 40 percent rate in this population before the ACA or the estimated 30 percent of low-income Texans still uninsured in 2018 in the absence of Medicaid expansion.[42]

Finally, Congress could also address the coverage gap with a fallback option for low-income adults in these states. One such option would be making adults with incomes below poverty in nonexpansion states eligible for Marketplace tax credits similar to those for people whose incomes are 100–133 percent of poverty. More aggressively, following the model of Massachusetts's 2006 health reform, Congress could fund fully subsidized Marketplace coverage with zero-dollar premiums for people in the coverage gap. In theory, this might lead some expansion states to consider reversing their expansions, since low-income adults would then have a subsidized alternative to Medicaid. However, Medicaid expansion remains quite popular, and reversing course would be politically challenging in most expansion states. Even with such a reversal in

some states, as long as low-income adults remained eligible for free coverage from one source or another, the net effect on health care access would still be quite positive.

For the estimated fifteen million uninsured people already eligible for subsidized coverage, the emphasis should be on two main issues: the ease of enrollment and the affordability of coverage. Restoring outreach efforts, advertising funds, and enrollment assistance could reverse some of the erosion in Medicaid and Marketplace enrollment since 2017. More dramatically, several policy makers and analysts on both ends of the political spectrum have advocated for the automatic enrollment of eligible uninsured adults in zero-dollar premium plans (typically low-cost bronze plans whose premiums are less than the ACA's income-based premium subsidy).[46]

To make Marketplace premiums more affordable, several features of the ACA that have expired or been repealed could be reimplemented, including reinsurance (which twelve states have already adopted through Section 1332 waivers)[47] and the individual mandate—though research evidence on how important the mandate was in boosting ACA enrollment is mixed.[5,48] A public option or Medicaid/Medicare buy-in could be another way to introduce lower-cost plans and guarantee insurance options nationwide, regardless of private insurers' participation decisions. However, without changes in subsidies, a public plan might still be unaffordable for many people. Thus, making premium subsidies more generous and eliminating the family glitch could increase participation (with or without a public option), though prior research suggests that fairly large subsidy increases would be necessary to induce the majority of eligible but uninsured people to enroll in Marketplace coverage.[49]

Policy Remedies For Reducing Underinsurance

There is no obvious market-based remedy for the increasing financial burden experienced by many people with private insurance, as there is little desire among employers or people who buy Marketplace coverage to move toward more expensive plans that offer better risk protection. One incremental option would be for the government to expand the availability of the ACA's cost-sharing subsidies, which increase the actuarial value of Marketplace coverage, to people with higher incomes (the current threshold is an income of 250 percent of poverty). However, this would do little to counterbalance the increasing affordability challenges for the majority of US residents with employer coverage.

Another policy option would allow some or all individuals with private coverage to buy into Medicaid, Medicare, or another public plan. This buy-in option could be implemented through the ACA Marketplaces and administered by the states (as in Washington's quasi-governmental public option), or it could be a stand-alone option for all US residents, as some 2020 presidential candidates have proposed. However, without any secondary coverage, traditional Medicare covers only roughly 80 percent of spending and has no cap on out-of-pocket spending for catastrophic expenses, which means that it would not necessarily be a major coverage upgrade for many people. In contrast, Medicaid provides comprehensive coverage with minimal cost sharing, which—compared to private coverage—has been shown to reduce financial strain on families.[28,50]

Amid increasing efforts to use cost sharing to reduce health care use, it is also worth noting that the US remains an outlier in spending not because of utilization but rather health care prices, which are higher in the US than anywhere else in the world.[51] As long as this remains the case, policies that target utilization—such as cost sharing and payment delivery reforms—are unlikely to recalibrate the level of spending in the US so that it becomes similar to that in other high-income nations.

Fundamental Health System Reform

Finally, no discussion of coverage and access to care would be complete without considering more dramatic proposals to overhaul the US health insurance system. Under the broad rubric of "single payer" or "Medicare for All," 2020 presidential candidates have floated a variety of approaches ranging from Medicare buy-in with a gradual transition to universal coverage, to the elimination of all private insurance in the US. A full assessment of the political and economic considerations of such proposals is well beyond the scope of this article, but these considerations warrant extensive debate. To vastly oversimplify matters, a publicly financed single-payer system would offer important advantages in terms of its universality, administrative efficiency, and potential for wringing price concessions from providers, hospitals, and drug and device makers that would get the US closer to its peers in terms of health care costs. But it would also involve enormous political and logistical challenges—particularly if it entailed eliminating private coverage for the over 150 million Americans currently insured through their employers—as well as shifting trillions of dollars in health care spending from the private sector to the federal government.

Conclusion

Ten years after its passage, the Affordable Care Act has proved remarkably resilient—like a cat, it has at least nine lives. Despite its often rocky implementation, dozens of attempts at congressional repeal, a president committed to its elimination, and numerous legal challenges (including an ongoing lawsuit in *Texas v. United States* that could still strike down the entire law), the ACA has perhaps surprisingly emerged mostly intact at its tenth anniversary. The US health care system remains deeply flawed, with major inequities, millions of uninsured people, and ongoing problems with affordability. But on all of those fronts, the ACA moved the nation in the right direction and created an opportunity for further progress—either by building on its framework or by replacing it with something more comprehensive. ■

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REVIEW ARTICLE

How Have ACA Insurance Expansions Affected Health Outcomes? Findings From The Literature

ABSTRACT A growing body of literature examining the effects of the Affordable Care Act (ACA) on nonelderly adults provides promising evidence of improvements in health outcomes through insurance expansions. Our review of forty-three studies that employed a quasi-experimental research design found encouraging evidence of improvements in health status, chronic disease, maternal and neonatal health, and mortality, with some findings corroborated by multiple studies. Some studies further suggested that the beneficial effects have grown over time and thus may continue to grow if the ACA insurance expansions remain in force. However, not all studies reported a significant positive relationship between ACA provisions that expanded insurance coverage and health status. We highlight the challenges facing researchers, including the importance of nonmedical factors in determining individual health and the use of outcome data predominantly drawn from self-reports. In closing, we identify opportunities to enhance researchers' understanding of the relationship between the ACA insurance expansions and health outcomes using new data sources, including electronic health records.

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One of the key goals of the Affordable Care Act (ACA) was to improve health outcomes by expanding insurance coverage to millions of Americans. There is tremendous interest in understanding the effects of the ACA on the nation's health, given the US's poor performance on many health measures relative to other developed nations, its high medical spending, and its substantial racial/ethnic disparities in health outcomes.[1–3]

A growing body of literature is using quasi-experimental research—which uses a comparison group and regression analysis to control for multiple variables—to examine the effects of insurance expansions on health. We summarize findings from this particularly rigorous body of literature, presenting results for four categories of health outcomes among nonelderly adults: self-reported physical and mental health, chronic disease, maternal and neonatal health, and mortality. We highlight results for the overall nonelderly adult population, as well as for different demographic subpopulations of interest—including racial/ethnic minority groups. We pay special attention to studies that allowed us to trace changes in the ACA's health effects over time. We conclude by highlighting limitations of the existing research and identifying promising areas for future research.

This article is informative for ongoing policy debates about health care reform and potential

changes to the ACA. It complements other reviews that discuss the ACA's impacts on health outcomes[4–7] and the relationship between insurance coverage and health more generally.[8] It updates these prior reviews with analyses of more recent articles, including some that used stronger data sources and stronger study methods and used objectively assessed health measures. In addition, this article takes a deeper dive into the health impacts of the ACA by summarizing new evidence on the effects of the coverage expansions on health over time.

Background On Coverage Expansions

One of the first insurance expansions of the ACA was the dependent coverage provision, which allows young adults to be included on their parents' insurance plans until age twenty-six. The provision was implemented in September 2010, and an estimated 5.5 million young adults took advantage of this form of coverage at some point within the first five years.[9]

A second component aimed to expand Medicaid coverage to all nonelderly adults with incomes below 138 percent of the federal poverty level, regardless of parental or disability status. A 2012 Supreme Court ruling made expansion optional for states, and only thirty-six states and the District of Columbia adopted the expansion in the period 2014–19. About twelve million adults gained Medicaid coverage under the ACA.[10]

The third insurance expansion component of the ACA was the creation of health insurance exchanges (known as Marketplaces). For people who lacked employer-sponsored or public coverage before the ACA, nongroup policies could be prohibitively expensive or restrictive. In 2014 the ACA established online Marketplaces where people can purchase regulated nongroup insurance policies, with government subsidies for those with incomes below 400 percent of poverty. In 2018 over ten million people enrolled in Marketplace plans.[10]

Other insurance-related provisions of the ACA included an individual mandate that required almost all individuals to have insurance or be subject to a tax penalty (the penalty for noncompliance has since been repealed), an employer mandate that required large employers to provide health insurance to full-time employees, and rules that prevented insurers from denying coverage or charging higher premiums to people with preexisting conditions.

Selection Of Relevant Articles

We identified studies for potential inclusion in our review by conducting a Google Scholar search for those released in the period January 2011–January 2020 with keywords related to the ACA and health (online appendix exhibit A presents the exact search phrases).[11] We included publicly available working papers in our search. This search yielded 222 nonunique results. We first deleted duplicate studies, those that had not examined health outcomes, and those that had studied populations other than nonelderly adults, which left us with 57 studies.

We then selected those that employed quasi-experimental research methods. To meet this definition, we required that studies include a reasonable comparison group and use regressions to control for differences in outcomes over time or across groups that were not directly affected by the policy being studied. Most of the studies tested or commented on whether the key assumptions required to interpret the results as causal estimates were met. For example, studies using difference-in-differences designs tested the assumption of parallel prepolicy trends in outcomes in treatment and comparison groups. While studies that employ quasi-experimental research approaches do not provide definitive evidence of causality, using regression to control for other potential factors increases the likelihood that observed associations flow from causal relationships. We did not consider the magnitude or statistical significance of effect sizes when deciding which studies to include. These selection criteria resulted in a final sample of 43 studies. Appendix exhibit B presents a detailed summary of these studies.[11]

We then grouped the studies into four categories, based on health outcomes: self-reported physical and mental health, chronic disease, maternal and neonatal health, and mortality. Some studies contributed evidence to multiple categories. We flagged studies that presented analyses by racial/ethnic groups to examine the potential impacts of the ACA on disparities. We also identified studies that calculated separate estimates by year of policy implementation, to contribute to our discussion of changes in health effects over time.

Of the forty-three studies included in our review, thirty-nine focused on the health effects of either the dependent coverage provision of 2010 or the state Medicaid expansions of 2014. These policies affected only clearly defined groups (adults younger than age twenty-six and low-income adults in Medicaid expansion states, respectively) and, compared to other policies, are easier to evaluate using quasi-experimental analyses. While other ACA provisions such as the individual mandate and insurance exchanges have likely affected health, they have been less studied because they were implemented nation-

wide at the same time—which makes it difficult to disentangle the impacts of specific policy changes. In this article we focus on the evidence related to the dependent coverage provision and Medicaid expansions. We then briefly summarize the smaller literature on the health outcomes of other coverage provisions.

Effects On Health Outcomes

This section summarizes studies that examined the health effects of the coverage expansions.

SELF-REPORTED PHYSICAL AND MENTAL HEALTH We first examined nineteen studies of self-reported health (exhibit 1), as this outcome was most often included in survey data and provides a strong summary measure of respondents' overall health. Though self-assessed health may seem subjective, a large literature has shown that it is highly correlated with objective measures of health, such as mortality.[12,13] Multiple studies reported that the dependent coverage provision substantially improved young adults' perceptions of their overall, physical, and mental health.[14–16] The estimates from these studies, when combined with the change in insurance status for young adults under the provision, suggest improvements in self-reported health of 12–86 percent among newly insured people (appendix exhibit G).[11]

Findings from the Medicaid expansions were more varied. Many studies found improvements in self-reported health.[17–24] There were also reductions in the probabilities of experiencing depression and psychological distress and in the numbers of days spent in poor mental health.[17,20–22,25] However, other studies did not detect significant impacts of the Medicaid expansions on self-reported health (exhibit 1).[25–32] Estimates in the studies that did find evidence of better self-reported health suggested improvements of 21–27 percent among the newly insured (appendix exhibit G).[11] Results were sensitive to the study sample used, with greater evidence of health improvements among childless adults and those with chronic health conditions—who face particularly high medical needs and expenses in the absence of insurance.[17,21]

CHRONIC DISEASE Next we examined fifteen studies of the ACA's impact on the diagnosis and management of chronic diseases such as diabetes, heart disease, cancer, and obesity (exhibit 2). Few studies examined changes in these outcomes under the dependent coverage provision, but there was evidence that the provision reduced body mass index for young adults[14] and increased early-stage cancer diagnosis.[33]

Several studies examined the effects of the Medicaid expansion on chronic disease. Three of these studies documented increases in early-stage cancer diagnosis, which is associated with improved patient outcomes.[34–36] Other studies reported improved cardiovascular health, including better blood pressure control among patients in community health centers, increased probability of early uncomplicated disease presentation among hospitalized patients, and increased diagnosis rates of diabetes and high cholesterol.[27,28,37–40] There was no evidence that the Medicaid expansions affected body mass index or rates of obesity.[20,21,24,31]

MATERNAL AND NEONATAL HEALTH Our third group included three studies that focused on maternal and neonatal health, which is reflective of mothers' health and health care (exhibit 3). The dependent coverage provision increased insurance coverage for reproductive-age women, which was linked in this literature to the reduced probability of preterm birth but not to changes in the likelihood of cesarean delivery, low birthweight, or admission to the neonatal intensive care unit.[41] Most states' Medicaid programs covered pregnant women generously even before the ACA. However, there are potential avenues to improved outcomes through better preconception health, improved contraception access, early prenatal care initiation, and increased access to care between pregnancies. The research to date found no detectable effects of the expansions on neonatal health.[42,43]

MORTALITY Finally, we analyzed eleven studies that examined mortality (exhibit 4). Measuring mortality effects is challenging because death is

EXHIBIT 1

Findings from 19 studies on the Affordable Care Act's coverage expansions and their effects on nonelderly adults' self-reported physical and mental health

Effects	Number of studies
DEPENDENT COVERAGE PROVISION	
Increased reports of excellent health or decreased reports of fair or poor health	2
Increased reports of both excellent physical and mental health	1
No impact on number of days per month of poor mental or physical health	1
EXPANSION OF ELIGIBILITY FOR MEDICAID	
Improved self-reported health	8
No impact on self-reported health	8
Fewer days per month of poor physical health	1
No impact on the number of days per month of poor physical health	5
Decreased probability of depression or psychological distress	2
Fewer days per month of poor mental health	1
No impact on number of days per month of poor mental health	5

SOURCE Authors' summary of findings from nineteen relevant studies in the final review sample published between January 2011 and January 2020. **NOTE** Appendix exhibit C provides full sources for the studies (see note 11 in text).

EXHIBIT 2

Findings from 15 studies on the Affordable Care Act's coverage expansions and their effects on chronic disease among nonelderly adults

Effects	Number of studies
DEPENDENT COVERAGE PROVISION	
Reduced body mass index and rates of obesity	1
Increased early-stage cancer diagnosis	1
EXPANSION OF ELIGIBILITY FOR MEDICAID	
Increased rates of early-stage cancer diagnosis	3
Increased rates of diabetes diagnosis	4
Increased rates of high cholesterol diagnosis	2
Increased probability of hypertension and cholesterol control	2
Increased probability of early uncomplicated disease presentation among patients admitted to hospitals for surgical conditions	1
No impact on diabetes control	3
No impact on body mass index or rates of obesity	4

SOURCE Authors' summary of findings from fifteen relevant studies in the final review sample published between January 2011 and January 2020. **NOTE** Appendix exhibit D provides full sources for the studies (see note 11 in text).

a rare event for nonelderly people, and most standard mortality data sets lack the statistical power needed to detect plausible effects for the general population.[44] Some studies aimed to study targeted populations that gained coverage. Notably, Sarah Miller and coauthors linked federal survey and administrative death data sets to identify a sample of near-elderly adults who were most likely to benefit from Medicaid expansion, based on income and citizenship status. The authors found that the Medicaid expansion reduced mortality by 9.4 percent for near-elderly adults, which was equivalent to a reduction of 39–64 percent for the new Medicaid enrollees.[45] Others found decreases in cardiovascular mortality among middle-aged adults[46] and mortality reductions for patients with end-stage renal disease,[47] but no effect on in-hospital mortality for acute myocardial infarction patients.[48]

The dependent coverage provision was estimated to have reduced disease-related mortality by 6.1 percent among young adults[49]—an effect whose magnitude was similar to that of the coverage change for this group. One study found large reductions in opioid mortality for young adults,[50] while others found no significant impact on opioid mortality[51] or in-hospital mortality for young adult trauma patients.[52]

OTHER COVERAGE PROVISIONS Four studies examined the health effects of other ACA provisions enacted in 2014. Anna Goldman and coauthors used longitudinal survey data to compare previously uninsured adults whose incomes made them eligible for Marketplace subsidies to those with similar incomes who had employer coverage before the ACA. This study found that Marketplace coverage increased rates of diagnosis of high cholesterol and hypertension for low-income adults but had no detectable effect on diabetes diagnosis rates.[53] Two other studies used triple-differences models that exploited pre-2014 differences in county-level uninsurance rates to estimate the effects of the individual mandate and Marketplaces after the second and third years of ACA implementation.[31,32] The authors found improvements in self-reported health in the third year.[32]

Of particular note was a randomized pilot study in which the Internal Revenue Service sent letters to some but not all individuals who were subject to the individual mandate penalty. Researchers found that new coverage resulting from the letters was associated with a 12 percent decline in mortality among people ages 45–64.[54]

IMPROVEMENTS IN RACIAL/ETHNIC HEALTH DISPARITIES Few studies have examined whether improved coverage under the ACA for historically disadvantaged populations translated to better health status.

One of the three studies that estimated separate effects by race/ethnicity found that, compared to non-Hispanic whites, non-Hispanic blacks experienced a greater reduction in poor mental health days or health-related activity limitations, and Hispanics had a larger reduction in the probability of fair or poor health status.[22] Another study found larger increases in hypertension control among Hispanics.[37] Finally, one study estimated a narrowing of disparities in neonatal health outcomes between non-Hispanic whites and non-Hispanic blacks after Medicaid expansion.[42]

Overall, the small literature on this topic suggested that racial/ethnic health disparities improved for hypertension, certain self-assessed health outcomes, and neonatal health outcomes. However, there is little evidence related to other

EXHIBIT 3

Findings from 3 studies on the Affordable Care Act's coverage expansions and their effects on maternal and neonatal health

Effects	Number of studies
DEPENDENT COVERAGE PROVISION	
Reduced probability of preterm birth, especially for unmarried women	1
No impact on likelihood of cesarean delivery, low birthweight, or NICU admission	1
EXPANSION OF ELIGIBILITY FOR MEDICAID	
No impact on low birthweight, preterm birth, or small size for gestational age	2

SOURCE Authors' summary of findings from three relevant studies in the final review sample published between January 2011 and January 2020. **NOTES** Appendix exhibit E provides full sources for the studies (see note 11 in text). NICU is neonatal intensive care unit.

outcomes, such as chronic disease. Moreover, disparities are still high in the post-ACA era.[55]

Changes In Health Effects Over Time

Next, we traced changes in the ACA's health effects over time. While coverage rates increased almost immediately after implementation of the ACA coverage expansions in 2014, they continued to grow substantially over the following two years.[56] Therefore, early evaluations did not capture the full reach of the coverage changes. There are also reasons to expect lags in downstream impacts of insurance coverage on health outcomes because of delays in finding providers, using health care, and modifying health behaviors. Furthermore, some types of medical care, such as preventive care and chronic disease management, may take longer to improve health.

We compared findings from three studies that examined the ACA's effects on nonelderly adults' self-reported health over time (exhibit 5). These studies estimated the change in each year post-ACA, relative to a pre-ACA baseline. We classified them by the policy change studied: Medicaid expansions or non-Medicaid ACA components that were implemented in 2014. Not all studies found evidence of improvements in self-reported health. However, those that did often found that the ACA's effects on health were growing over time. We observed this pattern across two separate sets of studies, despite differences in the policies examined and measures of health used.

EXHIBIT 4

Findings from 11 studies on the Affordable Care Act's coverage expansions and their effects on mortality among nonelderly adults

Effects	Number of studies
DEPENDENT COVERAGE PROVISION	
Reduced disease-related mortality rates	1
Reduced opioid mortality rates	1
No impact on opioid mortality rates	1
No impact on in-hospital mortality rates for young adult trauma patients	1
EXPANSION OF ELIGIBILITY FOR MEDICAID	
Typical mortality data lack statistical power to detect effects	1
Reduced mortality rates for all nonelderly adults	1
Reduced mortality rates for disadvantaged near-elderly adults	1
Reduced mortality rates for patients with end-stage renal disease	1
Reduced cardiovascular mortality rates	1
No impact on in-hospital mortality rates for acute myocardial infarction patients	1
No impact on opioid mortality rates	1

SOURCE Authors' summary of findings from eleven relevant studies in the final review sample published between January 2011 and January 2020. **NOTE** Appendix exhibit F provides full sources for the studies (see note 11 in text).

Discussion

The burgeoning body of research on the health effects of the ACA suggest promising improvements among nonelderly adults for certain health outcomes and some reductions in racial/ethnic disparities. Studies reported that the dependent coverage provision improved self-

EXHIBIT 5

Findings from 3 studies on the coverage expansions of the Affordable Care Act (ACA) and their effects on nonelderly adults' self-reported health over time, by study population

Outcomes	Pre-ACA baseline (mean % of population)	Estimated change from baseline by post-ACA year[a] (percentage points)			
		Year 1	Year 2	Year 3	Year 4
MEDICAID EXPANSION[b]					
All Medicaid expansion states[c]					
Very good or excellent health	46.2	−2.5	−2.9	−1.4	−2.1
Arkansas and Kentucky[d]					
Excellent health	12.2	2.4	5.0**	5.1*	—[e]
Fair or poor health	39.6	0.6	−3.7	−6.0*	—[e]
NON-MEDICAID ACA COMPONENTS[f,g]					
Good or better health	84.0	−0.4	0.1	1.5***	—[e]
Very good or excellent health	53.6	2.0***	2.0	4.3***	—[e]
Excellent health	20.4	1.4	0.9	3.5***	—[e]

SOURCE Authors' summary of findings from three relevant studies in the final review sample published between January 2011 and January 2020. [a]Non–Medicaid expansion population estimates are implied effects of the ACA at the mean pretreatment uninsurance rate and are from Courtemanche C, et al. Effects of the Affordable Care Act on health care access and self-assessed health after 3 years (see note 32 in text). [b]Among people ages 19–64 with incomes of 138 percent of the federal poverty level or less. [c]Miller S, Wherry LR. Four years later (see note 29 in text). [d]Sommers BD, et al. Three-year impacts of the Affordable Care Act (see note 19 in text). [e]Estimates not available for these years. [f]Courtemanche C, et al. (see note 32 in text). [g]Among people ages 19–64. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

reported health, increased early-stage cancer diagnosis, reduced poor birth outcomes, and decreased opioid mortality for young adults. Findings for the Medicaid expansion were more varied. Results for self-reported physical and mental health were mixed, though the expansion increased early-stage cancer diagnosis, improved cardiovascular health, and reduced mortality for certain groups of nonelderly adults. In addition, there was some evidence that the health effects of the ACA grew over time, based on self-reported health measures.

CHALLENGES FACED IN THE LITERATURE While increased insurance coverage under the ACA is clearly detectable in any standard study design, examining how this coverage increase translates to improved health outcomes is more challenging. Increased use of medical care might not immediately result in measurable improvements in health, which is a composite outcome of many social, environmental, genetic, economic, and medical factors. There have been documented increases in the use of preventive care and prescription drugs for chronic disease management under the ACA.[20,57] However, US policy had already expanded coverage to some of the most vulnerable populations (low-income mothers, infants, people with disabilities, and elderly people) before the ACA, and many uninsured people had already received subsidized emergency and hospital care as a result of the Emergency Medical Treatment and Active Labor Act of 1986.

In addition, few studies used objectively measured health data to measure the impact of the ACA. Most of the research to date has relied on self-reported health information in national surveys with larger samples. Surveys that contain clinical health information often have smaller sample sizes, which may make it difficult to detect morbidity effects. While self-reported evidence is strongly suggestive, it is difficult to know how changes in self-reported health map to changes in actual health. Increased insurance coverage may positively or negatively affect self-perceptions of health, as people increase their interactions with the health care system and receive new information about their health—including diagnoses of chronic disease. In addition, improved financial status and protection against the high costs of health care may affect people's overall sense of well-being, which could influence their reported health status.[58]

The recent literature also points to statistical challenges in detecting health effects related to changes in insurance coverage.[44] Data sets with objective health information, such as mortality rates or clinical measures, often do not contain information on individual characteristics such as income that can be used to identify targeted recipients of insurance expansions. Analyses of these data require that any health effects be detectable at the population level, but many people did not gain coverage under the ACA.

KEY AREAS FOR FUTURE WORK Many gaps in the literature remain. There has been little work on mental health conditions beyond self-assessed mental health. This is a particularly important outcome to study, given elevated rates of "deaths of despair" from suicide and drug overdoses.[59] Researchers also know little about health impacts for populations that previously faced high barriers in obtaining care, including racial/ethnic minority groups, rural populations, and self-employed people. In addition, there is a need to study other ACA provisions by finding ways to identify causal effects of the Marketplaces and the individual and employer mandates. Finally, there is a dearth of evidence on the health impacts of the portions of the ACA that change the nature of insurance—such as coverage of ten essential benefits.

As additional years of data become available, it will be important to explore longer-term health impacts. At the same time, it will be necessary to address an additional challenge: measurement error caused by individual changes in eligibility for the ACA programs over time—for example, resulting from moves between states and fluctuations in income.

There is also a critical need to use clinical, rather than self-reported, health measures, such as those available through insurance claims, physical examinations, and laboratory test data. Efforts under way to use electronic health records (EHRs) to track patient health may deepen researchers' understanding of the health impacts of the ACA's insurance expansions. For instance, researchers are beginning to assemble high-quality data sets on patients' morbidity outcomes over time through longitudinally linked EHRs; others are linking insurance data to administrative health care and mortality records for full populations of states.[60]

Conclusion

Improving outcomes in population health and reducing disparities were and remain key goals of the ACA. A growing literature suggests that there have been promising improvements for certain health outcomes, including early-stage cancer diagnosis and cardiovascular health. However, data are generally lacking on clinical measures of health, and results for self-reported physical and mental health are mixed. Recent research points to clear mortality improvements from insurance expansions and provides evidence of growing health effects of the ACA over

time. But while these results are encouraging and suggest that the ACA's health benefits will continue to accrue in coming years, the future of the ACA and the direction of national health care reform remain uncertain. The future health impacts of the ACA will largely be determined by policy decisions made or deferred moving forward. ■

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11 To access the appendix, click on the Details tab of the article online.

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Roundtable: From left, Rick Pollack, Matt Eyles, Nancy Nielsen, and Billy Tauzin.

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The ACA Turns 10: Reflections Of Four Industry Leaders

These leaders celebrate the ACA's successes, reflect on its shortcomings, and explain the politics that led to passage of the landmark act.

BY ALAN R. WEIL

Ten years ago President Barack Obama signed the Affordable Care Act (ACA) into law, achieving a goal that had been out of reach for his predecessors. Despite the obvious benefits that universal health insurance coverage would confer on health care providers and insurers, historically the most notable posture of the health sector has been opposition to increased government involvement in health care. From the hiring of Ronald Reagan by the American Medical Association (AMA) to speak out against Medicare's "socialized medicine" to the insurance industry's "Harry and Louise" ads that helped bring down President Bill Clinton's health reform plan, the voice of health interest groups has been loud and strong.

Hoping to avoid the fate of his predecessors, President Obama made engagement with health care industry groups a central element of his strategy for enactment of the ACA. Four important groups with a stake in health reform and the power to change public opinion and legislative votes were physicians, hospitals, health plans, and the pharmaceutical industry. On May 11, 2009, President Obama announced that the AMA, the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), and Pharmaceutical Research and Manufacturers of America (PhRMA) had agreed to work with his administration to reduce the rate of growth in health care spending by 1.5 percentage points in each year from 2010 to 2019. This laid the groundwork for negotiations on what became the ACA. These four organizations—each with distinct goals and constituencies—emerged as key players in the politics and content of the ACA.

Alan Weil, Health Affairs *Editor-In-Chief, sat down with Matt Eyles, Nancy Nielsen, Rick Pollack, and Billy Tauzin to discuss the factors that led to the ACA's passage, as well as the law's shortcomings and successes. Eyles has been president and CEO of AHIP since 2018. He was vice president for government affairs and public policy for a health plan at the time of the ACA's enactment. Nielsen was president of the AMA from 2008 to 2009. She serves as the senior associate dean for health policy and a clinical professor at the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo. Pollack has had a thirty-two-year career at the AHA. He was executive vice president at the time of the ACA's enactment and is now the organization's president and CEO. Tauzin, a former congressman from Louisiana, was president and CEO of PhRMA from 2005 to 2010. He is senior counsel of Tauzin Consultants, a government affairs firm he cofounded in 2011.*

What follows is an edited transcript of an interview conducted with these four leaders on December 2, 2019, at the offices of the AHA in Washington, D.C. The full interview can be heard at http://www.healthaffairs.org/podcasts.

Photographs by Cheriss May

Leaders: From left, Alan Weil, Rick Pollack, Nancy Nielsen, Matt Eyles, and Billy Tauzin.

ALAN WEIL: Take us back to the debate over and ultimate enactment of the Affordable Care Act. You each represented membership organizations. What was most important to your members at the time?

RICK POLLACK: Coverage expansion was the window through which the AHA looked at the whole issue. That was the top priority, and we knew everything would flow from that. And we thought it was a moment in time—a moment in history where we could expand coverage to literally millions of people.

NANCY NIELSEN: That was number one on the hit parade for the AMA as well—in addition to getting rid of the SGR [sustainable growth rate], which we just detested. We had started the "Voice for the Uninsured" campaign in 2007. We were very committed to trying to cover the uninsured and to reform some things that we thought needed reform in the insurance industry. But it was really important to us to get people covered. It had become such a problem, with almost 18 percent of Americans under age sixty-five lacking health insurance—and we knew how bad that was.

MATT EYLES: I'll add that as a representative of the industry responsible for providing coverage, certainly coverage was at the center. And finding a pathway to getting everyone in America covered—that was first and foremost for AHIP. The other critical piece was looking at the affordability of the system and seeing the path that we were on, and at some level still are on, and whether or not we could address some of the key drivers of costs.

BILLY TAUZIN: From our standpoint at PhRMA, we saw the bill as a great opportunity to expand the availability of health care to people in America who were obviously suffering lack of access. But we also were very concerned about protecting the discovery and development process here in America that is producing so many treatments and cures for disease in our country and around the world.

Contrast With Prior Efforts

WEIL: What differentiated this time from previous unsuccessful efforts?

NIELSEN: Looking back at the Clinton effort, I really believe that they thought no smart people had ever tried to tackle this before. And so you had policy wonks and Ira Magaziner in the room and nobody else. Then all of these very complex things came out, and it was destined to be shot down by all the stakeholders because they had been excluded.

EYLES: I think that's exactly right. What's really interesting is to compare and contrast what was mostly a top-down approach in the nineties with a recognition by the Obama administration that Congress was a critical partner and needed to help lead in a fundamentally different way than what we had seen fifteen years prior to that—and engaging the stakeholders from the beginning.

POLLACK: And the other thing that was really distinguishing—with Clinton, they kind of brought out a bill and gave it to Congress and said, "Take this." With the ACA they did it the other way around. They let the legislature legislate.

TAUZIN: That's exactly right. I was a member, during the Clinton efforts, of the House Energy and Commerce Committee. And that's exactly the way we saw it. This was just being handed to us in a way that Americans had not had a chance to digest it and understand it.

Engagement With Congress And The White House

WEIL: To what degree was your work on the legislation with the White House, with Congress, or with both?

NIELSEN: It clearly was with Congress, where we had multiple meetings. But it also was with the White House. The White House would call meetings. And if you remember, cost was the overriding factor, and we were all going to have to give something in order to "bend the [cost] curve." But staffers from our association were in multiple meetings with the committees of jurisdiction over many months.

POLLACK: It was driven by the White House and Sen. Max Baucus (D-MT). Those were the driving forces behind this more than anybody else. And it's funny you mentioned the "bending the curve" exercise. All of our groups were around the table, and the administration asked: "What can you do as a (fill in the blank) to reduce health care spending by $2 trillion over some period of time, or something like that as a goal?" And I always view that as being less about the substance than it was their effort to avoid what happened during the Clinton administration—which is, at the outset you had the industries largely opposed to what they were doing—and this was a way to get people lined up to say, "We're going to work with you."

TAUZIN: The president would call these meetings. I attended one of them, but I had to sort of sit in the back with the staff because he didn't want lobbyists in the meeting. I had to bring one of the CEOs with me, so I brought them.

POLLACK: We had the same experience.

Public Option

WEIL: If expanding coverage was the most important goal, what was second most important for your members?

NIELSEN: We didn't rank our priorities, but we did not want a government takeover of the doctor-patient relationship. That was very important to us. If you will remember, there was the possibility of a public option for a period of time, and it was pretty clear that the government plans that we already had were underfunded and a new one would only worsen that situation.

EYLES: That was the biggest issue for health insurers—the potential for a government-run public option. Insurers said that would be untenable and would change the equation about whether or not the industry could be supportive of what was being advanced.

TAUZIN: That's where we were at PhRMA. We made a decision early on that something was going to pass and that we ought to be part of the effort to get it done right, and avoid the public option and the public takeover of health care in America.

POLLACK: The real thing that the AHA was also looking for was delivery system reform. It was our view that the way to achieve efficiencies was through reforms of the delivery system, and we needed to begin the journey that we're still on: a journey from the fee-for-service system to different forms of what is now called value-based payment. We knew that if we were going to expand coverage, there was going to be a demand for some element of affordability and better value. And in our view, the way to get there was through innovation in the private sector, in the delivery system—as opposed to command-and-control regulation.

Reaching Agreement

NIELSEN: I want to talk, though, about some dissension, because in the AMA we have people representing the whole political spectrum, not just one party—despite what people used to think. And so what happened is, as soon as "Obamacare" became an epithet that stuck, people who were opposed to Obama were on principle opposed to the ACA before they had any idea what it was.

Among our ranks, the most obvious element was the individual mandate. Our policy was very clear. We have had an individual mandate as part of AMA policy for years. We had worked with economists. It was, of course, a Republican idea. It came out of the Heritage Foundation. But as soon as it was part of "Obamacare," it became the whipping boy.

WEIL: So here you are. Repeal of the SGR and malpractice reform are major issues for you. You don't get the first, and all you get on malpractice is some demonstration grants.

NIELSEN: We got nothing worth talking about.

WEIL: Yet, ultimately, the AMA endorses the bill.

NIELSEN: We did support the bill. I remember it vividly. It was for the board a moral issue. We did not get the SGR. We thought we might get it later, but we were not going to get it then. We already had dissension in the ranks. But were we going to stand in the way of twenty million Americans getting health insurance? The answer was, we could not. That would have been the wrong thing to do. I still think we made the right choice for history. I really do. But we paid a price in our membership for several years. Membership has gone back up now and continues to rise, but it was a tough time.

EYLES: The insurance industry overall was dissatisfied and disappointed with provisions that were put in with respect to a number of the market rules. The minimum medical loss ratio was high on the list, when you're putting in essentially a government margin control.

There were a host of other ones: the age band issue and rate compression, and knowing what was going to befall younger consumers by going to a 3:1 age band. And we've seen that actually play out in premiums. We have not seen younger individuals take up coverage as much as they probably would have under some alternative scenarios. Standardization is one thing in terms of being able to ensure that consumers can compare like benefit plans, but were we a little too prescriptive in terms of how we designed some of those elements? There were a host of issues that we had challenges with.

WEIL: And in the end, AHIP did not support the bill, is that right?

EYLES: AHIP was one of the first industry groups to express support for what the ACA was trying to achieve. But the combination of the market rules I've mentioned and the single largest industry tax in the bill—$150 or $160 billion, or about $15 billion a year—made it hard to swallow. Leading up to the vote, the administration and some congressional leaders started to demonize the insurance industry as a way to generate public support for the bill. We were quite vocal in our concerns and never formally signed on.

POLLACK: For us at the AHA, we signed on. And the biggest point of tension was the $155 billion or more that we had to forgo in Medicare reimbursement. Remember, at that time we thought we were going to get thirty-two million people covered, until the Supreme Court ruled on the optional approach to the Medicaid expansion. But I think our experience was exactly like what you described with the AMA board. For us it was a moral question, it was a moment in time—and that was something that we thought was worth stepping up to the plate for, in order to get thirty-two million people covered.

Ultimately, the rest of the other national hospital groups and all the fifty state hospital associations came along. We were in constant consultation and communication to ensure that we stayed united. And I think that the associations were all aligned and united. Our members had some different views, but ultimately it all came together.

TAUZIN: Keep in mind, PhRMA didn't agree to sign on to the bill until the very end. It was because we were deeply concerned about the public option and whether or not the House would get the Senate to agree to their version.

The House version was one we deeply opposed. When the special election to replace the late Sen. Ted Kennedy (D) happened in Massachusetts, and the sixtieth vote was gone and the House had to accept the Senate bill, it became much easier for us to come to a conclusion to support it because we had lost our worst fears of a public takeover of health care and a loss of this incredibly important place in the world where drug discovery and development is occurring like no-

where else on the planet.

It was important to us when we did sit down and work with the administration, and the Senate committee particularly, that if we're going to put up that amount of money—and there was dissension about that among the members, but they came together unanimously on every other issue and on that issue, eventually—we wanted to make sure that the money was spent well.

One of the things we wanted to make sure was that the hole in the doughnut, Part D, was covered with our contributions. We wanted to make sure that the fees that would be assessed against the companies were fairly in proportion. We had an agreement, for example, that the larger companies within PhRMA would pay larger fee percentages than the smaller companies in fairness, because big companies could afford it better. We wanted to make sure that we avoided things like cost-effectiveness and the systems that we saw in Europe.

WEIL: How much communication was there across your industries during this time?

TAUZIN: Oh, my goodness. It was a lot.

NIELSEN: We were all in the room together, and everybody knew what was happening. I don't think there were a lot of surprises.

TAUZIN: And we knew where we disagreed. Except for the fact that the insurance industry didn't support it in the end, we pretty much worked together around those disagreements to the extent we could.

POLLACK: There were really two conversations going on. There was the global one, and then there were the individual ones in terms of trying to work out what each interest group wanted to see in the ultimate package.

The 'Affordable' In 'Affordable Care Act'

EYLES: I do wonder now, though, where we have a little perspective, whether it was shortsighted not to include anything around cost at that time. When you look back and when criticisms are levied at the ACA, a lot of it is right. The law is all about coverage. No one really thought about affordability. And had we taken some modest steps to think about cost, whether in comparative effectiveness or some other areas, would we be having maybe a little different discussion today around affordability? Because the biggest issues today still are around affordability. We want to get the remaining people covered, but had we taken some incremental steps to think critically about cost, would we be in a little different spot today than we are?

WEIL: None of you have mentioned IPAB [Independent Payment Advisory Board]. I couldn't imagine we would get this far in the conversation without talking about it.

POLLACK: IPAB was an example for us where hospitals were exempt from it for several years. And that was attractive. Of course, we weren't a fan of IPAB to begin with, because the only thing IPAB could do was cut provider rates on a fast-track basis.

If perhaps they would have put issues on the table with regard to the sustainability of Medicare and Medicaid in the long run that may involve revenues, may involve benefits, may involve delivery system reform, may involve provider payment—maybe that would have been a productive discussion. But it ended up being constructed in a way that simply was just another vehicle in a very extreme way procedurally to cut provider payments. Even though we were exempt for—I think it was ten years.

TAUZIN: You're talking about cost control. This was not a little feature. IPAB provided a bureaucratic board with the capacity to make decisions about health care that Congress traditionally makes about what we're going to fund, to what degree we're going to fund it, and how much we're going to cut.

This allowed this board to make changes that would go into effect unless three-fifths of the Congress voted affirmatively to override it.

POLLACK: And if you tripped the wire and the board didn't act, the HHS secretary had the authority to do it on their own.

TAUZIN: Yeah. I mean, it was really not just a tiny issue.

NIELSEN: We all felt that we were very vulnerable. We all felt we'd be the turkey carved on the table.

WEIL: What more would you have wanted on cost?

POLLACK: Liability reform was one of them.

NIELSEN: That's one. I think comparative effectiveness is really critical. I remember a very instructive conversation with the House Doctors Caucus, trying to talk about that. I'm saying, Physicians need to know what works better than something else because right now we don't. With all due respect to personalized medicine, it would be really good to know. And all of them were trained as scientists as I was, yet the answer was: It's a slippery slope, it's going to be used for cost control. End of discussion.

EYLES: I think around cost, though, from the insurer perspective, a lot of it translated into, "What would the cost of the product be that you are selling, and how much flexibility might you have to manage costs, to design more flexible benefits that might come in at a lower price point? How are you going to bring additional people into the system when you have a very weak individual mandate, and what's that going to mean for the overall system?" Adding some of the things like the health insurance tax, which really just added to the premium. And knowing that you're out there trying to sell your products to employers and then individual consumers, and they were going to be at a price point that was higher than you thought you could otherwise offer for a competitive, attractive product.

POLLACK: You know, in some ways we're coming full circle on this right now. Right now, value and affordability and cost are really the critical issues that everybody is focused on across the board. Back then, history was to be made, and covering tens of millions of lives—that was the moral imperative, that was the moment in time. We'll get to the other stuff when we need to and not let all this other divisive stuff get in the way of getting coverage to that point—what we hoped was thirty-two million people on the pathway to universal coverage. Now we're still dealing with the cost.

TAUZIN: Yeah, let's talk about some of those suggestions to control cost. One was importation. Getting cheap drugs in and lowering the cost for health care, for everybody in America. We already have a law that governs importations.

NIELSEN: But another aspect of the cost that really continues to be a problem is for young people. And it doesn't do any good to have on the Marketplace, for example, options that they can sign up

for if the deductible is so high that it's outrageous. We simply haven't accomplished that third arm of what the ACA wanted, which was bending the cost curve. We really have not.

TAUZIN: No, we haven't. Medicare Part D provides that the government shall not interfere with the private negotiations between the insurers and the manufacturers. That language was not written by PhRMA. It was in seven Democratic bills offered during the Clinton administration. The provision was there to make sure that these would be private negotiations—that people on Medicare would get the benefit of these discounts that would be negotiated for them. It worked fairly well. It saved about $550 billion over ten years because of the discounts being negotiated.

You could argue for government negotiation in Part D. But it wouldn't really be negotiation—it would be price controls, much as what you see in the VA. It came up in the debate on the ACA that we again stood against, because in fact it's working very well.

Pleasant Surprises

WEIL: What elements have been surprisingly positive?

NIELSEN: The creation of the Center for Medicare and Medicaid Innovation, which designed things like ACOs [accountable care organizations]—which allow physicians the flexibility to do what they need to do with their patients. We have a lot yet to learn about value-based pay, and value is sometimes in the eye of the beholder. But there are some really cool things that have happened and that we've learned. We need to watch those experiments and see how we can better use the resources we have to get better care to more people.

POLLACK: And what's interesting, of course, is we started that journey—we're ten years into it, and we still are trying to discover what works and what doesn't work. We knew that ultimately you could never achieve better value and better affordability if the incentives under the fee-for-service system remained. And we still have a long way to go, because the incentives under the fee-for-service approach are strictly volume, and there's no incentive for prevention, and there's no incentive for coordinating care.

What was very important to us under the VBP [value-based purchasing] was that it not be used as a tool for budget cutting. It should be used as a tool for improvement. And keeping it budget neutral was a big piece of what we thought was very important and was in there.

EYLES: So many experiments are going on now that have their genesis in the ACA, and I think many of us couldn't have predicted exactly how those would turn out. But we knew that there was going to be this entity that was going to try and push things forward. And we're learning a lot, but there's still a lot more work to be done.

TAUZIN: Including the pilots on bundling, trying to move towards value purchasing and all of that.

EYLES: I will mention another pleasant surprise: Medicare Advantage. Plans were being paid all over the board, depending upon where they were in the market. The ACA took about $160 or $170 billion out of the program, and there were projections that enrollment would drop substantially.

The star ratings program has fundamentally changed how Medicare Advantage plans are serving Medicare beneficiaries and has been a big driver of improved care for Medicare beneficiaries, because it has provided strong incentives to focus on quality. And because we're rewarding quality, it has substantially driven investments in those programs by Medicare Advantage plans.

POLLACK: I already mentioned a few, but I will add the 340B drug pricing program. We would have wanted it expanded even farther than it was, but the ACA expanded it to children's hospitals and cancer hospitals and to critical access hospitals, and that was important. There were a series of changes that helped stabilize rural hospitals—although we're still very much focused on dealing with that because we have a lot of problems in terms of ensuring that the rural health care delivery system stays vibrant—but also changes to meet the needs of how we will deliver care in the future.

TAUZIN: And keep in mind there was great trepidation over health care cost swamping the American budget. There were provisions put in the law that if we hit a certain percentage, it would trigger all sorts of things happening to deal with that issue. But privatization has literally stepped up as part of the reaction to that concern.

The pharmaceutical industry doesn't particularly like some of the abuses within the 340B program, but we supported the expansion of it. And one of the really nice effects has been the creation of more and more community clinics around the country. I started the first one in my district as a congressman against all of the medical community. They thought I was a communist or something, but they came to love it because it took patients out of the emergency rooms, it took them out of their waiting rooms where they couldn't pay their bills anyhow, and now they're getting preventive care. The 340B program has helped keep those clinics going.

The other thing I want to focus on is that saving twelve-year data exclusivity for biologics has produced an incredible explosion of new products that are now available to caregivers around the country. I know it's hard to cover them—they're expensive drugs. But the fact that now they're available to us has produced some enormous health care successes for our country. The cost of developing these products is enormous, and I know it's difficult for us just to bear. But at least we have them—and our survival rates are going up, our cancer rates are going down. That's a blessing.

EYLES: Another thing that I'll throw out there is the ACA has helped shift the perspective of our system to be much more consumer and patient centered than perhaps it was a decade ago. I know many insurance providers were much more business-to-business sorts of operations rather than business-to-consumer, and I think that that has spread broadly across our health care system by trying to tailor how health care is delivered toward individual consumers—so they can make better decisions for themselves and their families. It has been an evolution, but I think that consumer element of the ACA has been overlooked a little bit.

Disappointments

WEIL: In addition to more work on the cost front, as you look back, what are the greatest disappointments?

POLLACK: What comes to mind is that people actually refer to this as universal coverage. On its best day, fully phased in

with full Medicaid expansion, there were still going to be twenty-three million people that were not covered. The disappointment is that a lot of people thought that the job was done. But it was never done, and even the estimates showed that it wasn't going to get there all the way.

The other disappointment is that here we are ten years later, and we're still fighting over this thing, and it's still such a flash point. And we're getting ready for another court fight on it—and it's just hard to believe that ten years later, when we have a system that's built on the private sector and has the potential of being effective in that regard, we're still fighting over it. Rather than working to improve it, we're fighting over it as a political issue.

EYLES: And I would agree very much with what was said about the lack of bipartisanship and this having a big impact. If you think about the state of the individual market—which is what most people associate with Obamacare more than any other market segment, right?—the fact that it was a partisan exercise has led, from the start of the implementation of the program really to the current day, to having it be much more challenged, much more unaffordable, especially for those individuals who don't qualify for significant subsidies and have been totally priced out.

NIELSEN: Especially in states that didn't expand Medicaid, people get caught in the coverage gap.

EYLES: I was working at the Congressional Budget Office (CBO) during the Clinton health reform debate. I worked on a paper that came out from CBO in August of 1994 called "The Budgetary Treatment of an Individual Mandate to Buy Health Insurance." It was a concept that was being advanced more in conservative health policy circles at the time—to say individuals should be responsible for making sure that they have coverage. And it has been interesting to see how now, twenty-five years later, we're still talking about it, although from a very, very different vantage point.

TAUZIN: But the mandate to buy coverage also made it imperative that we expand Medicaid. Our industry supported that expansion around the country, because if you're going to require people to have insurance coverage and you recognize that a family of four without Medicaid coverage could not afford to pay even the cheaper prices that were promised out of the ACA—you had to face that issue. Will you or will you not allow the states to expand Medicaid? And obviously that became a central part of the agreement.

NIELSEN: That's one of the disappointments, because that would have standardized eligibility for Medicaid across the country and not the craziness that we still have and all the lawsuits that we've had. It was a big disappointment when that became a states' rights issue.

POLLACK: And also, for us it goes back to, "What did you give up?" We accepted a reduction of $155 billion over a period of time in Medicare hospital reimbursement in exchange for coming on board and getting other things that we wanted accommodated. But, boy, that ended up playing out differently in different states. There are certain providers that had the benefit of expanded coverage in some states but not in others. And that created a lot of tension, and it still exists.

TAUZIN: It was a big issue just last month in Louisiana. The incumbent governor who supported the expansion had to defend it and barely survived reelection. It still creates tension. And you're correct: It creates disharmony in the program around the country.

Success, But Work Remains

NIELSEN: But I want to talk about the success—the real success. In 2010 almost fifty million Americans were uninsured. In 2018 it was down to about twenty-eight million. So good things happened.

The tragedy is the Medicaid expansion. Had that really been universally applied as it was thought it was going to be, we would have halved the uninsured rate in Texas, in Florida—in all the states where it still is an issue. We would still have the affordability issue; that is a major problem. But there is nothing good about being uninsured—nothing. We can all agree on that. And the ACA certainly cut that rate dramatically. So we have to celebrate that part.

EYLES: We do. I think that should be a big celebration, right? But the missed opportunity is we could have at a national level numbers that come closer to, say, what we see in the state of Massachusetts in terms of uninsured—which is 3 or 4 percent. There's probably always going to be some sort of transitional nature. I don't know if we would ever get to absolute zero, but we would be close.

NIELSEN: But we're still fighting. We're still fighting over whether this law is constitutional. I mean, we just don't even have that answer.

POLLACK: Looking back, the bill passed in 2010 and didn't get really implemented until 2014. And that four-year hiatus when the administration was working on the implementation gave an opening. And of course the midterm elections flipped the House at that point in time. And you look back and you see that there were four years there where the program was largely ramping up and being attacked, and it led to a political dynamic.

NIELSEN: It was a concept, not a benefit.

POLLACK: Maybe all of us, including the administration, didn't quite educate the public enough in that period of time to get people more invested in it.

NIELSEN: If you're going to pass a law, have the good things happen right away and have the things everybody hates be delayed. And make sure that the demonizing is immediately fought or preemptively decimated. Those are just some obvious lessons.

TAUZIN: Well, the other thing we can acknowledge is that this act could be improved rather dramatically if Congress got past all the demonization and really worked together to improve it—particularly for that crowd of Americans like the nine million who don't get the subsidies but ought to be able to afford coverage if we can make some changes. It could easily make this act work better for young people as well as old people. What I'm saying is, if we can get past the constitutional arguments to where people could quit hoping that the courts are going to deal with it and Congress has to deal with it, there's room for improvement.

WEIL: Thank you all for a very interesting conversation. ■

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By Sabrina Corlette, Linda J. Blumberg, and Kevin Lucia

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REVIEW ARTICLE

The ACA's Effect On The Individual Insurance Market

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ABSTRACT The vision of the Affordable Care Act (ACA) for a reformed individual health insurance market included requirements and incentives for insurers to manage risk instead of avoiding it, minimum standards for coverage adequacy, income-related subsidies, managed competition through health insurance Marketplaces, and new programs to promote insurer competition. Against this vision, we assessed how insurance markets evolved between 2014 and 2019, using metrics such as premium changes, insurer participation, and enrollment. We also assessed how federal and state policy choices during the implementation of the ACA may have affected market performance. The article closes with an assessment of recent federal-level policy choices and the evidence to date about their effect on insurance markets, together with a discussion of how market experience under the ACA can inform policy makers who seek to further expand consumers' access to affordable, comprehensive coverage.

The individual health insurance market is sometimes called a market of last resort. It's where people who have no other access to coverage—through an employer or via Medicare or Medicaid—turn for insurance. Some, such as those who are self-employed or whose employers do not offer coverage, are long-term denizens of the individual market. For others, it's a short-term solution while they are between jobs, in early retirement, or taking time off to care for a loved one. While the individual market is estimated to include only about seventeen million people,[1] it serves as an essential safety net.

A key element of the strategy of the Affordable Care Act (ACA) to expand coverage was to fix flaws in the individual market that made it difficult for people with health problems to obtain adequate, affordable insurance. Although the ACA reforms disrupted insurance companies' long-standing business practices and engendered early market turbulence, they have helped millions of people gain access to insurance that would be otherwise unavailable and have given millions more peace of mind knowing that coverage would be available should they need it. At the same time, an immediate political backlash to the ACA has had significant long-term consequences for the stability of the market and the security of the law's consumer protections. This article reviews the provisions in the ACA designed to reform the individual market, summarizes the impact of those reforms, and discusses options for policy makers who would build on the ACA to further expand access to affordable, comprehensive coverage.

Making A Dysfunctional Market Work: Individual-Market Reforms

BEFORE ENACTMENT Before the enactment of the ACA, under most state laws insurers in the individual market could deny coverage, charge an unaffordable premium, or limit benefits based

on a person's medical history.[2] Furthermore, individual-market insurance generally covered fewer benefits and came with higher out-of-pocket spending than employer-based insurance did.[3]

PROVISIONS OF THE LAW The ACA's architects intended to encourage individual-market insurers to no longer compete based on their ability to avoid risk, but rather on their ability to deliver high-quality care at an affordable price. To achieve this, the ACA included several reforms, the foundation of which was a social bargain referred to as the three-legged stool.

First, insurers were prohibited from denying coverage, charging higher rates, or limiting benefits as a result of an applicant's health status. Their coverage was also required to meet minimum adequacy standards, with prescribed essential health benefits and up to four levels of coverage generosity (bronze, silver, gold, and platinum).

Second, to prevent people from waiting to sign up for insurance until they became sick, consumers would be expected to maintain health coverage or pay a penalty (the individual mandate).

Third, to make that coverage more affordable, consumers with incomes of 100–400 percent of the federal poverty level could receive income-based Advance Premium Tax Credits and cost-sharing reduction (CSR) subsidies. Lower-income people would be eligible for Medicaid—although this eligibility expansion was ultimately made voluntary for states under the US Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius*.

The ACA also created state-based health insurance exchanges, known as Marketplaces, designed to encourage insurers to compete based on price and quality. Consumers need to buy their insurance through the Marketplaces to receive Advance Premium Tax Credits and CSR subsidies. To access that subsidized population, insurers need to offer plans that meet the Marketplaces' minimum standards. Furthermore, the amount of the tax credit that each enrollee receives is pegged to the premium for a benchmark plan (the second-lowest-cost silver plan) available in their area. Enrollees who choose to buy a more generous plan must pay the difference in premiums. The ACA's subsidy structure thus creates an incentive for consumers to seek out, and for insurers to offer, plans with lower premiums.

To further discourage insurers from avoiding consumers based on their health status and to promote affordability, the ACA included three premium stabilization programs: risk corridors, reinsurance, and risk adjustment. Risk-corridor and reinsurance programs help insulate insurers from losses by compensating them if they set premiums too low to cover the health care costs of the newly insured population or enrolled people with catastrophically high costs. Risk adjustment requires insurers that enrolled a greater share of healthier people to compensate insurers that enrolled a greater share of sicker people. (For more detail on the three premium stabilization programs, see online appendix exhibit A.)[4]

The ACA also included two programs designed to encourage new competition in the individual insurance market. The Consumer Operated and Oriented Plan (CO-OP) Program authorized $6 billion in start-up and solvency funds to encourage new nonprofit plans to enter the market. The Multi-State Plan (MSP) Program required the federal Office of Personnel Management to certify two health plans that could compete on the ACA's Marketplaces in at least 60 percent of states by January 1, 2014.

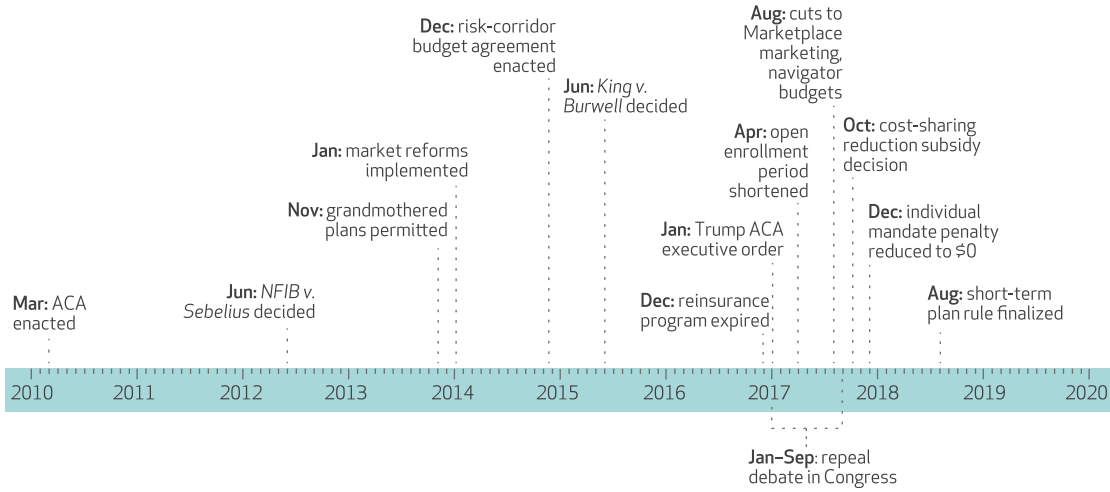
AFTER ENACTMENT: POLITICAL, LEGAL, AND REGULATORY CHALLENGES The ACA's reforms were designed to foster robust insurer participation and provide both a balanced risk pool and comprehensive health plans that would meet people's needs regardless of health status. However, in the wake of a political backlash against the law and unstinting opposition from many federal and state policy makers, the administration of President Barack Obama and Congress made several decisions that weakened the law's foundations. The law's opponents further undermined market stability through legal challenges that created uncertainty about the future of the law (exhibit 1).

CONTINUED AVAILABILITY OF UNDERWRITTEN INSURANCE OPTIONS To fulfill President Obama's campaign promise that "if you like your plan, you can keep it,"[5] the ACA exempted from most insurance market reforms all plans that were in existence before the law was enacted (known as grandfathered plans). In 2013 the Obama administration gave states the power to exempt another category of plans: those issued after March 2010 but before 2014 (grandmothered plans). In both cases, insurers could retain enrollees who had passed a medical history screen and were healthier, on average, than those signing up for ACA-compliant plans. Insurers were also allowed to set premiums for these plans based on the healthier status of enrollees and were not required to pool their risk with those enrolling in the reformed market.[6]

Many insurers also took advantage of regulatory loopholes that enabled them to sell products that, while not considered health insurance under federal law, could be marketed to consumers as a cheaper alternative to ACA-compliant plans, as long as the consumer was able to pass medical underwriting. These included short-term health

EXHIBIT 1

Timeline of events related to the Affordable Care Act (ACA) that affected insurance markets, 2010–20



SOURCE Authors' analysis. **NOTES** "Grandmothered plans" are explained in the text. The Trump ACA executive order, the first issued by the Trump administration, laid out interim steps in anticipation of a repeal of the ACA.

plans that could last up to twelve months, which created an alternative to ACA coverage that could siphon healthy people away from the ACA-compliant market. (For more detail on grandfathered, grandmothered, and short-term health plans, see appendix exhibit B.)[4] Although the Obama administration attempted to curtail the sale of short-term plans in 2016, the administration of President Donald Trump reversed that policy two years later and has since encouraged the sale of short-term plans.

UNDERMINING THE RISK-CORRIDOR PROGRAM The risk-corridor program was designed to keep premiums stable by compensating insurers that set their prices too low in the early years of the ACA's Marketplaces. The government's promise of payments from that program encouraged some insurers to price their plans lower than they might have otherwise. However, long after insurers' pricing decisions had been made for 2015, congressional opponents of the law enacted a budget provision that disabled the risk-corridor program by limiting the amount the federal government could pay insurers to compensate for losses. The government ultimately paid insurers only 12 percent of what they had been promised. This decision had a disproportionately severe impact on small insurers, including a number of new CO-OP plans, which did not have a large capital base or diverse sources of revenue.[7]

LITIGATION AND UNCERTAINTY AMONG POTENTIAL ENROLLEES AND INSURERS Opponents of the ACA challenged the law in federal court, resulting in two high-profile decisions by the Supreme Court in *NFIB v. Sebelius* and *King v. Burwell*. In both cases, the plaintiffs challenged critical provisions of the law and generated considerable uncertainty over its future.[8] If the Court had ultimately ruled in the plaintiffs' favor, the decisions would have struck down the ACA in its entirety or rendered the Marketplaces effectively unworkable in most states.[9] However, in both cases, the Court upheld the key tenets of the ACA's three-legged stool. More recently, a coalition of state attorneys general sued in federal court to have the entire ACA declared unconstitutional. That case, *Texas v. United States*, could be decided by the Supreme Court in 2021.

VARIATION IN STATE POLICY AND POLITICS While the ACA significantly strengthened federal standards, states have continued to be the primary regulators of insurance, and the ACA delegated many decisions to state policy makers.[10] This has led to significant policy variation across states. For example, in 2014 only sixteen states and the District of Columbia chose to operate their own Marketplaces.[11] Twenty-one states and the District of Columbia chose to prohibit grandmothered plans.[12] As of mid-January 2020 fourteen states had not yet expanded Medicaid under the ACA.[13] Nebraska is reported as having expanded, although its expansion encountered political resistance and is expected to be implemented in October 2020.[14]

The Impact Of The ACA On Insurance Markets

The transition to reformed individual insurance markets was far from smooth. Insurers were required to make significant changes in their ap-

proaches to pricing, enrollment, and benefit design. However, politically driven policy shifts after implementation disrupted the path to a natural market equilibrium. The transformation of the individual market into one in which insurers compete based on their ability to manage risk instead of avoiding it has been substantial but remains incomplete.

INSURER PARTICIPATION AND PREMIUMS Insurers varied in their responses to the ACA. New market entrants emerged in many areas, including some insurers that had previously provided coverage only to Medicaid beneficiaries. Many of these insurers, relying on lower-cost provider networks and anticipating that lower premiums would allow them to gain significant market share, priced aggressively low. Early on, Medicaid-only insurers tended to participate in urban areas, with some primarily serving the lowest-income (and most heavily subsidized) enrollees.[15] Newly established nonprofit CO-OPs also entered markets in twenty-four states, often pricing their plans low to start.[7] Many of these expected that their risk in pricing low would be mitigated by the risk-corridor program.

Other insurers, particularly for-profit national insurers, took a different approach, setting premiums much higher than their competitors did. In part, they were concerned that they would attract higher-risk enrollees and not be adequately compensated by the ACA's premium stabilization programs. In many cases, their premiums were sufficiently high that they participated in name only. Insurers affiliated with Blue Cross Blue Shield participated across the country, many relying on their existing broad provider networks. Many set premiums competitively, hoping to retain their dominant market shares. Regional insurers were also frequent participants in the ACA Marketplaces.

In 2014 average silver plan premiums were lower than anticipated in many rating areas.[16] The weighted average lowest silver plan premium for a forty-year-old nonsmoker was $256 in 2014 (exhibit 2), ranging from a low of $154 in Minneapolis, Minnesota, to a high of $461 in rural Georgia, and the average number of participating insurers in each rating region was five (data not shown). Insurers increased their rates only modestly in 2015.[17] However, several factors significantly increased insurers' risks, including the dismantling of the risk-corridor program and the exemption of grandmothered plans from ACA reforms. Furthermore, some insurers with lower-price plans, particularly CO-OPs, were required to make higher-than-expected risk-adjustment payments.[7]

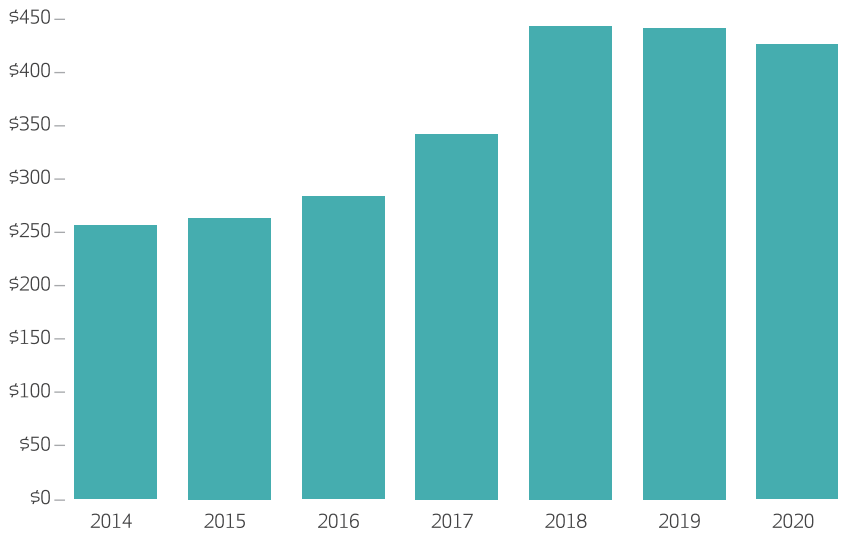
All but four of the twenty-four CO-OPs established under the ACA have been forced to shut down because of financial losses. Several national insurers also exited markets where they had high prices and low enrollment.[18] Meanwhile, the MSP Program was never able to offer a viable alternative to existing players (the primary sponsor of these plans was Blue Cross Blue Shield, which was already a dominant presence in most states). The Trump administration shut down that program with little fanfare in 2019.

Premiums tended to be lower in urban areas and areas with larger numbers of competing insurers.[19] Medicaid insurers frequently offered the lowest premiums in areas in which they participated.[15] However, the ACA did not address the lack of providers in areas with low populations and some urban areas. Where there is limited provider competition, insurers have little leverage to negotiate lower payment rates, and higher provider payments lead to higher premiums.

In 2016, with more complete data on enrollment, risk adjustment, and the health experience of the population, some insurers left the market or increased premiums significantly. For example, the average lowest silver plan premium increased 7.2 percent from 2015 to 2016 nationally. In 2016 Alaska was in danger of having no Marketplace insurers in 2017, so it created its own reinsurance program—thus lowering premiums substantially. Plans affiliated with Blue Cross Blue Shield increased their use of narrow networks in the Marketplaces in an effort to contain costs. While premium increases varied

EXHIBIT 2

Lowest average monthly silver plan premiums for a forty-year-old nonsmoker, 2014–20



SOURCE Authors' analysis of data from the following sources: (1) Blumberg LJ, et al., Marketplace price competition in 2014 and 2015 (see note 15 in text). (2) Blumberg LJ, et al., Increases in 2016 Marketplace nongroup premiums. (3) Holahan et al., Marketplace premiums and insurer participation: 2017–2020 (see note 23 in text). **NOTE** Full citation details for the sources are in appendix exhibit D (see note 4 in text).

considerably across the country in 2016 and tended to be large in 2017, investment analysts believed that those increases allowed the markets to move closer to an equilibrium and that future increases would be more predictable and smaller—with more insurers becoming profitable—as long as no further disruptive policy changes were introduced.[20]

FEDERAL POLICY AND MARKET INSTABILITY As a candidate, Donald Trump pledged to repeal the ACA as one of his first acts as president. The policy changes pursued by his administration and Congress beginning in early 2017 compromised the emerging but fragile stability of the individual market. With the well-publicized pursuit of legislation to repeal the ACA during 2017, many consumers were confused about whether the law would still be in place in 2018. Insurers were required to submit proposed plans and rates for 2018 in the summer of 2017, at a time they faced substantial uncertainty about what the market rules would be for 2018. While the repeal effort was ultimately unsuccessful (except for elimination of the individual-mandate penalties in December 2017), confusing news reports combined with aggressive administrative efforts to undermine the ACA framework (for example, shortening the open enrollment period, slashing outreach and enrollment assistance funding, eliminating federal reimbursement of CSR subsidies, and expanding short-term plans) led many insurers to set premiums conservatively high and some to pull out of the market entirely.[21]

Initially, some rural areas were at risk of having "bare counties," where insurers threatened not to participate in their Marketplace in 2018. State departments of insurance took steps to secure participation in those areas.[22] Insurers' conservative approach to pricing was intended to reduce the risk of substantial financial losses should the insurance pool shrink considerably because healthier-than-average enrollees chose to enroll in newly available underwritten short-term plans or forgo coverage entirely.

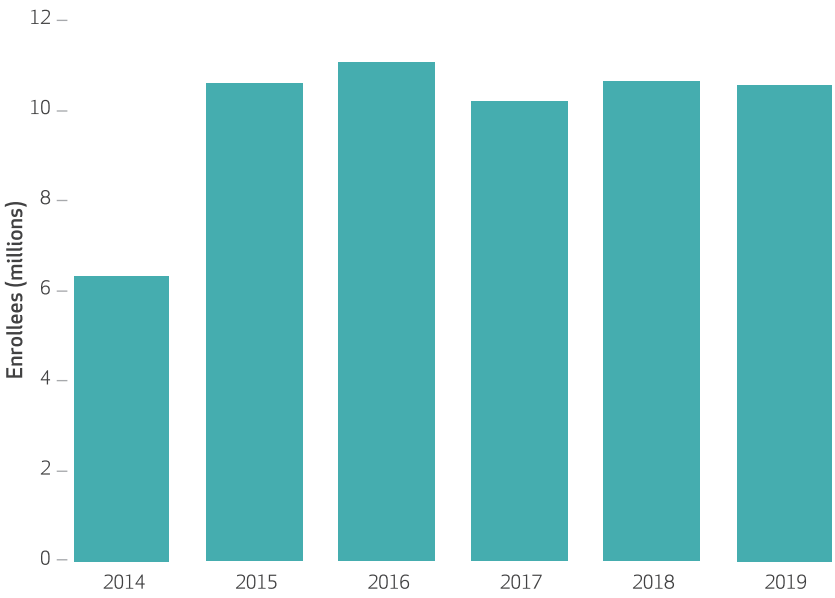
Thus, for 2018 the average number of participating insurers in a rating area fell from four to three, and the average lowest silver plan premium increased by 29.7 percent.[23] Most states either allowed or required insurers to load their expected costs associated with the loss of federal reimbursements for CSR subsidies into their silver plan premiums (a process called silver loading), which exacerbated the already conservative approach to pricing that year.[24] The structure of the ACA's premium subsidies—Advance Premium Tax Credits that increase dollar for dollar with premium increases for the benchmark silver plan—meant that many enrollees received increased subsidies in 2018. (For a graphic description of silver loading and its effects, see appendix exhibit C.)[4] This could explain why Marketplace enrollment in that year increased by 4.3 percent nationally, in spite of uncertainty about the future of the law.[25]

By mid-2018 many insurers realized that their risk pool was not as bad as anticipated and that they had overpriced. As a result, insurer participation grew in 2019, and premium increases were much lower, with premiums for the lowest-price offerings in many rating areas even decreasing. The national average lowest silver plan premium decreased by 0.4 percent, and the statewide average lowest silver plan premium decreased in twenty-three states.[23] This recalibration continued into 2020, with the average lowest silver plan premium declining 3.5 percent. Current Marketplace enrollment estimates for 2019 suggest a decrease from 2018 of less than 1 percent (exhibit 3).[26]

National averages mask considerable state-to-state variation in premiums and enrollment. State-level policy decisions have helped drive that variation. For example, states that chose

EXHIBIT 3

Enrollment in the Affordable Care Act Marketplaces, 2014–19



SOURCES Authors' analysis of data from the following sources: (1) CMS.gov. Early 2019 effectuated enrollment snapshot (see note 26 in text). (2) CMS.gov. Early 2018 effectuated enrollment snapshot (see note 25 in text). (3) CMS.gov. 2017 effectuated enrollment snapshot. (4) CMS.gov. March 31, 2016 effectuated enrollment snapshot. (5) CMS.gov. March 31, 2015 effectuated enrollment snapshot. **NOTES** Full citation details for the sources are in appendix exhibit D (see note 4 in text). March snapshot data were used for each year for which they were available for comparability. Because March snapshot data were unavailable for 2014, we used average monthly effectuated enrollment (that is, the numbers of enrollees who have paid their first month's premium payment). As a consequence, the increase in enrollment shown between 2014 and 2015 is larger than was actually the case. Using full-year data for both 2014 and 2015 indicated an enrollment increase of 38.5 percent between the two years.

Politically driven policy shifts after implementation disrupted the path to a natural market equilibrium.

to run their own Marketplaces have, on average, had better enrollment and insurer participation than states with a federally run Marketplace. Premiums in the period 2016–18 also grew at a slower rate in states that ran their own Marketplaces than in states that relied on the federally run Marketplace.[27] Not coincidentally, states operating their own Marketplaces were also more likely to prohibit grandmothered health plans.

The ACA's Future: 2020 And Beyond

The ACA is caught in an ideological tug-of-war over how best to finance and deliver health care services to individuals. Parties on the ideological extremes of the policy spectrum envision dismantling the ACA and replacing it with a different system. Some on the right argue that individuals should be able to choose a health insurance option that fits their specific needs and that the price they pay should reflect the risk they pose to the insurance company (and be at most minimally subsidized by taxpayers). Some on the left would replace the ACA with a single government-run health insurance program. In the middle are those who argue that the ACA's structure is sound and that in spite of unstinting political opposition, it has had considerable success in covering more people, increasing access to critical health care services, and improving the financial stability of millions of families. But even the ACA's most ardent supporters recognize that it could be enhanced to expand coverage and improve affordability more than its original design allows. Regardless of their ideological bent, policy makers considering reforms that would depend on the participation and decisions of private insurers would do well to consider the experience—positive and negative—of the individual market under the ACA.

Experience Of The Individual Market Under The ACA

SUCCESSES

▶ **EXPANDED COVERAGE:** The ACA expanded coverage to twenty million mostly lower-income people.[28] Those who gained coverage had measurable improvements in their financial situation as well as in their ability to obtain needed care.[29,30] Furthermore, people with preexisting health conditions were no longer "locked out" of the insurance market as a result of inaccessible, inadequate, or unaffordable offers of coverage.

▶ **STABLE ENROLLMENT:** The structure of the ACA's financial subsidies have kept enrollment through the ACA's Marketplaces relatively stable, in spite of policy changes that drove up pre-subsidy insurance prices. In turn, stable enrollment has helped maintain significant insurance company participation. Several insurers have expanded their areas of participation in recent years or announced their intention to do so. Insurers' revenues are now meeting or exceeding the cost of covering their enrollees.

▶ **FINANCIAL PERFORMANCE:** Insurers posted strong financial performance in 2018 and 2019, on average.[31] Furthermore, the ACA's subsidy structure and the Marketplaces through which those subsidies flow have helped demonstrate that managed competition can drive down premiums and promote consumer choice, although long-standing challenges remain in less densely populated regions of the country.

CHALLENGES AND POTENTIAL SOLUTIONS

▶ **AFFORDABILITY:** People who do not qualify for the ACA's premium subsidies can face steep prices for their coverage. For example, in some regions of Georgia, a family of four that doesn't qualify for premium tax credits could be asked to pay over $1,700 per month for a silver plan in 2019.[32] As premiums spiked in 2018, an estimated 1.2 million unsubsidized people dropped their Marketplace insurance.[33]

State and federal policy makers have several options to make ACA coverage more affordable for unsubsidized people. Reinsurance programs, which are proven to lower premiums, have been authorized in twelve states.[34] Five states have enacted their own individual mandate laws to keep healthy people enrolled, and twenty-four states have limited the sale of short-term plans.[35] California passed legislation in 2019 to expand premium subsidies to families with incomes up to six times the federal poverty level. Similar proposals are pending in Congress and have been promoted by some Democratic presidential candidates. Massachusetts and Vermont also offer additional subsidies on top of the federal ones.

▶ **COMPETITION AND CHOICE:** The ACA's Marketplaces rely on the voluntary participation of private insurers to cover enrollees. Market and political uncertainty in the period 2015–18 prompted many of these insurers to either exit the market or reduce their service areas. In 2018, 26 percent of enrollees had only one insurer to choose from and often faced high premiums if they were ineligible for subsidies.[36]

In the face of evidence that most Marketplace consumers were willing to trade a broad provider network for a lower price, many insurers in the ACA's Marketplaces have shifted to narrow-network plans. As a result, people seeking broader network choices are less likely to find them.

Policy makers have several options to encourage competition and expand consumers' choices. Reinsurance, discussed above, has helped maintain insurer participation. Some states have tied insurer participation in the Marketplaces to winning contracts for other state programs, such as Medicaid (in Nevada) and the state employee health plan (in Washington).

States or the federal government could also develop a "public option" or government-sponsored plan for either underserved areas or entire states that would ensure that enrollees had additional—and perhaps more affordable—coverage choices. States could also consider capping provider payment rates, which would give individual-market insurers a greater incentive to participate in areas with provider monopolies.[37] Increasing individual-market subsidies, pegging premium tax credits to gold instead of silver plans, or both would also tend to increase enrollment and thus the attractiveness of the Marketplaces for insurers.[38]

Conclusion

Under the Trump administration, the ACA Marketplaces have faced sustained efforts to undermine them, yet they have remained remarkably resilient. Although premiums spiked in 2018 and many states faced the threat of having bare counties, ultimately no one lost access to coverage, subsidized enrollees benefited from the practice of silver loading, and enrollment declined only modestly at the national level.

A stable, functioning individual market is important as a safety net for millions of people going through career and life transitions.

The ACA's premium tax credit structure has been the backbone of the Marketplaces, providing insurers with a safety net of enrollees who are insulated from the premium increases that stem from recent federal policy choices. However, the Trump administration has made efforts to weaken that backbone. In 2020 an estimated 7.3 million subsidized Marketplace enrollees are paying more in premiums than they did in 2019, because of an administrative change in the way their tax credits are calculated.[39]

There is evidence that the number of uninsured people may have increased for two consecutive years.[40] Uninsurance rates could keep rising if enrollment in the Marketplaces decreases further. This could happen as more people become aware that there are no longer financial penalties for remaining uninsured and if companies selling short-term and other noncompliant plans continue their aggressive sales tactics.[41] In addition, a Supreme Court decision for the plaintiffs in *Texas v. United States* could invalidate the entire ACA and throw the individual insurance market into chaos.

A stable, functioning individual market is important as a mechanism to reduce the number of uninsured people and as a safety net for millions of people going through career and life transitions. The ACA's sensitivity to policy change serves as both a lesson and a warning for policy makers contemplating future reforms. ■

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By Matthew Fiedler

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REVIEW ARTICLE

The ACA's Individual Mandate In Retrospect: What Did It Do, And Where Do We Go From Here?

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ABSTRACT The Affordable Care Act required most people to obtain health insurance or pay a tax penalty. Legislation enacted in December 2017 effectively repealed that requirement, starting in 2019. This article reviews recent research on the mandate's effects, concluding that the mandate meaningfully increased insurance coverage, but likely by less than was projected before implementation. These coverage gains are likely to erode as mandate repeal takes hold. Looking ahead, policy makers have many options for expanding insurance coverage without restoring an individual mandate. However, achieving universal coverage without some form of mandatory individual contribution to health insurance would have a very large fiscal cost.

Starting in 2014 the Affordable Care Act (ACA) required all Americans to obtain health insurance or pay a tax penalty that gradually increased to the greater of $695 per person or 2.5 percent of household income when fully in effect in 2016 (with some exceptions, such as if coverage was deemed unaffordable). This requirement, commonly called the law's "individual mandate," was expected to be a major contributor to the overall expansion in insurance coverage under the ACA, alongside the law's expansion of eligibility for Medicaid and subsidies for people purchasing individual coverage through the Marketplaces.[1] Tax legislation enacted in December 2017 eliminated the tax penalty associated with the mandate starting in 2019, effectively repealing the mandate.

With the mandate having come and gone, now is an opportune time to examine what can be learned from it and what role mandates or similar policies might play in future efforts to expand coverage. To this end, this article makes two main points. First, on balance, recent research suggests that the mandate meaningfully increased insurance coverage, but likely by less than was projected before its implementation, and repeal has likely increased the uninsurance rate and may increase it more over time. Second, while it is possible to expand insurance coverage without restoring an individual mandate, achieving universal coverage without some form of mandatory individual contribution to health insurance would have a very large fiscal cost.

The Rationale For An Individual Mandate

The main arguments for an individual mandate have a long history,[2,3] but it is worth briefly reviewing such a mandate's two main objectives.

EXPANSION OF COVERAGE The first objective is to expand insurance coverage. A common premise of health policy debates is that too few people have health insurance. That is, some people lack coverage even though the social benefits of that coverage (better financial security and better health) exceed the social cost of that coverage (namely, the cost of delivering any additional services that enrollees are induced to consume and the cost of administering that coverage).

There are at least three reasons why coverage rates are likely to be too low without an individual mandate (or appropriate subsidies). First,

people can often obtain some care without paying for it—notably, through hospital emergency departments—which reduces the benefit people receive by purchasing insurance.[4,5] Second, some people may underestimate the value of insurance coverage, perhaps because the risk of falling ill is not fully salient.[6] Third, when insurers are barred from varying premiums or other coverage terms based on health status, as they are under the ACA, premiums will generally exceed the expected health spending of healthier people, causing the cost of coverage to them to exceed its social cost.[7,8]

INCREASED POOLING OF RISK The second main objective of an individual mandate, related to the first, is to increase the pooling of health care spending burdens among people in better and worse health. This objective generally reflects a belief that pooling such burdens reduces the hardship that those burdens create. The ACA pursued this goal by barring insurers from varying premiums or other coverage terms based on health status. But this approach can be successful only if healthier people purchase coverage, and research finds that they are relatively less likely to do so.[7,8]

MANDATES VERSUS SUBSIDIES An individual mandate advances both objectives by increasing the price of being uninsured and thereby causing more people—particularly healthier ones—to obtain coverage. But a mandate is not the only way to create financial incentives to obtain coverage. Indeed, the ACA also greatly expanded the availability of subsidized coverage through its Medicaid expansion and Marketplace subsidies. In principle, an approach that relied solely on subsidies could achieve equivalent coverage outcomes.

The appropriate balance between subsidies and a mandate depends on judgments about who should bear the cost of insurance coverage. Relying more heavily on subsidies places more of the burden on the government, with the ultimate incidence depending on the taxes levied to finance those subsidies. In contrast, relying more heavily on a mandate places more of the burden directly on individuals. The appropriate approach may be different for different groups. Indeed, the ACA placed a particular emphasis on reducing financial burdens for low- and moderate-income people and thus relied more heavily on subsidies at lower income levels and more heavily on a mandate at higher income levels.

Evidence For The Mandate's Effectiveness

Research on Massachusetts's 2006 health reform law demonstrated that a mandate could be an effective tool for increasing coverage.[7,9,10] Several recent empirical analyses have sought to determine whether the same was true for the ACA. Exhibit 1 summarizes those empirical analyses, as well as several projections of the mandate's effects, which are discussed later in this section.

The exhibit reports two measures of the mandate's impact. The first is the percentage change in the number of uninsured people due to the mandate, relative to a scenario without the mandate. The second is the corresponding effect on individual-market enrollment, which facilitated the inclusion of analyses that examined only the individual market. Note that the various analyses examined different populations, which may be one reason that estimates vary across analyses. The methods used to extract estimates from each analysis are described in online appendix A.[11]

Isolating the mandate's effect on insurance coverage is challenging because the mandate was implemented simultaneously nationwide and in tandem with the ACA's other major coverage provisions. The empirical analyses summarized exhibit 1 used three main strategies to surmount this obstacle, each of which has strengths and weaknesses.

INTENT TO KEEP OR DROP COVERAGE The first group of studies in the exhibit[12–14] surveyed insurance enrollees about whether they intended to drop their coverage in response to mandate repeal (or, in the case of Vicki Fung and coauthors,[13] whether they would have obtained coverage in the first place without the mandate). This approach is conceptually straightforward, but it has the limitation that respondents' actual choices might not match their stated intentions.

All three studies in this group found that the mandate increased individual-market enrollment, although the magnitude of the increase differed markedly across studies (8–23 percent). The study by Sara Collins and colleagues[12] is the only one of the three that examined the mandate's effects outside the individual market. It found that the mandate reduced the overall number of uninsured people by 21 percent. Fung and coauthors also predicted health spending for each respondent based on their health and demographic characteristics.[13] The authors estimated that the departure of people who reported that they would not have obtained coverage without the mandate would increase average individual-market claims spending by 6 percent.

VARIATION IN PENALTY SIZE The second group of studies[15–17] aimed to estimate the effect of the mandate by comparing people who faced larger penalties to those who faced smaller penalties, using the fact that the applicable penalty varied based on income, place of residence, and other

EXHIBIT 1

Estimates of the effect of the individual mandate on insurance enrollment

Analysis	Population	Estimated change in coverage type due to mandate: Uninsured	Estimated change in coverage type due to mandate: Individual market
SURVEYS THAT ELICITED INTENDED RESPONSES TO REPEAL OF THE MANDATE			
Collins et al., 2018 (note 12)	Nonelderly adults, 2018	–21%	10%
Fung et al., 2019 (note 13)	California adult individual-market enrollees, 2017	—[a]	23%[b]
Kirzinger et al., 2018 (note 14)	Adult individual-market enrollees, 2018	—[a]	8%
STUDIES THAT USED VARIATION IN THE AMOUNT OF THE APPLICABLE PENALTY			
Frean et al., 2017 (note 15)	Nonelderly people, 2014–15	1% to 3%	—[a]
Lurie et al., 2019 (note 16)	Single adults with incomes close to penalty schedule nonlinearities, 2015–16	–18% to –5%	–4% to 36%
Saltzman, 2019 (note 17)	California and Washington Marketplace enrollees, 2014–15	—[a]	15% to 23%[c]
STUDIES THAT EXAMINED PEOPLE IN TAX UNITS WITH INCOMES ABOVE 400% OF POVERTY			
Fiedler, 2018 (note 18)	Nonelderly people with incomes >400% of poverty, 2016	–27%	—[a]
Jacobs, 2018 (note 19)	Adults ages 26–64 without employer coverage and with income >400% of poverty, 2016	–35% to –23%	—[a]
PROJECTIONS FROM PROMINENT MICROSIMULATION MODELS BASED ON PRE-ACA EVIDENCE			
CBO, 2016 (note 24)	Nonelderly people, 2026	–35%	30%
Saltzman et al., 2015 (note 25)	Nonelderly people, 2017	–30%	34%
Blumberg et al., 2013 (note 26)	Nonelderly people, ACA fully in effect	–33%	37%
PROJECTIONS FROM A MICROSIMULATION MODEL THAT INCORPORATED POST-ACA EVIDENCE			
CBO, 2019 (note 27)	Nonelderly people, 2021	–21%	29%

SOURCE Author's analysis of specific analyses cited in the text. **NOTES** Where authors reported multiple point estimates that reflected different populations or econometric models rather than a single summary estimate, the exhibit shows a range of estimates that reflects the range of the underlying point estimates. Online appendix A gives details of how estimates were extracted from each analysis (see note 11 in text). [a]Not applicable. [b]Estimate reflects effects on enrollment in Affordable Care Act (ACA)–compliant individual-market plans only. [c]Estimate reflects effects on enrollment in on-Marketplace individual-market plans only.

factors. This approach has the virtue of using data on actual enrollment decisions, not intentions, but it has limitations of its own. Most important, because the rules governing the mandate were complex and in effect for only a short period, some people might have made enrollment decisions based on a general awareness that there was a penalty for being uninsured rather than a precise understanding of what size penalty applied to them. This class of research design will generally miss these types of enrollment responses because they are, by their very nature, likely to be weakly correlated with penalty exposure. Another factor that could have attenuated the measured effect of the mandate in these studies is that the researchers generally observed people's actual income for the year, not their expectations about their annual income at the time of enrollment—which is what determines expected penalty liability.

While subject to the limitations described above, the research design used by Ithai Lurie and colleagues[16] was otherwise quite strong. Using administrative tax records for 2015 and 2016, the authors examined enrollment in narrow income bands in which the incentives created by the mandate changed sharply, but other policies did not. The authors conducted two analyses: a regression discontinuity analysis at the income threshold for the mandate exemption available to low-income people in states that did not expand Medicaid and a regression kink analysis at the income level at which the penalty amount transitioned from being a flat amount to being a percentage of income. In general, they found that the mandate increased insurance coverage, although the magnitude of that effect varied widely across analyses—which could reflect statistical noise or differences in awareness or responsiveness by income group. They also found evidence suggesting that people with lower health care needs were more responsive to the mandate, compared to those with greater needs.

The other two studies in this group made use of broader variation in the size of the applicable mandate penalty across people. Molly Frean and coauthors[15] used a "triple difference" research design and survey data through 2015 to examine whether people in geographic areas and income groups for which the mandate created larger enrollment incentives had larger gains in insurance coverage. Unlike the other studies reviewed here, the authors found no evidence that the mandate increased coverage and estimated

that, if anything, it slightly reduced coverage. Evan Saltzman[17] estimated the effect of the mandate using cross-household variation in the applicability and size of the mandate penalty by income and geography. His analysis used administrative enrollment records for the California and Washington State Marketplaces for 2014–15, augmented with survey data. He estimated that the mandate increased Marketplace enrollment by 15 percent in Washington and 23 percent in California.

A limitation of the latter two studies is that the effects of the ACA's Marketplace subsidies and Medicaid expansion also varied by income and geography. The authors aimed to address this concern by separately accounting for these other policies in their statistical models. However, this is challenging to do perfectly, which could be one reason the studies obtained differing results.

EFFECTS AT HIGHER INCOME LEVELS The third group of studies examined trends in coverage for people in tax units with incomes above 400 percent of the federal poverty level.[18,19] (Two other studies that focused on this population[20,21] are not included in exhibit 1 because they did not report estimates of the effect of the mandate alone.) The logic of this approach is that people in this income group were ineligible for the ACA's Marketplace subsidies or Medicaid expansion, which makes it easier to isolate the role of the mandate in observed coverage trends. However, these studies still must contend with changes in plan availability, pricing, and characteristics because of the ACA's introduction of community rating, guaranteed issue, and other regulatory requirements. Prior research generally suggests that these nonmandate policy changes would be more likely to reduce coverage than to increase it,[22,23] in which case focusing on raw coverage trends in this income group could understate the effect of the mandate. These studies also have the limitation that they can directly assess only the effects of the mandate on people in this income group.

The two studies included in this category[18,19] found that the uninsurance rate among people in tax units with incomes above 400 percent of poverty declined sharply after 2013, seemingly primarily because of gains in coverage in the individual market. This followed several years of stability, which strongly suggests that the ACA was responsible for the decline. The authors used various strategies to determine whether these coverage gains were driven primarily by the mandate or other factors, and both concluded that most—perhaps almost all—of the gains in this income group were attributable to the mandate.

Paul Jacobs focused on people in this income group without employer coverage and estimated a state-level regression model that directly controlled for a variety of potential confounding changes following 2013—including the introduction of community rating and changes in individual-market premiums and plan characteristics.[19] He found that even after these other factors were controlled for, the uninsurance rate in his study population was sharply lower after 2013, although measuring changes in premiums and plan characteristics is challenging given data limitations. Jacobs also found that people in this population who were subject to larger penalties tended to have larger coverage gains, consistent with the findings of two of the three studies that used variation in the amount of the applicable penalty.[16,17]

The balance of the evidence implies that the individual mandate increased insurance coverage.

In a previous study I aimed to isolate the mandate's role using an approach related to that used by Jacobs by focusing on coverage trends in two states that had community rating and guaranteed issue requirements before the ACA and directly adjusting for post-ACA premium changes.[18] While I faced measurement challenges that were similar to those Jacobs faced, I also concluded that the mandate substantially reduced the uninsurance rate in this income group. I also found that the uninsurance rate held steady or declined even among young and healthy people in this income group during this period. Because the ACA's regulatory changes were generally believed to have increased premiums for young and healthy people, this finding suggests that the mandate exerted downward pressure on the uninsurance rate.

SUMMARIZING THE EVIDENCE Taken as a whole, the studies summarized in the first three sections of exhibit 1 support two conclusions. First, the balance of the evidence implies that the individual mandate increased insurance coverage. It also appears likely that part of this increase occurred in the individual market and that increases were larger among people in better health, although evidence on the latter point is somewhat weaker. Given the variation in esti-

People who leave the individual market appear likely to have lower claims spending than those who remain.

mates across studies and the limitations of the various methodologies, the magnitude of these effects remains somewhat uncertain.

Second, the mandate's effect on coverage appears to have been smaller than predicted by prominent microsimulation models constructed using pre-ACA evidence.[24–26] Those projections, summarized in the fourth section of exhibit 1, are larger than almost all of the empirical estimates in the previous three sections of the exhibit. While the microsimulation analyses captured enrollment declines stemming from higher individual-market premiums, which the empirical analyses generally did not, calculations in appendix B show that these indirect effects of the mandate were likely relatively small.[11] Recently, the Congressional Budget Office issued revised estimates of the mandate's effects (also summarized in exhibit 1) that are smaller than its earlier estimates and broadly consistent with the empirical estimates.[27]

Looking Ahead

Repeal of the individual mandate appears likely to increase the uninsurance rate, although the precise magnitude of that increase is uncertain—as is its timing. Survey research suggests that as of early 2018 only 30 percent of the public was aware that the mandate had been repealed and that about two-thirds of the people who were aware of the repeal incorrectly believed that it had taken effect for 2018.[13] This suggests both that the repeal could have affected coverage before it formally took effect and that the full effect of the repeal might not be felt for some time. Coverage decisions could also be "sticky," which could further delay the effects of repeal. For example, some people who obtained coverage because of the mandate may retain that coverage as long as they remain eligible for it.

People who leave the individual market appear likely to have lower claims spending than those who remain. The resulting long-run increase in individual-market premiums seems likely to be meaningful but far from catastrophic. As noted above, Fung and coauthors estimated that the loss of enrollees as a result of the mandate repeal will increase average claims spending by 6 percent.[13] Calculations that used other evidence on the relative claims spending of people for whom the mandate likely played a pivotal role in enrollment decisions lead to broadly similar estimates, as discussed in appendix C.[11] Premium increases of this size are unlikely to drive large follow-on enrollment reductions, particularly since Marketplace subsidies shield most enrollees from premium increases.

Paths Forward For Expanding Coverage

Nine percent of the US population was uninsured in 2018,[28] and mandate repeal will likely put upward pressure on that rate over time. What are the options for policy makers interested in resuming progress in expanding coverage?

One straightforward option would be to restore an individual mandate. Relative to many other approaches, this option would have a low fiscal cost per person covered. This is particularly true for state governments, because the federal government bears most or all of the cost of increased enrollment in subsidized coverage.[29] Several states recently joined Massachusetts by creating their own mandates.

Other policies could also significantly expand coverage. For example, the federal government could make Marketplace subsidies more generous and ensure coverage of low-income people in non–Medicaid expansion states by creating either new financial incentives to encourage states to expand their Medicaid programs or a new federal program to cover the expansion population.[30,31] Microsimulation modeling of one suite of policies similar to these found that they could reduce the number of uninsured people by about one-half at an annual cost to the federal government of $125 billion.[31]

However, merely expanding subsidized coverage would not be sufficient to achieve universal coverage. Prior experience indicates that take-up of subsidized coverage is incomplete even when premiums are very low.[8,32] Thus, to achieve universal coverage, subsidy expansions would need to be paired with a mechanism to ensure that people enrolled in the subsidized coverage for which they were eligible—and paid any premium due. One approach would be to deem people to be enrolled in a "backstop" plan in each month they lacked other coverage.[33,34] The federal government would collect premiums for that plan,

less any applicable subsidy, on each year's tax return, and people could rely on the plan if they ended up needing care.

This policy would differ from the ACA's individual mandate—notably, in that it would actually achieve universal coverage. However, both policies share the important feature that they would require people who did not actively obtain coverage to make a payment. Such payments could, in principle, be avoided if subsidies were large enough to ensure that a zero-premium plan was available at all income levels. Subsidy expansions similar to those discussed above would achieve this objective for people at low and moderate income levels. But doing so for people at all income levels would require offering higher-income people subsidies far larger than the existing tax subsidy available for employer-provided coverage. Such subsidies would likely be taken up by the large population that currently has employer coverage, which would greatly increase federal subsidy costs for this group and cause this approach to have a very large fiscal cost.

A decade after the ACA's enactment, the fiscal logic that drove the inclusion of an individual mandate in the ACA is thus unchanged. Policy makers thus face a choice among three paths: settle for something short of universal coverage; achieve universal coverage through a plan with a very large fiscal cost, whether a single-payer plan or a multipayer plan with very deep subsidies; or require the small fraction of middle- and upper-income people who would otherwise be uninsured to make some contribution toward their insurance coverage. ■

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NOTES

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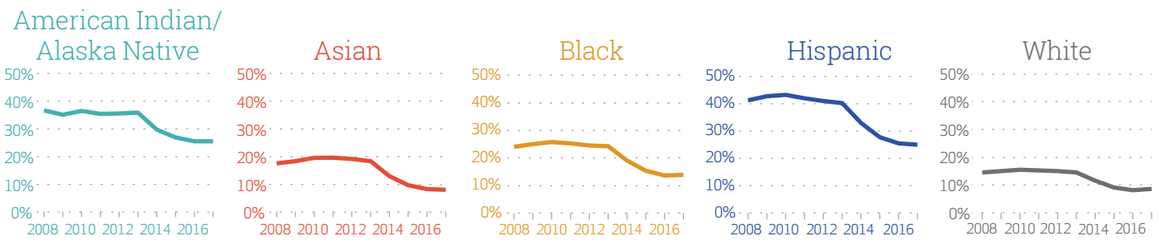
The Affordable Care Act Turns 10

The ACA has increased access to health care for vulnerable populations; decreased the percentage of Americans who say they went without care due to cost; and spurred America's insurers, hospitals, and clinicians to change how they deliver and pay for health care. At the same time, the ACA has been challenged in the courts of justice and public opinion.

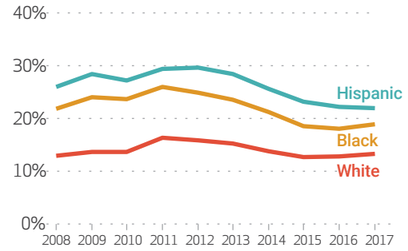
UNINSURANCE RATES BY RACE & ETHNICITY



Source: Analysis by Buchmueller and Levy (pp. 395–402) of Census Bureau data

FORGONE CARE DUE TO COST

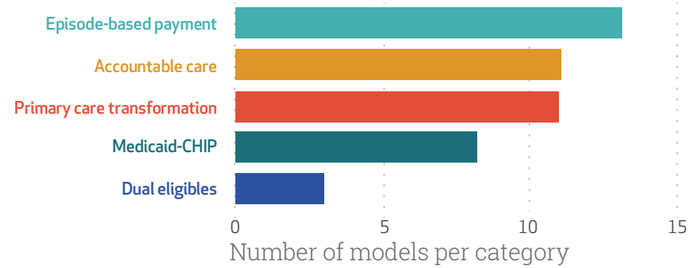
The percentage of Americans who say they went without health care due to cost declined for all racial and ethnic groups, particularly Hispanics and blacks.



Source: Buchmueller and Levy (page 399)

HEALTH CARE DELIVERY INNOVATIONS

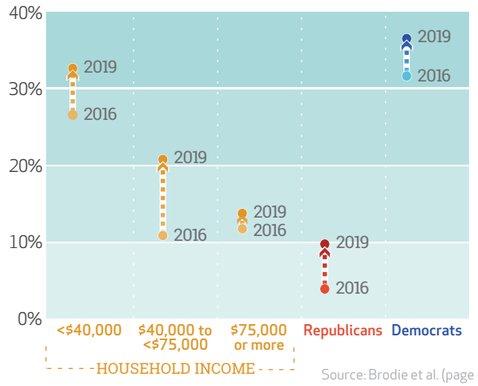
The ACA launched the CMS Innovation Center and funded it at $10 billion over 10 years, with the mission of testing new ways of paying for and delivering health care to improve quality, cut costs, or both. The center operates dozens of models and initiatives in various categories.



Source: Center for Medicare and Medicaid Innovation

PUBLIC OPINION

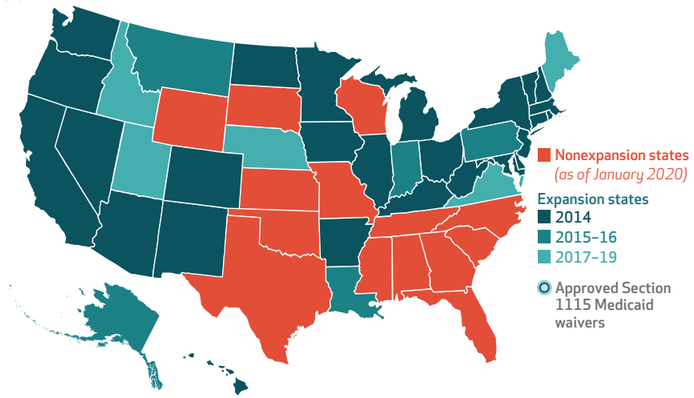
Between 2016 and 2019, the percentage of people who credit the ACA with helping them or their families increased across household income groups and political party identification.



Source: Brodie et al. (page 464)

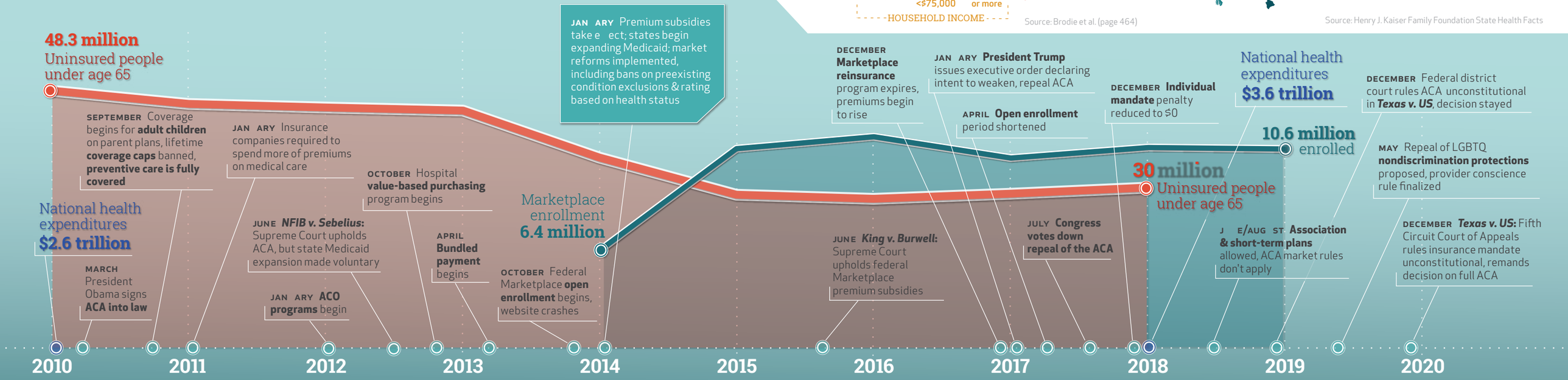
MEDICAID EXPANSION OVER TIME

A majority of states have adopted Medicaid expansion, but many have negotiated waivers with the federal government requiring beneficiaries to work.



Source: Henry J. Kaiser Family Foundation State Health Facts

COVERAGE, SPENDING & EVENTS



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REVIEW ARTICLE

The Changing Landscape Of Primary Care: Effects Of The ACA And Other Efforts Over The Past Decade

ABSTRACT Providing high-quality primary care is key to improving health care in the United States. The Affordable Care Act sharpened the emerging focus on primary care as a critical lever to use in improving health care delivery, lowering costs, and improving the quality of care. We describe primary care delivery system reform models that were developed and tested over the past decade by the Center for Medicare and Medicaid Innovation—which was created by the Affordable Care Act—and reflect on key lessons and remaining challenges. Considerable progress has been made in understanding how to implement and support different approaches to improving primary care delivery in that decade, though evaluations showed little progress in spending or quality outcomes. This may be because none of the models was able to test substantial increases in primary care payment or strong incentives for other providers to coordinate with primary care to reduce costs and improve quality.

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By the time the Affordable Care Act (ACA) was passed in 2010, primary care had endured decades of insufficient reimbursement and support, even though extensive research suggested that a strong primary care infrastructure was associated with lower per capita costs, better health outcomes, and lower premature mortality rates for various conditions.[1–3] Most US payers have reimbursed specialty and hospital-based services relatively generously, while inadequately supporting accessible, continuous, comprehensive, and coordinated primary care. Relatively low payments for primary care have stifled investments in technology and staff, contributed to primary care physician burnout,[4] and amplified shortages of primary care physicians.[5] Bolstering primary care was one of the ACA's many policy goals.

Private and public efforts to strengthen primary care predated and continued alongside ACA-sponsored efforts. In 2006 the American Academy of Family Physicians launched the two-year TransforMED National Demonstration Project to test supports for primary care redesign.[6] In the same year the Patient-Centered Primary Care Collaborative brought together private and public stakeholders to promote improved primary care. In 2007 the four major primary care physician associations released the Joint Principles of the Patient-Centered Medical Home (PCMH).[7] These principles, along with work by the Agency for Healthcare Research and Quality[8] on the patient-centered medical home, built on the conceptualization of Barbara Starfield[1] and the Institute of Medicine[9] that primary care encompasses five key elements: access, continuity, coordination, comprehensiveness, and whole-person orientation. To address the growing burden of multiple chronic illnesses, these efforts incorporated the Chronic Care Model's focus on chronic illness management.[10] That same year

the National Committee for Quality Assurance launched standards for designating primary care practices as patient-centered medical homes.

Public and private tests of primary care transformation models have since burgeoned. The number of PCMH pilots in the US more than quadrupled from 26 in 2009 to 114 in 2013, touching almost twenty-one million patients.[11] Although the Joint Principles highlighted the need for payment reform, the dominant payment approach in these models remained fee-for-service, supplemented by relatively small enhanced payments (often giving care management fees and pay-for-performance bonuses or shared savings to participating practices).[11]

The ACA's Tests Of Primary Care

Against this backdrop, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) to test new care delivery models and payment reforms. The ACA conveyed to CMMI far more resources than the Centers for Medicare and Medicaid Services (CMS) had previously had available for this purpose, increasing the budget more than tenfold—to $10 billion per decade. The ACA also gave the health and human services secretary the authority to expand payment and delivery models tested by CMMI that reduce costs without harming quality, improve quality without increasing costs, or both reduce costs and improve quality.

In CMMI's first decade, its primary care models have tested various care delivery strategies to improve cost and quality outcomes. The start of the ACA's second decade is an ideal time to reflect on the models tested to date, their effects, and lessons learned.

To support this retrospective, we drew on our collective experience as evaluators of the Comprehensive Primary Care (CPC)[12,13] and CPC Plus (CPC+)[14] initiatives; decades of experience conducting research on primary care; and, for two of us, delivering primary care. We also reviewed the most recently available CMS-sponsored independent evaluation report for each of CMMI's primary care initiatives in the past decade[12,14–20] and a CMS-funded meta-analysis.[21] We focused on examples from our evaluations of two models: CPC+ and its predecessor, CPC. These were natural choices because both served many practices and beneficiaries. Moreover, CMMI's reporting requirements for practices and the evaluations' survey, claims, and qualitative data provide rich insights about implementation. As the last model launched in CMMI's first decade, CPC+ reflects CMMI's learning over time. Finally, we asked the evaluators of all models to confirm our depiction of the models and results.

How Did CMMI Attempt To Redesign Primary Care?

In its first decade, CMMI launched eight initiatives[12,14–20] that focused on primary care delivery and payment reforms, with the broad goals of improving the quality of care, reducing costs, or both (online appendix exhibit 1 describes the initiatives).[22] While the initiatives differed substantially, all aimed to improve primary care by focusing on strategies such as providing care management, coordinating care, increasing access, making care more patient centered, and improving quality. Five of the eight worked directly with primary care practices: the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, the Independence at Home (IAH) Demonstration, CPC, and CPC+. These models varied in whether and how they required practices to change care delivery. MAPCP requirements varied by state and included National Committee for Quality Assurance or state PCMH recognition by the end of the first year. The FQHC demonstration required participants to pursue National Committee for Quality Assurance PCMH recognition. IAH asks practices to deliver home-based care with limited requirements. CPC and CPC+ had many specific care delivery requirements. Two other models—the Health Care Innovation Awards: Primary Care Redesign (HCIA-PCR) programs and the State Innovation Models (SIM) initiative—supported diverse types of awardees. HCIA-PCR supported awardees that tested similar strategies in a wide range of settings (including hospitals, health systems, and clinics). SIM supported states that pursued various statewide health care transformation approaches related to patient-centered medical homes, health homes, integrated or accountable care, and payment reform. The remaining model, the Transforming Clinical Practice Initiative (TCPI), focused on providing technical assistance to help primary care clinicians and specialists adopt quality improvement strategies and develop their workforces.

CMMI recognized the importance of bringing multiple payers together for delivery system and payment reform in several models (MAPCP, CPC, CPC+, and SIM).[23] Multipayer collaboration combines commercial and public payers in a region to promote the provision of high-quality primary care through aligned incentives. Benefits include collectively covering a sizable proportion of a given practice's patients, helping ensure that practices have incentives to pursue changes in care delivery, aligning payment approaches, and providing data-driven feedback on provider performance.[24]

The eight initiatives targeted different types of patients: chronically ill and functionally limited Medicare patients (IAH); primarily low-income patients seen in federally qualified health centers (FQHC); Medicaid, some commercial patients, and (in some programs) Medicare (SIM); children on Medicaid (some HCIA-PCR awardees); or all patients (CPC, CPC+, MAPCP, TCPI, and many HCIA-PCR awardees). Almost all involved large numbers of primary care clinicians.

Several models featured new payment approaches to address some of the financial challenges that primary care providers face. These models largely provided enhanced payments for some new or expanded primary care services, such as improved care management and enhanced access. None increased payments for existing services specifically to alter primary care clinicians' compensation. Any shared savings or bonuses were calculated based on patients' use of services from all providers, not just primary care.

MAPCP, CPC, CPC+, and FQHC provided monthly or quarterly care management fees in addition to traditional payments for care delivery. Typical annual care management fees ranged from just over $30,000 per clinic for FQHC to almost $200,000 per practice for practices in the more advanced track of CPC+.[14,16] CPC supplemented care management fees with shared savings to reward practices whose regions generated savings, and IAH exclusively uses practice-level incentive payments to reward performance, based on how much lower the total costs of practices' patients are than target expenditures. CPC+ supplements care management fees with comparatively small payments for performance, and it provides some practices with prospective payments not tied to visits, to encourage alternatives to traditional office visits (such as telemedicine, e-visits, text messages, and group visits). No Medicare payments were made directly to HCIA-PCR, SIM, or TCPI providers. However, in HCIA-PCR and SIM, some awardees shared savings with practices or paid practices for transforming care.

Most models offered learning activities or technical assistance, with approaches varying substantially in type, delivery mode, and quantity.[21] For example, IAH provided no technical assistance but only information on the model's administrative requirements. CPC and CPC+ provided in-person and virtual meetings, webinars, individualized coaching, implementation tools such as an annual implementation guide, and a social networking platform. In the awardee models of SIM and HCIA-PCR, learning activities varied considerably across awardees.

Most models also provided practices with practice- or provider-level data feedback, often compared to others in the region, to guide quality improvement. The data often consisted of utilization measures (for example, rates of hospitalizations and emergency department [ED] visits); quality measures (such as colorectal cancer screening rates for adults ages fifty and older and immunizations among children); and costs (for example, total, inpatient, and prescription costs). Sometimes patient-level data and lists of patients who needed specific preventive care were included.

Most commonly, feedback involved quarterly claims-based reports (MAPCP, FQHC, and CPC) or interactive tools (CPC+). A few models aggregated data across payers (in selected regions of MAPCP, CPC, and CPC+) or used sources other than claims, such as registries (MAPCP) and practice-reported data (TCPI). HCIA-PCR provided claims extracts if an awardee requested them, IAH provided data files, and SIM's feedback varied by state. For TCPI, quarterly reports of Medicare claims and practice-reported data went to organizations that provided technical assistance rather than to practices, and those organizations could choose whether to provide feedback to practices and what feedback to provide.

Lessons On Care Delivery Strategies And Model Supports

Evaluations of CMMI's primary care models have generated broad and specific lessons about how to improve primary care delivery. (See appendix exhibits 1 and 2 for information about care delivery strategies and supports and lessons learned.)[22] Below we discuss overarching lessons derived mainly from evaluations of CPC and CPC+, supplemented by evaluations of other models.

CARE DELIVERY STRATEGIES Practices generally valued the strategies they were required to implement and believed that the strategies improved patient care. In particular, CPC and CPC+ practices that had embedded care managers to enhance the work of primary care physicians noted that this new role improved chronic condition management. Practices more systematically linked patients to a single primary care clinician to improve continuity of care and contacted patients after an ED visit or hospital discharge. Practices also increased behavioral health integration, which clinicians noted led to improved access to care for some previously unmet mental health needs and freed primary care clinicians to focus on other aspects of clinical and preventive care. Efforts to engage patients in primary care improvement included patient and family advisory councils, which gave practices more details about patients' experienc-

es with care than surveys provide. Many practices made care delivery improvements based on the councils' input.

However, practices often struggled to find sufficient time and resources to fully implement changes. Practices reported lacking funds or sufficient numbers of qualified candidates to hire enough new staff and, in some cases, lacking skills to engage patients, integrate new staff, and make many care delivery changes simultaneously. Model developers' and participating practices' experiences suggest the following ways to improve how practices implement complex, multipronged changes.

▶ **EDUCATE CLINICIANS:** Clinicians should be educated about what they are expected to implement, and why. Busy primary care clinicians and staff struggled to see the need for some innovative care delivery approaches that the models required. For example, some practices that were required to enhance care management and use care plans did not know how to integrate new care managers into their teams or were unsure whether care plans could improve patient outcomes or reduce work for their practice. (Care plans set forth the patient's goals, needs, and self-management activities and are meant to be accessed and used by all team members to guide ongoing care for high-risk patients.) Clinicians and staff often conflated care plans with after-visit summaries, progress notes, and condition-specific action plans for patients.

▶ **MEET PRACTICES WHERE THEY ARE:** Practices have different levels of prior transformation experience, health information technology capability, staff resources, and practice-level autonomy, and these are often related to the practice's size and ownership. Each of these may affect clinicians' ability to identify and alter care processes. Therefore, practices need flexibility to adapt models to their circumstances. This entails accepting practices' current status and encouraging them to advance. Small independent practices may need creative ideas about pooling resources for health information technology, data analytics, care managers, behavioral health providers, and pharmacists. Larger health systems often need to work more closely with clinicians and staff at practice sites to ensure their buy-in when the systems introduce changes.

▶ **ENCOURAGE A LEARNING CULTURE:** Practices with a culture that embraced change to help improve patient care, promoted good working relationships among staff and clinicians, and enabled team members to speak openly about and solve problems seemed to have an easier time implementing care delivery changes. Encouraging this type of learning culture facilitates transformation.

▶ **SIMPLIFY REPORTING REQUIREMENTS:** Most models required participating practices to document changes and report on performance and quality measures. Unsurprisingly, practices felt burdened and wanted to see reporting requirements harmonized across payers and initiatives.

▶ **RECOGNIZE THAT REDESIGN TAKES TIME:** Many practices spent the first year trying to understand the model, before identifying and training staff and learning how to engage patients in behavior change efforts. Given long-standing inadequacies in financial support for primary care, absent substantial changes in payment, a longer time horizon may be required for changes in care delivery and chronic condition management to translate into lower costs and improved quality.

▶ **INVOLVE OTHER PROVIDERS:** Although primary care is an important driver of patient experience and costs, it accounts for less than 6 percent of US health care expenditures (far lower than in other industrialized countries).[25] Primary care practices could control costs through changing their approach to when and to which specialized services they refer patients. However, their control is limited because fee-for-service Medicare patients can refer themselves to specialized services. Additionally, primary care practices may lack information on the most efficient, highest-quality providers available and are generally not incentivized to refer patients to them.[14] Moreover, practices that are part of health systems are encouraged to refer within their own systems.

SUPPORTS FOR CARE MODELS CMMI's primary care models have included a range of supports such as payment or other financial incentives, learning activities, and data feedback (appendix exhibit 1 lists the specific types of supports provided under each model).[22] Experiences with these supports offer several lessons.

▶ **DEVISE A PAYMENT SYSTEM WITH STRONGER INCENTIVES:** The models did not fundamentally alter the volume-based incentives of Medicare fee-for-service payment. They tested several payment approaches, most commonly providing care management fees in addition to traditional fee-for-service payments. Although some models offered substantial payment, all were relatively marginal tweaks, and none fundamentally changed the volume-based payment system. For example, in CPC, where payments were large relative to those in other models, the median practice received almost $180,000 in total care management fees from all payers in the model's final year.[12] Yet 90 percent of practice revenue was still driven by traditional payments. The same was true in the first year of CPC+. Other models' payments were more modest (MAPCP

and FQHC), were awarded only if Medicare expenditures for the practice's patients were below the practice's target expenditures (IAH), or did not directly pay practices (some HCIA-PCR awardees, SIM, and TCPI). Moreover, although CPC+ tries to align incentives across primary care and other health care providers in some accountable care organizations (ACOs) (for the half of CPC+ practices that are also in a Medicare ACO),[14] these ACOs are still predominantly paid by fee-for-service and primarily pay their providers based on productivity incentives. The other models focused exclusively on primary care practices.

▶ **CLARIFY PAYMENT APPROACHES:** Payment approaches should be clear, transparent, and relatively simple. Whatever the payment approach being used, providers need to understand the incentives to make informed decisions about the benefits versus costs of model participation and investment in care delivery changes. For example, practices need to understand the revenue opportunities, which patients are covered, and the standards that need to be met for success in shared savings or performance bonus calculations. These factors influence the practice's assessment of staff, technology, and other investments needed for successful performance and the likelihood that any rewards would cover these investments.

▶ **PURSUE MULTIPAYER COLLABORATION:** While there is no formal evidence that multipayer approaches are more effective, stakeholders from both single-payer and multipayer initiatives preferred a multipayer approach.[21] Payments from commercial payers were a fraction of those from Medicare, but adding other payers still yielded larger enhanced payments and better aligned the data, quality improvement, and payment signals for providers.[24,26]

CPC, CPC+, and MAPCP proved the value of neutral, skilled conveners—organizations that are independent of participating payers and practices—that organize payers in multipayer models. Organizations that played convener roles included those with expertise in practice transformation, quality improvement, data exchange and aggregation, or state health policy. Such conveners can provide active, substantive, and strategic leadership in organizing payers. They can build trust among payers, establish decision-making processes, and work with payers individually to identify and then build on areas where payers were interested in collaborating (such as harmonizing practices' participation requirements or aligning performance measure definitions).[24,27]

▶ **OFFER TAILORED LEARNING SUPPORTS:** Given that practices' needs, contexts, and experiences differ, delivering a coordinated and useful approach to learning supports can be challenging. What may be too basic for one practice (such as closely reviewing detailed data feedback and helping the practice identify three actionable areas for improvement) may be just right, or perhaps too advanced, for another.[12,13,16,21] When resources allow, tailoring learning supports to practices' needs and offering one-on-one assistance are optimal. Moreover, practices often find it challenging to find time for learning activities, so offering flexible, relevant, and engaging learning opportunities is key.

▶ **PROVIDE DATA FEEDBACK AND TRAINING:** Data feedback must be salient and actionable to practices. Payers or organizations that aggregate data across payers should aim for reports or tools that are timely, are easily interpreted, and have the right level of detail to guide action. Interactive feedback tools can help practices drill down to identify specific improvement opportunities. Incorporating admission, discharge, and transfer data, which are more timely and actionable than claims data, can substantially increase the value of data feedback to practices.

Practices also need training and support on how to use data feedback effectively.[14,16,21,26,28] Often, practices focused—at least initially—on factors that were beyond their control, such as the behavior of specialists and hospitals.[28] Organizations working with practices need to emphasize actionable areas for improvement. In addition, narrowly distributing feedback limits its use. For example, some health systems did not share data with or encourage the use of data at affiliated practices.[12,13] A top-down approach may shield practices from spending time on this work, but it ignores their preferences about where to make changes.

As efforts to improve primary care progress, a continued push to improve data feedback is key. Data aggregation efforts to date have been resource intensive, and their return on investment is unclear. However, practices, health systems, and technical assistance providers continue to tout the usefulness of streamlining data sources and distributing aggregated performance data to practices, particularly in markets with many payers.[29]

How Did Initiatives Alter Cost, Quality, And Service Use?

Model results show how hard it is for primary care delivery—in the context of modestly reformed payment that still rests firmly on a fee-for-service chassis—to improve cost and quality outcomes. Exhibit 1 summarizes the models' effects on cost, quality, and hospitalizations and ED visits (excluding TCPI, whose results are

EXHIBIT 1

Effects of 7 primary care models of the Center for Medicare and Medicaid Innovation (CMMI), 2011–19

		Effects on fee-for-service Medicare beneficiaries			
Model (years)	**Participants**	**Spending[a]**	**Hospitalizations**	**ED visits**	**Quality**
Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration (2011–16[b])	More than 800 MAPCP practices in 8 states	No states with savings; 2 states with increased spending	Reduced in 1 state; increased in 2 states	Increased in 2 states	Process-of-care measures: unfavorable results in 3 states, favorable results in 3 states; preventable hospitalizations: increased in 2 states
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration (2011–14)	503 FQHCs nationally	Small increases[c]	Small increases	Small increase	Mixed effects on patient experience
Independence at Home (IAH) Demonstration (2012–20)	14 practices around the US providing home-based primary care	No effect	No effect	Reduced 4% through fourth year	Preventable hospitalizations reduced 6.7%; no effect on potentially preventable outpatient ED visits or hospital readmissions
Health Care Innovation Awards: Primary Care Redesign (HCIA-PCR) programs (2012–16[b])	14 programs around the US; 10 were evaluated	One awardee (hospital) reduced Medicare spending by 31 percent	Evaluation examined hospitalizations, ED visits, and both combined; 2 awardees reduced combined visits by 6 and–15%, 1 reduced ED visits by 5%	See the cell to the left	4 awardees improved quality-of-care measures (by 2–10%); 1 increased and 1 reduced preventable hospitalizations
Comprehensive Primary Care (CPC) initiative (2012–16)	502 primary care practices in 7 regions	No effect	Reduced 2%	Reduced all ED visits by 2%; likelihood of ED revisit within 30 days decreased by 3%	No appreciable effect
State Innovation Models (SIM) initiative, round 1 (2013–18)[b,d]	Of 6 states that began round 1, 3 tested PCMHs and are included here	Increased in 1 of 3 states by 12.3%	Inpatient admission rates decreased by 34.6% in 1 state and increased by 15.5% in 1 state	No effect	Small improvements in quality-of-care measures in 2 states
Comprehensive Primary Care Plus (CPC+) initiative (2017–22)	3,070 primary care practices nationally	Overall, 2–3% increase in first year	No effect	Reduced by less than 2%	Small improvements in quality-of-care measures

SOURCES Authors' analysis of the following Center for Medicare and Medicaid Innovation (CMMI)-funded evaluation reports: (1) Peikes D, et al. Evaluation of the Comprehensive Primary Care initiative (see note 12 in text). (2) Peikes D, et al. Independent evaluation of Comprehensive Primary Care Plus (see note 14 in text). (3) RTI International, et al. Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration (see note 15 in text). (4) Kahn KL, et al. Evaluation of CMS's Federally Qualified Health Care (FQHC) Advanced Primary Care Practice (APCP) demonstration (see note 16 in text). (5) Kimmey L, et al. Evaluation of the Independence at Home Demonstration (see note 17 in text). (6) Peterson G, et al. Evaluation of Health Care Innovation Awards (see note 18 in text). (7) RTI International. State Innovation Models (SIM) initiative evaluation (see note 19 in text). NOTES This exhibit includes models with a major substantive focus on primary care. CMMI and the Government Accountability Office may classify models in categories other than primary care transformation. The MAPCP demonstration was planned before the ACA but implemented by CMMI. ED is emergency department. PCMH is patient-centered medical home. [a]Includes enhanced payments. [b]Some regions or awardees ended earlier, as planned. The final year shown was the final extension date. [c]When underserved populations receive care from settings that are participating in a primary care model, increases in utilization and spending may be appropriate and desirable. [d]Final dates were Arkansas, 2016; Oregon, 2017; and Massachusetts, 2018.

not yet available). None of the seven initiatives with results appreciably improved these outcomes.[12,14–20]

A meta-analysis of three-year outcomes from CPC, MAPCP, FQHC, and HCIA-PCR combined also found little effect on patient outcomes.[21] It found no significant changes in Medicare expenditures (without taking initiative-related payments into account), outpatient ED visits, hospitalizations, or thirty-day readmissions. There

were some modest positive and negative effects when results were disaggregated into the seven CPC geographic regions, eight MAPCP states, the six HCIA-PCR programs included in the meta-analysis, or FQHC. For example, four of these twenty-two settings had lower hospitalizations, while three had higher hospitalizations.

In many ways, the inability to rapidly reduce costs or achieve improvements on the limited set of measurable quality outcomes was not surprising. First, the models paid only small increases to primary care practices for their additional efforts and generally did not provide financial incentives to other providers, which limited incentives and the capacity to improve outcomes. Second, implementing change in primary care staffing, processes, and work flows is complex and takes time to translate into key outcomes such as improving patients' health and reducing health care use and costs. Finally, these outcomes are affected not only by new primary care delivery and payment models, but also by how specialists, hospitals, and other providers deliver care and the payment models they face; the practices' health information technology and information exchange capabilities; and broader social determinants of population health.

Principles For Future Initiatives To Bolster Primary Care

In its second decade, CMMI is rolling out models that take bolder approaches to payment. For example, the Primary Care First Model Options, which begin in 2021, will substantially shift primary care payment away from fee-for-service through population-based payment and performance-based adjustments with the potential for substantial bonuses and penalties. In Maryland's Total Cost of Care Model, Medicare and the other payers in Maryland are testing global budgeting with an explicit focus on primary care and alignment of incentives across diverse providers.

In addition to building on the lessons above, two fundamental principles should guide future primary care transformation initiatives.

INCLUDE CHANGES FOR OTHER PROVIDERS Even with increased payment and support, primary care practices will struggle to reduce the unnecessary use of specialists and hospitals over which they have little control but that account for approximately 95 percent of Medicare spending.[12,14,30] The rapid rise in hospital systems' acquisitions of primary and specialty care practices increases prices and pressures to refer patients to systems' own specialized services and providers.[31] This underscores the need to engage other providers alongside CMMI's continuing efforts to bolster primary care. Requiring new hospital system– and specialty-focused payment models to coordinate and be integrated with primary care would facilitate progress toward a high-functioning health system.

TEST INCREASED FUNDING FOR PRIMARY CARE CMMI faces two challenges. First, the share of health care spending on primary care in the US is less than half that of other countries, which reflects the long-standing inadequacy of support.[25] Accordingly, some analyses estimate that full transformation of primary care practices will require substantially more revenue than has previously been tested.[32] Second, CMMI cannot increase payments to primary care without expected offsetting reductions in services from other providers during a model's testing period.

Primary care payment could be boosted using enhanced payments in new models, combined with changes to the Medicare fee-for-service schedule that would increase payment for primary care relative to other services.[25] Absent such fundamental changes in primary care payment, CMMI may find it difficult to test whether substantially increased spending on primary care can achieve the cost and quality benefits observed in other countries' health care systems. ■

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POLICY INSIGHT

The Ten Years' War: Politics, Partisanship, And The ACA

ABSTRACT After decades of failed efforts to overhaul American health care, the Affordable Care Act's 2010 enactment was the most important health reform achievement since Medicare and Medicaid's passage. But ten years later, ACA politics are more tenuous than triumphal, and the ACA has not escaped the controversy that surrounded its enactment. This article explores why the ACA has been so divisive despite its considerable accomplishments. The ACA contains an array of controversial policies that contravene policy principles and political priorities held by the contemporary Republican party. It also imposes costs on stakeholder groups whose opposition, in many cases, to measures that altered the status quo has never ceased. Moreover, ACA benefits often have been obscured, partly because of the law's complex structure and incoherent programmatic identity. Additionally, the ACA's performance on its central promise—to make health insurance affordable—has been mixed. The law also confers benefits on populations that command less political sympathy than those previously favored with public coverage, and it has surfaced perennial racial/ethnic tensions related to who receives government benefits. I argue that the ACA's turbulent political journey ultimately reflects the larger trends in American politics of growing partisanship and polarization that continue to shape US health policy.

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The Affordable Care Act (ACA) has had a remarkable political journey. The ACA barely survived a bruising partisan fight, public debate, and congressional gauntlet to become law in 2010. Its passage was a political triumph, breaking a decades-long pattern of incrementalism and inaction in the face of a growing uninsured population and rising health care costs. Previous failures had led observers to wonder whether the American political system was capable of delivering meaningful health reform, given institutional fragmentation, interest-group influence, and partisan divisions.[1] The ACA's passage demonstrated that progress was possible and the status quo could be changed.

But a decade later, ACA politics are more tenuous than triumphal. Since its enactment, the ACA has been mired in controversy and beset by legal, legislative, and administrative challenges. Stunningly, although it is a law of enormous magnitude that has been on the books for ten years, the political fight that surrounded the ACA's passage has not ended. While the ACA has fundamentally reshaped US health politics, its future remains uncertain. The ACA's political legacy is not what its advocates or many analysts envisioned a decade ago.

This article explores ACA politics—past, present, and future. Why did the ACA pass? Why hasn't it become an accepted part of American health policy, with bipartisan incremental fixes

to the law rather than partisan fights over its existence? And how has the ACA reshaped health politics? I argue that the law's turbulent political journey reflects the larger trends in American politics of growing partisanship and polarization that continue to shape US health policy.

The ACA's Origins

The ACA grew out of the ashes of the failed 1993–94 health plan of President Bill Clinton and the seeds of the successful 2006 Massachusetts reform initiative. The Clinton plan came nowhere close to passing, although the Democrats held the White House and had sizable congressional majorities.[1–4] Adding electoral insult to legislative injury, following the Clinton plan's demise, in 1994 the Republicans won control of both the House and Senate for the first time in four decades. Democrats took a number of lessons away from the policy and electoral debacle—among them, the political dangers of disrupting coverage for already insured workers, the challenges of fighting a multifront battle against influential stakeholders who stood to lose substantial income from cost control measures, the political risks of a slow legislative process, and the importance of securing intraparty agreement on a reform model and the president's engaging Congress proactively in devising legislation.[4–7] In short, the Clinton administration provided reformers with painful lessons in what not to do to pass a major health care bill. Those lessons formed the basis for a new reform playbook that Democrats would use during 2009–10.

Meanwhile, Massachusetts provided a blueprint for what health reform in the aftermath of the Clinton administration's misadventure could look like.[8,9] The Massachusetts model—endorsed by the state's Republican governor, Mitt Romney—combined "Medicaid expansion, subsidized private health insurance, a health insurance exchange, insurance market reforms, and requirements for individuals and employers."[10(p444)] The law's political appeal was that it expanded coverage by building on existing insurance arrangements and did not disrupt employer-sponsored coverage or implement controversial cost controls that would alienate stakeholders.

It also had the imprimatur of bipartisanship. Conservatives had supported the core ideas used in Massachusetts, including the individual mandate (which some Republicans had advocated in the 1990s as an alternative to the employer mandate) and an organized marketplace in which uninsured people could purchase private plans (the Heritage Foundation had proposed such an insurance exchange).[9] The Massachusetts health care bill achieved liberal ends through conservative means.[2] It passed the state legislature by a nearly unanimous vote, underscoring the broad bipartisan appeal of this approach (which proved to be a mirage when health care left the temperate political currents of the Bay State for Washington, D.C.).[8,9] Moreover, the Massachusetts reforms quickly and substantially reduced the state's uninsured population.[10]

In the 2008 Democratic presidential primary, the leading contenders all proposed health care plans that emulated the Massachusetts model. There were differences—for example, their proposals called for establishing a new government-run public insurance program to compete with private plans. Yet Democrats had clearly coalesced around the Massachusetts formula of expanding insurance coverage through a combination of regulation, subsidies, mandates, and Medicaid.[5–8]

Opening The Window

The ACA passed in 2010 partly because the administration of President Barack Obama and congressional Democrats successfully applied lessons learned from the Clinton administration and Massachusetts in crafting both a health plan and a legislative strategy. The ACA's major provisions largely tracked those of the Massachusetts law. The ACA embodied the presumptions that radically upending the status quo through single-payer insurance was not politically feasible and that the only viable route to passing reform was to build on private insurance and Medicaid rather than Medicare—whose expansion stakeholders saw as a greater threat.[5,7]

The goal was to minimize disruption in the prevailing arrangements, not to remake private insurance or fundamentally alter the circumstances of people with employer-sponsored coverage. Centralized, controversial cost containment measures were largely deferred in implementation or omitted altogether from the ACA in favor of politically friendlier experiments in payment and delivery reform (though the law did reduce some Medicare provider payments).[5,6] That made it easier to court support from stakeholders who stood to gain financially from expanded coverage. The Obama administration pursued deals with industry groups, and an array of stakeholders—including the American Medical Association, American Hospital Association, and PhRMA—backed the ACA's enactment.[5,6]

During 2009–10 Democrats also had high levels of intraparty agreement on both the importance of not falling short again on major health care legislation and the contents of a reform

There has been more bipartisanship related to the ACA at the state level than in Washington.

package.[5–7] That relative consensus enabled them to coordinate a collaborative legislative process across usually independently minded congressional committees and survive the loss of a sixty-vote, filibuster-proof Democratic majority in the Senate following the victory of Republican Scott Brown in a Massachusetts special election to fill the seat of Sen. Edward Kennedy (D) after his death. It also enabled Democrats to enact the ACA on a partisan vote, including the use of budget reconciliation rules that required only a simple majority for passage—which proved crucial to pushing reform forward after Democrats lost their sixty-vote Senate majority. Consensus made it possible to pass legislation that contained compromises and concessions disliked by many Democrats. These included leaving the public option, which had failed to clear the Senate, out of the ACA.

The ACA's enactment was a product of lessons well learned, savvy political strategies, pragmatism and flexibility, and the commitment of Democratic leaders—President Obama, Speaker of the House Nancy Pelosi, and Senate Majority Leader Harry Reid—to make health care reform a priority and see it through.[5]

The ACA also passed because of an extraordinary confluence of circumstances.[4–7] The Great Recession of 2007–09 unleashed a period of severe economic hardship and distress, creating a climate favorable to federal action. As millions of Americans lost their jobs and health coverage, the vulnerabilities of employer-sponsored insurance were again exposed, which underscored the imperatives of reform. Barack Obama's victory in the 2008 presidential election, combined with the Democrats' widening their majority in the House and attaining a rare supermajority of sixty in the Senate, created a political environment in which ambitious health reform was possible. Without the first filibuster-proof Senate majority for either party since 1979, which was enabled by the decision of Sen. Arlen Specter (R-PA) to switch parties, it is unlikely that we would be marking the ACA's tenth anniversary.

Following Medicare's Path

The ACA's passage through Congress was controversial (including a furor over the law's alleged establishment of mythic "death panels") and partisan (not a single Republican lawmaker voted for the final bill). Yet the ACA's architects could reasonably have expected both the partisanship and the controversy to fade after the law's enactment.[11,12] The ACA promised to deliver important benefits (insurance coverage, subsidies, and consumer protections) to tens of millions of people. Once Americans experienced the ACA as reality rather than myth, presumably support for the law—which had been underwhelming before its enactment—would grow. The ACA would generate a large new political constituency of beneficiaries, entrenching the law as a popular, central, and permanent fixture in American public policy. Not only would the ACA's widespread benefits be impossible to take away once in place, but reformers would build on the "starter home" to make "additions and improvements."[11]

Medicare, too, had been enacted following a highly controversial debate. Its opponents had denounced federal insurance for the elderly as "socialized medicine" and "evil."[13(p26–7)] However, while Democrats led the push for Medicare and many Republicans opposed it, the party lines were not drawn nearly as sharply in 1965 as they would be in 2010.[4] After Medicare's enactment the controversy abated, as the program became extraordinarily popular—generating a large, politically active constituency of older Americans with a strong interest in protecting their benefits. Bipartisan coalitions of lawmakers came together to reform Medicare, episodically overhauling arrangements for paying medical providers, shoring up its financing, and liberalizing its benefits.[13] There were no widespread calls to repeal Medicare and no serious legal challenges to its existence. Medicare became an accepted part of US health care and public policy. For the program's first three decades, postenactment Medicare politics were largely incremental, with policy makers focused on how to reform the program instead of seeking to undo or radically restructure it.

The Partisan Divide

In 1975 Wilbur Cohen, the former health, education, and welfare secretary, declared that "Medicare was a breakthrough.... In its 10 years, it has broken the back of the ideological opposition to the public role in health insurance."[14] Ten years after the ACA's enactment, it is clear that such opposition remains a potent force in American politics. Instead of ending the debate over the

government's role in health care, the ACA became the object of intense conflict over both the boundaries between the market and state and tensions between individual and social responsibility—which helped fuel the rise of the Tea Party movement and shifted the Republican party farther to the right.[15,16]

The ACA's political trajectory has had little in common with that of Medicare. During its brief history the ACA has faced relentless efforts to repeal and undermine it.[15–18] Conservatives have mounted legal challenges to the ACA, questioning the constitutionality of the entire law and the legality of its major components. The 2012 Supreme Court decision, *National Federation of Independent Business v. Sebelius*, that effectively made Medicaid expansion optional for the states dealt a major blow to the law.[17,18] Legal challenges also have served the political goal of delegitimizing the ACA.

In Congress, GOP lawmakers have sought to repeal and replace Obamacare, culminating in 2017 legislation passed by the House that fell just short of passage in the Republican-majority Senate. GOP lawmakers have reduced funding for some ACA programs, let others expire, and overturned selected policies.[15] And the administration of President Donald Trump has pursued policies to reduce enrollment in and destabilize the ACA's insurance Marketplaces, while soliciting state waivers that—through work requirements and other mechanisms—would reverse enrollment increases in Medicaid.[15]

Meanwhile, the ACA's reliance on states to implement key provisions gave Republicans opportunities to obstruct legislation that they were not able to stop in Congress, and *NFIB v. Sebelius* increased those opportunities.[3,17,18] Many, though not all, Republican-governed states have boycotted core Obamacare provisions, declining to set up their own insurance exchanges (forsaking state governance in favor of ceding control to Washington) or to expand Medicaid eligibility (forsaking federal money, economic benefits, and improved hospital finances in favor of leaving lower-income people uninsured).[15,17]

To be sure, there has been more bipartisanship related to the ACA at the state level than in Washington. Many Republican-led states have embraced Medicaid expansion. However, the opposition to Medicaid expansion is exclusively partisan: All fourteen states that have not expanded have either Republican governors or legislatures with Republican majorities.[15] Consequently, while the ACA aimed to reduce state variation in Medicaid eligibility, it has instead engendered greater divergence between two Americas in health policy, with much lower uninsurance rates in states that have expanded Medicaid than in nonexpansion states.

The ACA's political history is also striking for what has not happened: namely, bipartisan efforts to address its myriad problems, including Marketplace instability, inadequate subsidies, the affordability of insurance, and the coverage gap for lower-income people in states that haven't expanded Medicaid.[15] There has been cross-party agreement to rescind some ACA policies, including the implementation of the Independent Payment Advisory Board that was to help moderate Medicare spending growth and the "Cadillac tax" on high-cost private insurance plans. But there has been no successful bipartisan effort to pass legislation that would improve the ACA. The politics of addition in Obamacare have proven much more challenging than those of subtraction.

Despite occasional efforts at collaboration across party lines, bipartisan action on the ACA in Congress has remained a unicorn—more the stuff of fantasy than legislative reality. Most Republicans have been more interested in dismantling the law than in repairing its shortcomings, which has deprived the ACA of a broad bipartisan coalition (though three Republican senators joined their Democratic colleagues in 2017 to save it from repeal).[15] The resulting inaction has weakened the ACA by allowing problems that could be addressed to fester.

Puzzling Politics

Why has the ACA been so controversial, and why has fierce opposition to the law persisted? Why have ACA politics remained existential rather than incremental? Why hasn't the ACA traveled the path of Medicare? Why has a law that is moderate in crucial respects, that embodied conservative ideas in both philosophy and key policies, that built on private insurance instead of replacing it with a single payer, and that emulated a program supported by a Republican governor triggered such an immoderate reaction?

CONTROVERSIAL POLICIES The ACA contains an array of controversial policies. Some policies—higher taxes on the wealthy, the expansion of a government insurance program, private insurance regulation, and employer mandates—are contentious because they contravene core public policy principles, political priorities, and health reform ideas held by the contemporary Republican party.[12,16] In particular, the ACA's progressive financing is in tension with the GOP's deep commitment to tax cuts for the wealthy.[16]

Another source of controversy is that the ACA imposed costs and changes on many groups. The cancellation in 2014 of several million individual insurance policies belied President Obama's

The ACA's performance on its central promise—to make health insurance affordable—has been mixed.

promise that "if you like what you have, you can keep it."[8(p108)] There was a compelling case for regulating the individual market and establishing more robust benefits standards that protected consumers. Even so, the politics of taking away insurance policies (even inferior ones) from people who already have coverage or making changes that compel some people to pay more for insurance are very difficult. The individual mandate, which triggered libertarian objections and cast health reform in a punitive light, proved highly unpopular.

The ACA additionally contained myriad policies that imposed visible costs on concentrated interests: penalties on employers for not offering adequate coverage; regulations on insurers that prohibited discrimination on the basis of preexisting conditions and established new benefit standards; taxes on medical device manufacturers, insurers, pharmaceutical manufacturers, high-income people, and high-cost employer health plans; reductions in Medicare payments to hospitals and Medicare Advantage plans; and a board to help restrain Medicare spending.

Stakeholder groups had strong incentives to oppose these policies. A broad array of constituencies—employers, insurers, medical providers, device manufacturers, and unions—found something in the ACA to dislike. Any ambitious health care bill will be redistributive, compelling changes and imposing costs that some groups will resist. The point of reform, after all, is to alter the status quo. However, many individuals and interests benefited from and were satisfied with the arrangements that existed before the ACA, which made these changes controversial and led groups to mobilize after enactment to overturn multiple ACA measures. Thus, the fight over the ACA did not end in 2010.

OBSCURED BENEFITS Even as some ACA policies have imposed costs, generated controversy, and produced backlash, the law's benefits have often been obscured.[11,12,18] The ACA has transformed US health insurance, prohibiting insurer discrimination on the basis of health status and sex, providing subsidies to help make coverage affordable, enabling states to expand Medicaid eligibility, allowing young adults to stay longer on their parents' plans, and much more. Those policies, which substantially reduced America's uninsured population, are highly popular. Moreover, the ACA has been less expensive than predicted, and national health spending has grown at slower rates than anticipated at the law's enactment. Nevertheless, for most of its existence the popularity of the ACA as a whole—rather than its component parts—was underwhelming, with more Americans opposing than favoring the law in 2010–16.[19]

One reason may have been that the ACA lacked a coherent programmatic identity. Unlike Medicare and Social Security, the ACA does not have an easily discernible set of beneficiaries or benefits. It is less a singular program than a series of subsidies, regulations, and mandates that affect different population groups in different ways.[11,12,15] That has made it harder for the ACA to generate favorable public opinion, overcome implementation problems, gain credit for its achievements, and build a political constituency (though as I note below, it has done so nonetheless). It also helps explain why the Obama administration struggled to produce effective messaging on health reform. If the ACA's benefits were more visible and widely understood, the program's opponents would have been less likely to attack it.

'UNDESERVING' BENEFICIARIES Additionally, core ACA policies such as Medicaid expansion and insurance subsidies concentrate most of their benefits on low-income Americans—who are not the objects of compassion that policy makers had previously favored with public coverage, such as older people, children, and pregnant women. If the ACA had been a universal program that spanned income classes or focused its benefits narrowly on sympathetic populations perceived as deserving, it might not have been under siege to the extent that it has been over the past decade, and its politics might have looked more like Medicare's.

Moreover, the ACA has surfaced perennial racial/ethnic tensions in the US over who receives government benefits. In some quarters, the opposition to Medicaid expansion and the ACA is animated by old anxieties about "undeserving" recipients and the fear that the law is unfairly benefiting minority groups and immigrants.[20] It is as disquieting as it is striking that eight of the eleven states of the former Confederacy have not expanded Medicaid.

Self-Inflicted Wounds

There is no question that the ACA's problems are partly self-inflicted. The ACA reflects compromises that were made, as well the political calculations and fiscal constraints that prevailed in 2010. They have contributed to the law's shortcomings. President Obama asked Congress not to exceed a total of $900 billion in spending on the ACA over its first decade, which led Democratic lawmakers to reduce the generosity of insurance subsidies and coverage.[8] A decade later it is clear that the law did not contain sufficient funds to ensure that insurance would be affordable for all people who purchased coverage through the Marketplaces, especially for those who qualified for no or only limited financial assistance. Advocates hoped that the ACA's subsidies could be improved over time. However, GOP resistance to repairing Obamacare has meant that the original limits of the law's affordability provisions have persisted.

While people eligible for subsidies have generally been protected from premium increases in ACA plans, those without subsidies have been exposed to the full burden of hikes, which appears to be contributing to declining enrollment in the individual insurance market.[21] Moreover, the ACA did not resolve affordability problems for Americans who already had coverage, a fact underscored by the substantial increase in deductibles for employer-sponsored insurance plans over the past decade (although premium growth for such plans has been relatively moderate).[22] While the ACA has successfully reduced the uninsured population, underinsurance is a mounting problem. In short, the ACA's performance on its central promise—to make health insurance affordable—has been decidedly mixed. That gap between promise and reality has likely undermined public support for the law, making it a more vulnerable political target.

Polarized America

The most powerful explanation for the protracted controversy that has engulfed the ACA has little to do with the law itself. Instead, the divisive politics surrounding the ACA reflect broader trends of growing partisanship and polarization in American politics. After all, Medicare has always had serious gaps in its benefits that leave many enrollees susceptible to high out-of-pocket spending. Medicare also "crowded out" private coverage with government insurance. Moreover, while Medicare's implementation was both fast and smooth, the program initially lacked any cost controls, and its expenditures far surpassed initial projections.

By 1972 Medicare faced a trust fund shortfall. The reaction of policy makers, including Republicans, was not to try to repeal Medicare but to stabilize it.[13] That response may have been a product of the program's sympathetic beneficiaries; the advantages of social insurance financing; and the political strength of a universal, cross-class constituency. However, it was also attributable to a political environment that was relatively more conducive to bipartisanship, compared to the current one.

According to one common measure, Democrats and Republicans in Congress are now farther apart ideologically than at any point in the past 160 years.[23] The ideological polarization between the parties has been rising since the 1970s and increased substantially during the past two decades. It is asymmetric, with most of the growing gap due to a rightward ideological shift by Republicans. The causes of polarization are multiple and in dispute among political scientists, ranging from the impact of civil rights legislation and the ensuing realignment of southern politics to a fractured media environment and rising economic inequality.[23] The influence of activist groups funded by conservative donors such as Charles and David Koch, which have played an important role in campaigning against the ACA, is another force pushing the GOP farther to the right.[16,24]

Additionally, electoral incentives may be increasing partisanship. American elections in recent decades have been highly competitive by historical standards.[25] Competitive elections can exacerbate partisanship because if the minority party believes it has a realistic chance to win the next election, then it has incentives to pursue obstructionist strategies to deny the majority party legislative victories.[15,25] The result is more delays and brinksmanship, and less ability for lawmakers to form cross-party coalitions to address policy problems.[23]

The ACA was born into a fiercely polarized and partisan crucible that it has been mostly unable to escape. Large Republican gains in federal and state elections in 2010, which partly reflected a backlash against the ACA, provided the GOP with institutional platforms to undermine the law and its institutionalization.[12] In contrast, Medicare did not face Republican majority control of the House and Senate until thirty years into its operation.

Partisanship has infused every aspect of the ACA's political life, from enactment to state implementation, federal administration, and litigation.[15] The extraordinary levels of polarization and partisanship in US politics help explain many things: why Republicans have abandoned health policy ideas they once favored, why not a single Republican voted for the ACA, why many

The ACA was born into a fiercely polarized and partisan crucible that it has been mostly unable to escape.

states have rejected Medicaid expansion, why the ACA has been subject to so many legal challenges and why the courts have become another venue of political conflict, why public opinion has been divided over the law, why there has been no successful bipartisan effort to remedy the law's shortcomings, why ACA politics persist as existential rather than incremental, and why the ACA has engendered so much controversy over the past decade despite its moderate roots and considerable achievements. The political fight over the ACA is a front in a broader partisan and ideological struggle that defines contemporary American politics.

Breakthrough Politics

Despite the ACA's shortcomings and struggles and the deep partisan divisions that have colored its brief history, there is no question that it has transformed American health care politics. That transformation was evident in 2017 when Republicans, with majority control of Congress and Donald Trump in the White House, sought to make good on the party's long-standing promise to repeal and replace Obamacare.[12,15–17] The Republican repeal bill passed by the House was itself a concession to the ACA's realties. It did not strip away all of the ACA, retaining the Marketplaces, subsidies, and insurance regulation (albeit with waivers that allowed states to opt out of that regulation and much more limited subsidies for lower-income people).

There were other signs of the changing politics of health care. GOP proposals to roll back the ACA's Medicaid expansion drew opposition from some Republicans, including GOP governors whose states had embraced expansion. The Republican repeal plan became the least popular major bill in the past thirty years, largely because of its proposed cuts to ACA benefits and coverage gains, and GOP repeal efforts ended up significantly increasing the ACA's popularity.[15–17] Indeed, Republicans' failure to devise a viable plan to replace the ACA that could come anywhere close to replicating its coverage gains and consumer protections has helped sustain the ACA. While the ACA did not attract a single Republican vote in 2010, in 2017 three Republican senators provided the decisive votes to retain it (though a bigger Republican Senate majority likely would have yielded a different outcome).[16]

The 2018 elections provided further evidence of the new politics of health care. For the first time since 2010, Democrats campaigned on the ACA as a central issue, targeting Republicans who had voted in Congress to reverse the law's consumer protections and coverage gains. The GOP's repeal efforts likely contributed to substantial Republican losses and to the Democrats' regaining a majority in the House. While there has been substantial public confusion about the ACA, the threat of repeal clarified the ACA's benefits and focused attention on the impact of its provisions that protect people with preexisting conditions against discrimination. And in Kentucky and Louisiana the electoral prospects of Republican gubernatorial candidates in 2019 may have been damaged by public anxieties over their support for reversing Medicaid expansion, helping Democrats win both of those elections. The political costs of unraveling the ACA and its core policies are now visible. The ACA has changed health politics by creating a new status quo that, despite the law's myriad problems, will not easily be changed.

Conclusion

As the ACA's tenth anniversary arrives, the law's future is uncertain. Another legal challenge, which could roll back the entire law or major portions of it, casts a shadow over the ACA. A federal judge in Texas has invalidated the entire ACA, and an appellate court upheld his ruling that the law's individual mandate is now unconstitutional—while returning to the lower court the question of how much of the ACA should consequently be eliminated.[26] This is a reminder of the ACA's fragility in the context of an increasingly conservative judiciary (the Supreme Court could eventually decide the case). Meanwhile, the longer-term impacts of the Trump administration's executive actions and the elimination of the individual mandate on insurance coverage are unclear, even as the uninsured population has started to increase again. If President Trump is reelected in 2020 and Republicans win congressional majorities, the GOP could launch another repeal drive. In contrast, if Democrats win the White House and majority control of Congress, they could look to move

beyond the ACA in pursuit of Medicare for All or a Medicare-like public option.

The ACA's enactment demonstrated that major progress is possible in US health policy. The past decade has shown just how difficult and divisive the politics of progress are. ■

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NOTES

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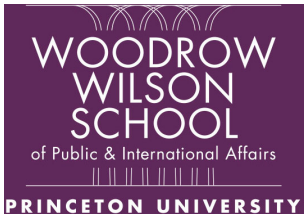

FEB, 24, 2020

The Department of Homeland Security Begins Implementing Its Public Charge Rule on February 24, 2020

Allison Orris, Elizabeth Dervan, Alice Lam, and Patricia Boozang, Manatt Health

The Supreme Court has granted the Administration's requests to stay preliminary injunctions that blocked the Department of Homeland Security (DHS) public charge final rule from taking effect in October 2019. As a result of the Supreme Court rulings, the government will move forward with its dramatic changes to public charge.

The new rule was implemented nationwide on February 24, 2020, as announced by DHS's U.S. Citizenship and Immigration Services (USCIS) on January 30, 2020 (https://www.uscis.gov/news/news-releases/uscis-announces-public-charge-rule-implementation-following-supreme-court-stay-nationwide-injunctions) and February 22, 2020 (https://www.uscis.gov/news/news-releases/dhs-implement-inadmissibility-public-charge-grounds-final-rule-nationwide). This means that for applications for admission or lawful permanent residence (a green card) submitted on or after that date, DHS public charge determinations will newly consider certain immigrants' use of non-emergency Medicaid (with exceptions for pregnant women and children under

21), housing assistance, and Supplemental Nutrition Assistance Program benefits as well as an expanded set of factors about an applicant's circumstances, including credit history and English proficiency. Coverage through the Children's Health Insurance Program, the Marketplace, Medicare, and state or local health care programs will not be considered. Importantly, the rule will not be enforced retroactively; USCIS clarified that it will not consider a person's receipt of, or applications for, non-cash benefits prior to the February 24, 2020 effective date.

DHS had been blocked from implementing the rule since October as a result of preliminary injunctions issued by federal district courts in multiple states. Three courts (in New York, Maryland, and Washington) had issued nationwide orders, while two others (in California and Illinois) issued injunctions that were more limited in scope. Soon thereafter, the federal government asked Courts of Appeals in the Second, Fourth, Seventh, and Ninth Circuits to stay the preliminary injunctions while the government appealed the lower court decisions. The Fourth and Ninth Circuits granted the government's requests, rolling back nationwide orders from Maryland and Washington as well as a limited order from California that applied to 13 states. The Seventh Circuit denied the stay request and kept a preliminary injunction in place for Illinois. On January 8, the Second Circuit also denied the government's stay request, allowing the New York nationwide preliminary injunction against DHS to remain in effect. DHS then appealed the Second Circuit's decision to the Supreme Court. In a January 27 order, the Supreme Court allowed DHS to begin implementing the final rule in all states but Illinois, where the statewide preliminary injunction remained in effect. DHS also then appealed the Seventh Circuit's decision to the Supreme Court and, on February 21, the Supreme Court granted the Administration's request and lifted the Illinois preliminary injunction, clearing the path for DHS to implement the rule nationwide on February 24.

The status of the DHS rule could change dramatically in the months ahead while litigation over the merits of the preliminary injunctions continues in all four circuit courts. The circuit courts have each set expedited schedules for the appeals, which means briefing will likely be complete by early March and decisions may be issued by the end of May. In the Seventh Circuit, arguments have been scheduled for February 26 and, in the Second Circuit, for March 2. These courts could decide to again enjoin the rule (a decision the Administration would likely appeal back to the Supreme Court) or could determine that the rule can go into effect.

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FEB, 14, 2020

A Mixed Bag for States: The Proposed 2021 Notice of Benefit and Payment Parameters

Sabrina Corlette, Georgetown University's Center on Health Insurance Reforms

On February 6, 2020, the U.S. Department of Health & Human Services (HHS) published its annual draft rule (https://www.govinfo.gov/content/pkg/FR-2020-02-06/pdf/2020-02021.pdf) governing core provisions of the Affordable Care Act (ACA), including the operation of the marketplaces, standards for individual and small-group market health plans, and premium stabilization programs. Referred to as the "Notice of Benefit and Payment Parameters" or NBPP, a detailed summary of the proposed rule is available through Katie Keith's three-part blog series for Health Affairs, here (https://www.healthaffairs.org/do/10.1377/hblog20200201.499854/full/), here (https://www.healthaffairs.org/do/10.1377/hblog20200201.566219/full/), and here (https://www.healthaffairs.org/do/10.1377/hblog20200203.306242/full/). This expert perspective focuses on several policies that would have implications for state insurance regulation and the operation of the state-based marketplaces (SBMs). Comments on the rule are due March 2, 2020.

Risks for low-income Marketplace consumers who automatically re-enroll

In December 2019, Congress enacted legislation prohibiting HHS from taking two actions in 2021: banning "silver loading (https://www.healthaffairs.org/do/10.1377/hblog20180805.711405/full/)" and ending the automatic re-enrollment of qualified enrollees who do not proactively dis-enroll or switch plans during open enrollment. In spite of that ban, HHS is seeking comment on whether it should adjust the automatic re-enrollment process so that any enrollee whose premium tax credit (PTC) would be enough to cover their entire premium would be re-enrolled without any PTC unless they returned to the Marketplace for a new eligibility determination. In 2019, 1.8 million enrollees in states using Healthcare.gov were automatically re-enrolled. Of those, 270,000 received PTCs sufficient to cover their entire premium. HHS argues such a change is needed to ensure that no one receives PTCs to which they are not entitled, and suggests they would conduct outreach to affected enrollees alerting them to the new process and the importance of returning to the Marketplace if they want to maintain their eligibility for PTCs.

State Comments Needed? HHS notes that SBMs currently have flexibility to establish their own annual redetermination processes (though such alternative processes must receive HHS approval), and seeks comment on whether its proposed change to the automatic re-enrollment process should apply only to FFM and SBM-FP states, or to all Marketplaces. Further, all states may wish to comment that reducing bureaucratic hurdles to re-enrollment can help maintain a stable risk pool and thereby lower premiums, help reduce administrative costs for insurers, and prevent gaps in coverage and care.

User Fees for the FFM: Staying the Same or Going Down?

HHS is proposing to keep the user fees for operating the FFM at 2020 levels (3.0 percent for FFM states, 2.5 percent for SBM states using the federal platform (SBM-FPs)). However, HHS is seeking comment on whether they should lower the user fee rate below the current level to reflect their 2021 premium and enrollment projections, as well as their lower operational costs due to cuts in marketing, outreach, consumer assistance, and plan oversight.

State Comments Needed? SBM-FP and FFM states considering a transition to a full SBM may wish to comment on the budget impact of a change in the user fee rates. FFM states may further wish to comment on the impact of the Administration's past cuts to the marketing and consumer assistance programs.

New Annual Reporting Obligation on Benefit Mandates

HHS is proposing to require states, beginning July 1, 2021, to report to HHS all state benefit mandates and indicate whether any are in addition to the essential health benefits (EHB). If a state does not submit such a report, HHS is proposing to conduct its own determination of which benefits are in addition to EHB in the state. HHS notes that such reporting is a predicate to determining whether any state benefit mandates would trigger the ACA's requirement that states defray the cost.

State Comments Needed? States may wish to comment on the time and effort that would be associated with complying with such a reporting requirement. Further, HHS seeks comment on whether the state, the Marketplace, or HHS should be the entity responsible for determining whether there will be a defrayal obligation.

New Flexibility for Insurers on Application of Drug Manufacturers' Coupons

In its 2020 NBPP, HHS allowed insurers to discount an enrollee's use of drug manufacturers' coupons to defray cost-sharing associated with brand-name drugs when determining the enrollee's annual out-of-pocket spending, so long as an equally effective generic is available. HHS is now proposing to enhance this flexibility by allowing insurers to exclude those coupon amounts from the calculation of enrollees' annual cost-sharing, regardless of whether a generic equivalent is available. HHS further notes they would expect insurers to inform enrollees of their policy with respect to the use of drug coupons and enrollees' out-of-pocket liability under their plans.

State Comments Needed? HHS notes that this flexibility will only be available to insurers "to the extent consistent with state law." States that limit insurers' ability to discount the use of drug coupons in determining enrollees' annual out-of-pocket liability may wish to comment in support of state authority to regulate fully insured plans in this context. Further, states may wish to encourage HHS to require, instead of encourage, insurers to clearly and prominently disclose to consumers their policies with respect to drug coupons.

Improving Special Enrollment Period (SEPs) Policies

HHS is proposing several changes to SEP policy to enhance consumers' choices and improve efficiency. These include:

- Allowing enrollees who become newly ineligible for cost-sharing reduction (CSR) plans to switch from a Silver plan to either a Bronze or a Gold plan.
- Allowing individuals who are not dependents, but whose dependents are enrolled in a Marketplace plan, and who qualify for a SEP, to be added to their dependent's current plan or into a separate Marketplace plan.
- Allowing individuals who enroll through a SEP after the 15th of the month to effectuate coverage on the 1st of the following month (i.e., if the individual enrolls on May 17, their coverage would be effective on June 1). SBMs would be allowed to retain their current coverage effective dates.
- Allowing individuals who are eligible for retroactive coverage, whether due to a SEP, a favorable appeal decision, or a processing delay, the option to pay the premiums for all the months of retroactive coverage, or only the premium for one month of coverage and receive prospective coverage only.

State Comments Needed? States may wish to applaud these SEP policy changes for improving consumer choices, reducing potential consumer confusion, and lowering the risk of gaps in coverage. SBMs may want to comment on any operational issues with respect to implementing any of the above proposed policies for plan year 2021.

Quality Rating: Some (Limited) State Flexibility

In August 2019, HHS extended its Quality Rating Information pilot to all Marketplaces for plan year 2020. Up to that time, SBMs had been permitted to display their own quality rating information. The proposed NBPP provides that SBMs have some flexibility to customize the ***display*** of quality rating information, but they must use the quality ratings that have been developed by HHS.

State Comment Needed? SBMs that have developed state-specific customization of their quality rating information to reflect local priorities may wish to comment on the importance of ensuring that those local priorities are reflected in plans' ratings.

Program Integrity Changes to Improve Efficiency

HHS is proposing several changes to periodic data matching (PDM) and other program integrity processes to improve efficiencies. These include:

- Giving SBMs greater flexibility to verify applicants' eligibility for or enrollment in employer-sponsored coverage through their own risk assessments. HHS is

conducting a study to support its own risk assessment and is encouraging SBMs to do the same.

- Allowing SBMs not to re-determine eligibility for subsidies for enrollees who are (1) dually enrolled in Marketplace and Medicare, Medicaid/CHIP or the Basic Health Plan, (2) have not responded to update their information within 30 days, and (3) consent to the Marketplace terminating their coverage if data show they are dually enrolled or eligible.
- Allowing SBMs, when they identify a deceased enrollee through PDM, to terminate coverage retroactively to the date of death, without undertaking a redetermination of eligibility.

HHS also seeks comment from states on whether applicants who request eligibility pending an appeal should be limited in their choice of insurer or plan. They also ask for comment on whether a timeliness standard should be imposed on such requests, and whether SBMs should have flexibility to determine their own timeliness standards.

State Comment Needed? SBMs may wish to comment on the proposed new flexibility and program integrity efficiencies.

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FEB, 07, 2020

Open Enrollment Recap: States Driving Progress

Julie Bataille and Alison Kruzel , GMMB

Overview

As we round out the seventh year of ACA open enrollment, State Health and Value Strategies (SHVS) is reflecting on the successful steps that states have taken to provide quality, affordable health coverage to more residents and draw on lessons learned as this work moves forward. States are leaning in to implement new policy solutions to reduce premium costs and stabilize their markets, and doubling down on marketing and outreach efforts in the face of reduced federal funding. Seven years in, marketplaces and markets are stable, consumers have more options, and we continue to see a demand for quality, affordable coverage. In fact, early results show the number of new consumers enrolled through HealthCare.gov increased during this open enrollment period, and several state-based marketplaces saw increases in their total enrollment figures.[1] There is certainly more work to be done to increase access and improve affordability for all Americans, but the momentum is in the states. As such, SHVS is excited to launch a series of posts featuring policy and outreach

strategies states are employing to meet the needs of their residents. This Expert Perspective highlights some of the key ways in which states are driving efforts to increase enrollment this past open enrollment period. Subsequent posts will include deep dives into certain specific state policies and outreach strategies, such as plan standardization and targeted outreach to address health disparities in coverage.

Policy and Outreach Lessons from States

As states seek ways to ensure that consumers have access to options for health coverage, many have implemented new policies to foster competition and participation in the market, so that they can remain robust and sustainable moving forward. Alaska, Colorado, Delaware, Maine, Maryland, Minnesota, Montana, New Jersey, North Dakota, Oregon, Rhode Island and Wisconsin have implemented reinsurance programs, ensuring carriers are reimbursed for covering the most expensive patients and lowering the cost of premiums for consumers by nearly 20 percent on average.[2] California, D.C., Massachusetts, New Jersey, Rhode Island and Vermont have established their own state-level health insurance mandates. Colorado saw the formation of a cooperative alliance, Peak Health Alliance, to leverage buying power and lower premiums for consumers. And 23 states have imposed limits on short-term health plans to ensure comprehensive coverage and protections for consumers—something we expect to remain a focus as results of a federal inquiry into deceptive marketing practices surrounding theses plans is expected in the coming weeks. Furthermore, some states (https://www.shvs.org/standardizing-health-plan-benefit-design-opportunities-and-implications-for-states/) are considering standardizing plans to allow consumers to make “apples- to-apples” comparisons. More states are considering similar initiatives as they see the results of these efforts taking hold.

Beyond these significant policy changes, the operational efficiencies and robust outreach and education efforts of the state marketplaces continue to be critical to their success. We’ve seen increasingly sophisticated customer support tools available to help consumers make informed plan selection decisions; improved online experiences reflecting user testing and optimizations; online chat features and integration of online, in-person and telephone customer support. Combined, these factors have eased burdens on call centers, lowering wait times and improving the overall consumer experience.

States have promoted these tools as well as enrollment dates and events via targeted integrated marketing campaigns, using research-based messaging that emphasizes the availability of financial help, annual changes in plans and prices, and enrollment

deadlines. States have also employed targeted outreach strategies to improve access to coverage for specific populations, such as Hispanics, young adults, and the remaining uninsured.

The outreach happening in states—including in those who still use the HealthCare.gov platform—has been crucial in engaging the hard-to-reach populations and counteracting reduced federal marketing and outreach funding. By building on outreach strategies that have been successful year after year and continuing to innovate, states are making progress in reaching and enrolling residents.

States efforts helped counteract the Congressional Budget Office's expected loss in coverage following the 2017 congressional action mandate repeal. And in part thanks to these enhancements, Maryland (https://www.marylandhbe.com/wp-content/uploads/2019/12/OpenEnrollment2020.pdf)saw their highest enrollment numbers in four years, while Massachusetts (https://www.bostonglobe.com/2020/01/30/business/health-connector-sign-ups-reach-new-high-2020/)' enrollment increased by more than 5 percent compared to the previous year.

Looking Ahead

Despite the tireless work of state policymakers, health insurance marketplaces, outreach workers and others, much work remains to be done to provide consumers with affordable health care options. States are constantly facing new challenges as federal policies and rulemaking shifts, and as the ***Texas v. U.S.*** court case makes its way to the Supreme Court—this makes state innovation all the more important.

As the first state to transition from HealthCare.gov to a fully operational state-based marketplace platform, Nevada Health Link has seen promising 2020 enrollment numbers that demonstrate consumer demand and pave the way for other states positioned to make this move. Doing so allows states more autonomy in decision-making and complete access to data to drive their enrollment efforts. Other states have taken note—New Jersey, Pennsylvania and New Mexico have passed legislation authorizing the state to establish a state-based marketplace in the future, while others including Oregon, Maine, Virginia and Illinois are in the early stages of exploring this possibility. How states operationalize, implement and evolve their marketplace is something we will be watching closely.

It is clear that states are making progress and building on what they have learned in their ongoing efforts to make health care more accessible, affordable and equitable for their residents. We are looking forward to seeing more state innovations and sharing those stories.

Sources:

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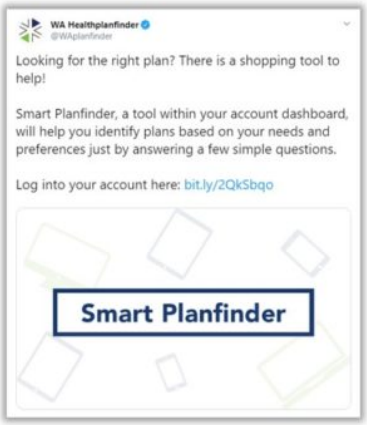
Optional examples of state marketing & outreach efforts to include



The Heritage Foundation

BACKGROUNDER
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DOMESTIC POLICY STUDIES

The Public Option: Single Payer on the Installment Plan

Nina Owcharenko Schaefer and Robert E. Moffit, PhD

KEY TAKEAWAYS

Although touted as less radical than "Medicare for All," a government health plan would still result in government control of America's health care system.

More lawmakers are proposing the incremental approach to government-controlled health care through a public option health insurance plan.

A public option would impose rules that favor the government while reducing personal choices and costing taxpayers more.

> Whether conceived as an expansion of Medicare or the creation of a government health-care plan, the public option is a Trojan horse with single-payer hiding inside.
>
> —Seema Verma, Administrator, Centers for Medicare and Medicaid Services, *The Washington Post,* July 24, 2019

Tactical differences aside, many liberal Democrats in Congress are diligently pursuing a common strategic goal: a government takeover of American health care.

The two leading legislative proposals to achieve that goal, the so-called Medicare for All proposals, S. 1129, sponsored by Senator Bernie Sanders (I–VT),[1] and H.R. 1384, sponsored by Representative Pramila Jayapal (D–WA),[2] would abolish virtually all existing

coverage arrangements, private and public, and replace them with a single, national health insurance plan, centrally controlled and directed by federal officials in Washington, DC.

Short of such a drastic and direct federal takeover of American health care, a number of prominent congressional leaders and presidential candidates are proposing a more incremental approach to a government-controlled health care system through a "public option." A public option (public = government) is a new government health plan that would compete directly against private health plans. Proponents of this approach purport that it would enhance competition in the nation's health insurance markets, expand choice for consumers, and reduce America's overall health care costs.

Yet, the dynamics inherent in the leading public option proposals would guarantee an outcome quite the opposite of the claims. The underlying components of these proposals—the power of the government to drive out private competition and coverage, compel provider participation in the government plan, consolidate enrollment into the government plan, and shift costs to taxpayers and providers—are the cornerstones of a single payer, government-run health system. Although touted as less radical than "Medicare for All," a government option would ultimately result in near-total government control of American health care.

The Public Option Concept

The public option and its purpose are not new. Helen Halpin, director of the Center for Health and Public Policy Studies at the University of California, and public option advocate Peter Harbage traced the origins of the public option concept to a 2001 state health care reform project in California.[3] From there, a national version of the public option concept was introduced in 2003 as part of the *Covering America Series*, funded by the Robert Wood Johnson Foundation. At the time Halpin wrote in a piece for the series that the public option, then called the CHOICE program, "is a new approach to health care reform that very quickly achieves nearly universal access to a single-payer health insurance system for all U.S. residents."[4] For liberals in Congress, arming the government with strong statutory and regulatory advantages to undercut private insurance emerged as the mechanism to achieve their long-sought single payer victory.

A Down Payment for Single Payer. In 2008, Democratic presidential candidate Barack Obama incorporated a version of the "public option" as a key component of his comprehensive health care reform agenda.[5] A public

option was also a part of the 2009 legislative debate over the Affordable Care Act's (ACA's) creation. Though this public option was later excluded from the final version, during the 2009 congressional debate, then-Representative Barney Frank (D–MA) said: "I think that if we get a good public option it could lead to single payer and that is the best way to reach single payer. Saying you'll do nothing till you get single payer is a sure way never to get it.... [T]he only way, is to have a public option and demonstrate the strength of its power."[6]

Fully arming the government with powerful statutory or regulatory advantages, the public option would be the mechanism to, over time, undercut private insurance, and pave the way for a single payer, government-run health care system.

The Leading Public Option Proposals: Single Payer on the Installment Plan

Short of launching an immediate, full-scale government takeover of American health care, as provided under the House and Senate "Medicare for All" bills, a number of House and Senate Democrats are sponsoring bills that create a "public option."[7] These proposals would grant the government the power to drive out private competition and coverage, coerce provider participation in the government plans, consolidate enrollment in favor of the government option, and shift costs of the government plan to taxpayers and health care providers. While these public options do not explicitly outlaw private coverage, all of these proposals put in place the infrastructure to facilitate a transition to a single payer system of government-run health care and an end to private coverage as we know it.

The Medicare for America Act of 2019 (H.R. 2452). Representative Rosa DeLauro (D–CT) is sponsoring H.R. 2452, the Medicare for America Act,[8] which has 24 Democratic co-sponsors and no Republican co-sponsors.[9] This proposal would establish a temporary public option and transition to a more robust government-run health plan, which lays the foundation for a potential single payer model in the future.

A Transitional Public Option. The bill would establish a temporary public option that would be offered through the ACA exchanges for two years, and would be made available to those individuals eligible to purchase coverage through the exchanges and who are in an area where the Secretary of Health and Human Services (HHS) offers the public option.[10] This temporary public option must meet the benefit requirement of a qualified health plan as defined under the ACA, including ACA essential benefits.[11]

The HHS Secretary would set premiums for the public option. Premiums would be capped so that no individual or household will pay more than 8 percent of adjusted gross monthly income toward premiums. Federal subsidies would be set so that individuals with household incomes below 200 percent of the federal poverty level (FPL) ($24,980 for an individual/$51,500 for a family of four) would pay no premium, and those between 200 percent of FPL and 600 percent of FPL ($74,940 for an individual/$154,500 for a family of four) would receive a sliding scale subsidy.[12]

Payment rates for reimbursing services would be based on Medicare rates and set as necessary to "maintain network adequacy."[13] A health care professional who is a participating provider in Medicare or Medicaid on the date of enactment would be a participating provider for the public option. The HHS Secretary would be required to establish a process to allow additional providers that are not in Medicare or Medicaid to participate in the public option.[14]

The act also states that "health care providers may not be prohibited from participating in the public health insurance option for reasons other than their ability to provide covered services.".[15] Further, health care providers, hospitals or other institutions would be prohibited from denying individuals access to *any* covered benefits or services because of "religious objections."

The Medicare for America Act would establish a fund for the administration of the public option and would appropriate "such sums as may be necessary" from funds not otherwise obligated to operate the public option.[16] It also specifies that there would be no restriction on federal funds for the use toward *any* reproductive health services.[17]

The Medicare for America Plan. In 2023, the HHS Secretary would establish the "Medicare for America" plan, a more robust version of the initial, temporary public plan.

An individual who is a resident of the United States, who is lawfully present[18] or would be eligible for coverage under immigration exceptions described in Medicaid at the time of enactment,[19] would be eligible for enrollment in the Medicare for America plan.

Starting in 2023, the Secretary would automatically enroll in the Medicare for America government plan those individuals who are eligible at the time of birth, those Medicare beneficiaries enrolled in fee-for-service Medicare, future Medicare beneficiaries when they turn 65, and those individuals deemed to not have "qualified" health coverage as defined by the act.[20] Members of Congress and staff would also be enrolled.[21]

Under full implementation, traditional Medicare,[22] Medicaid, CHIP, and the ACA exchanges would be terminated, and enrollees of those programs would be enrolled in the Medicare for America plan.[23]

Individuals enrolled in "qualified" health plans, including newly defined qualified employer coverage,[24] military/TRICARE coverage, services through the Veterans Administration, the Federal Employees Health Benefit Program, and the Indian Health Services, would have the option of remaining on their existing plan or enrolling in the Medicare for America government plan.[25] The Secretary would also set up a process for allowing employers to enroll their employees into the plan.[26]

Moreover, as part of the enrollment process, the Secretary would issue Medicare for America identification cards. Participating providers in the Medicare for America plan would be required to facilitate enrollment, as would state entities responsible for enrolling individuals in Medicaid and the Children's Health Insurance Program (CHIP).[27]

The Medicare for America plan would provide all benefits as covered under Medicare Parts A and B, Medicaid, and those "as determined to be medically necessary," including an extensive and highly specified list of services.[28] The Medicare for America Act would also prohibit a private insurer from selling coverage that duplicates benefits under the Medicare for America plan.[29]

Under the Medicare for America plan, individuals would pay a monthly community-rated premium set by the HHS Secretary. The premium would be based on benefit and administrative costs and family composition. Like under the transition, no individual or household would pay more than 8 percent of monthly income toward a premium, and federal subsidies would prevent individuals with household income below 200 percent of the FPL from paying a premium, and a sliding scale subsidy would be set for those individuals with household incomes between 200 percent and 600 percent of the FPL.[30] The Medicare for America Act would also set cost-sharing subsidies based on ACA gold-level coverage rather than silver-level coverage (as under the ACA), and would further reduce cost-sharing requirements by income.[31]

There would be no deductibles in the Medicare for America plan. The maximum out-of-pocket limit would not exceed $3,500 for an individual or $5,000 for a household, and there would be no lifetime or annual limits for services or benefits that are covered under the Medicare for America plan.[32]

The HHS Secretary would set provider reimbursement rates based on Medicare or Medicaid, whichever is higher. If benefits or services are not covered under Medicare or Medicaid, the Secretary would set a rate to ensure "adequate access" to services. In addition to other payment changes, the bill provides exceptions for inpatient and outpatient hospital services, where the payment rate would be set at 110 percent of the Medicare or

Medicaid rate, whichever is higher. For hospitals serving underserved areas, the Secretary would increase the rate as necessary.[33] Moreover, providers would be prohibited from billing patients above government set payment rates, and providers would also be prohibited from entering into private contracts with individuals for services covered under the Medicare for America plan.[34]

As with the temporary public option, a health care provider who is a participating provider under Medicare or Medicaid on the date of enactment would remain a provider under Medicare for America. [35] The HHS Secretary would also be required to establish a process to allow additional providers, who are not in Medicare or Medicaid, to participate in the public option.

The Secretary would "negotiate" rates for prescription drugs under the Medicare for America plan. If the Secretary is unable to reach an agreement with a manufacturer, the Secretary is authorized to use any patent, clinical trial data, or other exclusivity granted for the purposes of manufacturing the drug for sale to Medicare for America.[36] The bill also establishes a Prescription Drug and Medical Device Board to monitor and enforce a "prohibition on excessive drugs prices."[37]

The Medicare for America Act would establish a unified Medicare Trust Fund for the administration and operation of the Medicare for America plan. Any revenues attributable to Medicare for America and premiums collected would be taken from the general fund and deposited into the Trust Fund; as well as any amounts that would have been appropriated for Medicare and Medicaid[38] starting in 2027. Additional appropriations would be authorized "as needed to maintain maximum quality, efficiency, and access…"[39]

The act also stipulates that there would be no restrictions on federal funds for any reproductive health service, including abortion. The act also states that providers may not be prohibited from participating in Medicare for America "for reasons other than their ability to provide covered services," and that providers would be prohibited from "denying covered individuals access to covered benefits and services because of their [the providers'] religious objections" and would explicitly supersede any conscience protections.[40]

While the Medicare for America plan would not eliminate the Medicare Advantage (MA) program, it does set new requirements for MA plans. For example, an insurer could only offer coverage in the individual market if the insurer also agrees to sponsor coverage under the new Medicare Advantage (MA) for America program. The provider payment rates for MA for America would be set at 95 percent of the average Medicare for America cost in each

county, and the payment rate for prescription drugs under MA for America would not exceed the amount set for prescription drugs under the Medicare for America plan.[41]

In addition to a variety of other health-related initiatives,[42] the act would establish a new services and support program for federal, home, and community-based, long-term care. Any individual who is eligible for Medicare for America and is unable to perform at least one activity as defined under IRS rules would be eligible for services and support under this new program. State entities responsible for administering such services under Medicaid would be legally responsible for administering services under this new federal program.[43]

New Taxes. Title II of the act outlines a sundry list of new tax increases for taxpayers.[44] It would sunset the entire Tax Cuts and Jobs Act, add a 5 percent surtax on incomes that exceed $500,000, revise tax treatment related to inheritance property, increase the Medicare payroll tax from 2.9 percent to 4 percent, increase the net investment tax from 3.8 percent to 6.9 percent, terminate deduction for contributions to health savings accounts (HSAs), increase the excise tax on various tobacco products, increase the excise tax on alcohol, add a tax on sugared drinks, and repeal the ACA's excise tax on high-cost employer-sponsored health coverage.

Choose Medicare Act (S. 1261/H.R. 2463). Senator Jeff Merkley (D–OR) and Representative Cedric Richmond (D–LA) are sponsoring the Choose Medicare Act.[45] The bill has 15 Democratic co-sponsors in the Senate and seven Democratic co-sponsors in the House of Representatives. Neither have Republican co-sponsors.[46] The bill would establish a government-run plan (Medicare Part E) that would be in the individual, small group, and large group markets. Although not explicit, this proposal would put in place the regulatory infrastructure from which a single payer model could evolve from in the future.

An individual would be eligible for the new public option if he is a resident of the U.S., as defined by the Secretary of HHS, and is not eligible for, or enrolled in, Medicare; is not eligible for Medicaid; and is not enrolled in CHIP.[47]

The Part E plans would be required to offer ACA gold-level coverage and meet the requirements of a "qualified" health plan as defined in the ACA, including ACA essential benefits, Medicare benefits, and all reproductive services, including abortion.[48]

The act would extend the ACA health insurance rating rules to the large-group market,[49] and would permit new federal rules and restrictions on insurance rates that the Secretary deems "excessive, unjustified, or

unfairly discriminatory."[50] The bill would also pre-empt any state actions prohibiting the Part E plan from being offered in the state or prohibiting the outlined benefits.[51]

These plans would be available to employers on a voluntary basis one year after enactment. An individual who is enrolled in a Part E plan through her employer and later separates from her employer would be able to maintain her enrollment in the Part E plan, regardless of whether that individual has access to new coverage through a new employer.[52] It would also require employers who do not provide "qualified" coverage, meaning the employer coverage is deemed "unaffordable" or does not meet minimum actuarial value, to refer employees to an ACA Navigator and authorizes appropriations for "such sums as may be necessary" for the Navigator program to carry out related tasks.[53]

The Secretary would set premiums for the Part E plans based on its offering in the individual, small-group markets, or large-group markets, and their rating areas. The plan's premiums would be required to be sufficient to fully finance the benefits and administrative costs of the plans and to comply with the requirements under the ACA.[54]

The act would change the benchmark for ACA premium tax credits from the second-lowest silver-level plan to the second-lowest gold-level plan, and would expand eligibility for the subsidy for persons with incomes from 400 percent to 600 percent of the FPL. The act would change the ACA cost-sharing subsidy from silver-level coverage to gold-level coverage, and would further reduce cost sharing by income level.[55]

The Secretary would set reimbursement for services at levels that are not lower than Medicare rates and not higher that the average rates in the ACA exchanges.[56] The bill would also require the Secretary to negotiate rates for prescription drugs in Medicare Part D, Medicare Advantage Prescription Drug plans, and for the new Medicare Part E plans.[57] If the Secretary is unable to reach an agreement with a drug manufacturer after one year of negotiations, reimbursement rates will be set at the price paid by the Veterans Administration or as set by the federal government through the Federal Supply Schedule.

A health professional who is a participating provider under Medicare would be assigned as participating provider under the new Medicare Part E plan and a process would be established to accept providers who do not participate in Medicare.[58] The bill would also impose the same Medicare balance-billing limitations—the prohibition on medical professionals to charge any amount above the Medicare payment—on participating providers in Part E.[59]

The bill would appropriate $2,000,000,000 out of funds not otherwise obligated for fiscal year (FY) 2020 for purposes of establishing the Part E program, and "such sums as may be necessary" for the first year to fund initial claims. The bill would establish a reinsurance fund and appropriates $30,000,000,000 out of funds not otherwise obligated for two years for the states to provide reinsurance payments to insurers or to provide assistance to reduce out-of-pocket costs for individuals enrolled in plans through the exchanges.[60]

The proposal would remove any federal funding restriction for reproductive health services, including abortion.[61] In a similar vein, the bill includes a Sense of Congress supporting open access to reproductive services.[62]

Medicare-X Choice Act of 2019 (S. 981/ H.R. 2000). Senator Michael Bennett (D–CO) and Representative Brian Higgins (D–NY) are sponsoring the Medicare-X Choice Act.[63] The bill has 11 Democratic co-sponsors in the Senate and 25 Democratic co-sponsors in the House of Representatives. Neither has a Republican co-sponsor.[64] Similar to the Choose Medicare Act, the bill would establish a new government-run health plan (Medicare-X) that would be available in the individual and small group markets. This proposal, although not explicit, would put in place a regulatory framework for a single payer model to evolve from in the future.

The Medicare-X Choice Act would offer a government plan (Medicare-X) through the ACA exchange. An individual would be eligible to enroll in the Medicare-X plan if the individual is qualified to purchase coverage through the ACA exchanges and is not eligible for Medicare.[65]

Starting in 2021, the plan would be available in priority areas, as determined by the Secretary, where no more than one health plan is offering coverage in the ACA exchange or where there is a shortage of health care providers or a lack of competition. Availability of the Medicare-X plan would increase so that the plan is available to all residents in all rating areas by year 2024 and to the entire small-group market by 2025.[66]

The Medicare-X plan would have to comply with the same requirements as those of the ACA, as well as other federal health insurance requirements.[67] The Medicare-X plan would offer ACA silver-level and gold-level coverage, and may offer no more than two versions of the plan for each of the four ACA coverage levels. After 2021, all enrollees in a state would be in a single risk pool, unless the Secretary establishes, or the state has established, a separate risk pool for the individual and small-group markets.[68]

The Secretary would set premiums to cover the plan's full actuarial costs and administrative costs. The premiums would vary by geographical region and between the small-group and individual markets.[69] The bill would require

that, if premiums collected are in excess of costs, the funds will remain available to the Secretary for administration in subsequent years. The bill would also expand availability of the ACA premium tax credit for those individuals earning below 100 percent of the FPL and for those earning above 600 percent of the FPL, and make it more generous for certain groups.[70]

The Secretary would set reimbursement for health care providers at Medicare fee-for-service rates.[71] The Secretary would be able to increase reimbursement rates by 25 percent for services in rural areas. The proposal would require the Secretary to "negotiate" prescription drug payment rates for Medicare-X, and would remove the existing prohibition forbidding government intervention in setting prices for in Medicare Part D.[72]

The proposal would set as a requirement that a provider must participate in Medicare-X if he is also participating in Medicare or Medicaid.[73] The Secretary would establish a process for providers who wish to opt out of Medicare-X, and to accept new providers who are not participating in Medicare or Medicaid.

The Treasury Deparment would establish a Plan Reserve Fund, and the Secretary of HHS would administer the fund.[74] The bill would appropriate $1,000,000,000 out of funds not otherwise obligated for FY 2020. There would also be a fund established at the Treasury, also administered by the Secretary of HHS, for updating technology and data collection for purposes of establishing appropriate premiums.

The bill would also direct the Secretary to establish a national reinsurance mechanism to pool the cost of the highest-cost patients with individual coverage (on and off the ACA exchange). The bill would authorize the appropriation of $10,000,000,000 each fiscal year for 2021, 2022, and 2023.[75]

Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act (S. 1033/H.R. 2085). Senator Sheldon Whitehouse (D–RI) and Representative Jan Schakowsky (D–IL) have sponsored this bill.[76] It has eight Democratic co-sponsors in the Senate and 20 Democratic co-sponsors in the House. Neither has Republican co-sponsors.[77] Like others, the CHOICE Act would establish a new government-run health plan and would put in place the regulatory framework needed for a single payer model in the future.

The CHOICE Act would make a government plan available through the ACA exchanges at the silver and gold levels, and may also offer coverage at the bronze level. The government plan would comply with the ACA's various insurance requirements and would be required to offer "comprehensive" benefits, including ACA essential health benefits.[78] The bill would pre-empt any state laws that would prohibit a public option.

The Secretary would establish geographically adjusted premium rates for the public option based on ACA premium-rate requirements and other data collected, at levels sufficient to fully finance benefit and administrative costs.[79] A state could establish a state advisory council to provide recommendations to the Secretary on policies to integrate quality improvement and cost-containment mechanisms, mechanisms to facilitate public awareness of the public option, and an alternative payment mechanism. The Secretary would be able to apply those recommendations to that state, in any other state, or all states.[80]

The Secretary would negotiate the plan's payment rates with providers. If the Secretary and providers are unable to reach an agreement, the Secretary would set provider reimbursement rates at Medicare fee-for-service rates and set payment rates for services not covered under Medicare. Similarly, the Secretary would negotiate payment rates for prescription drugs as well. If the Secretary were unable to reach an agreement, the Secretary would use Medicare fee-for-service rates, and would set payment rates for drugs not covered under fee for service.[81]

An account would be established at the Treasury for the administration of the public option. The bill authorizes "such sums as necessary" for start-up funding with the Secretary required to repay those start-up funds over a 10-year period, and authorizes additional appropriations as necessary. The bill also states that there would be no prohibitions on federal funding for "any reproductive health service," presumably including abortion.[82]

Health care professionals who are participating providers under Medicare or Medicaid would automatically be participating providers under the public option, unless the medical professional opts out of participating in the public option through a process determined by the Secretary. The Secretary would also establish a process to allow non-Medicare and non-Medicaid providers to participate in the new public plan. Participating providers would have to be licensed and certified under state law, and a provider could not be excluded for reasons other than his or her ability to provide covered services.[83]

Medicare at 50 Act of 2019 (S. 470). Senator Debbie Stabenow (D–MI) is sponsoring the Medicare at 50 Act, to expand the Medicare program.[84] The bill has 20 Democratic Senate co-sponsors and no Republican co-sponsors.[85] This bill would expand the Medicare program to individuals ages 50 to 64, and, although not explicit, its regulatory design, would put in place an infrastructure for a single payer model to emerge from in the future.

Under the act, individuals who are between 50 and 64 would be eligible for the new buy-in program.[86] Individuals who are eligible for Medicaid would not be eligible for the Medicare buy-in program, and states would

be prohibited from buying-in their Medicaid enrollees between 50 and 64 to Medicare, unless their Medicaid coverage does not meet "minimum essential coverage" under government-sponsored-plan requirements.[87]

Eligible individuals enrolled in the program would be entitled to the same benefits available in Medicare Parts A, B, C, and D. Individuals who enroll in the Medicare buy-in program would also be eligible to purchase Medigap coverage on a guaranteed-issue basis when they first enroll.[88]

The Secretary would determine a monthly premium based on an estimated combined per capita average for benefits and administrative expenses. Nothing would preclude an individual from choosing a Medicare Advantage or Part D plan that requires a higher premium, understanding the individual would be responsible for the premium difference.[89]

Medicare buy-in enrollees would not be eligible for traditional Medicare cost-sharing assistance, but enrollees would be eligible to receive assistance that is "substantially similar to the assistance the individual would have received" if obtaining coverage through the exchange.[90] The Secretary, with certification from Centers for Medicare and Medicaid Services (CMS) Actuaries and in consultation with the Department of the Treasury, would determine amounts that would be transferred from what otherwise would have been allocated to individuals in the exchange.

While not explicit in the text, the bill would presumably depend on participating Medicare providers and reimbursement rates for new enrollees. Section 3 of the bill would strike the current legal prohibition that forbids the Secretary to intervene in setting prices for Medicare prescription drugs.[91] In short, the bill would eliminate existing private market negotiations between health insurers and drug manufacturers.

The Secretary would award grants to entities, either states or nonprofit community-based organizations,[92] to carry out outreach, public education, and enrollment activities "to raise awareness of the availability of, and encourage enrollment" in this program, as well as the availability of premium assistance and cost-sharing reductions.[93] The bill would appropriate $500,000,000 out of funds not otherwise obligated for each year and prioritizes grants to those geographic areas with no qualified health plans available in the individual market.

Finally, the bill would establish a Medicare Buy In Oversight Board to oversee implementation and make periodic recommendations,[94] as well as a Medicare Buy In Trust Fund that would collect premiums and follow the same rules as applied to Medicare Part B.[95]

State Public Option Act of 2019 (S. 489/H.R. 1277). Senator Brian Schatz (D–HI) and Representative Ben Ray Lujan (D–NM) re-introduced

the State Public Option Act.[96] The bill has 22 Democratic co-sponsors in the Senate and 51 Democratic co-sponsors in the House of Representatives. Neither has Republican co-sponsors.[97] This proposal would allow states to open the Medicaid program as a government-run option for those individuals not currently eligible for Medicaid. Here, too, the regulatory design sets in place a framework for a single payer model in the future.

The bill would create, at state option, a new category of individuals eligible for Medicaid benefits who are residents of the state and who are not enrolled in another health plan.[98] It would require states to provide coverage that meets minimum "benchmark" coverage as defined in Medicaid,[99] and would require coverage of comprehensive reproductive health care services, including abortion services, as a condition of state Medicaid plan approval.[100] A state could also require an individual who obtains coverage through the Medicaid buy-in program to enroll in a managed care plan as a condition of receiving such services.[101]

A state would be able to impose premiums, deductibles, cost sharing, and other charges, but may only vary the premium based on those factors described in the ACA.[102] Premiums would not exceed 9.5 percent of household income, and cost-sharing requirements would be limited as set in the ACA.[103] An individual who qualifies for a premium tax credit and cost-sharing reductions under the ACA would also be eligible for a premium tax credit under the Medicaid buy-in program.[104]

With regard to reimbursement rates, while not explicit in the text, presumably state Medicaid payment rates would generally apply, with certain exceptions. For example, Section 4 of the act would set a federal floor for primary care services at the 100 percent of Medicare, and not less than the rate that was set in Medicaid for 2013 and 2014 or on the first day after enactment of this proposal.[105] Section 5 of the act would allow states that adopt the ACA Medicaid expansion to receive the full, enhanced match rate.[106] Additionally, it would extend an enhanced federal match rate of 90 percent for expenses related to the administration of the Medicaid buy-in program.[107] Finally, the bill would direct the Agency for Healthcare Research and Quality to develop standardized, state-level metrics on Medicaid enrollee access and satisfaction.[108]

How Public Option Schemes Expand Government Control and Weaken Access to Care

Though seemingly less radical than the leading House and Senate "Medicare for All" bills, the public option proposals nonetheless lay a firm foundation for a single payer, government-run health care system to take

hold in the future. All these proposals—whether they create a new government plan or broaden the scope of existing government programs (Medicare and Medicaid)—would erode and eventually eliminate private alternatives to the government health plan, compel provider participation, consolidate enrollment in the government plan, and shift costs to taxpayers and health care providers.

These public option schemes would:

1. **Drive Out Private Competition and Coverage.** According to the U.S. Census, approximately 213 million Americans have private health insurance, primarily through their place of work.[109] These public option proposals would undermine and erode private coverage in favor of government-run heath care.

   All the public option proposals either create or expand a government-run health program. The Medicare for America Act extends a public option as a transition to a robust government-run model. The Choose Medicare Act, the Medicare-X Act, and the CHOICE Act create a new government plan to be available in the private market. The Medicare at 50 Act and the State Public Option Act expand existing government programs—Medicare and Medicaid—as the base for the public option.

   An analysis of a plan broadly similar to the Medicare for America proposal found that job-based coverage would drop by 33 million, and that coverage in the individual market would drop by 12 million.[110] Similarly, analysis of the Medicare-X proposal found that job-based coverage would drop by 22.6 million persons and coverage in the individual market would drop by 12.6 million.[111] An Urban Institute analysis of various public option concepts found similar outcomes, with the number of persons enrolled in employer coverage dropping between 3 million and 16 million, depending on the scenario.[112]

   As Hoover Institute economist Scott Atlas points out, "[G]overnment insurance options erode, or 'crowd out,' private insurance, rather than provide coverage to the uninsured."[113] He also points out that Jonathan Gruber, a key architect of the ACA, found that public insurance expansions "clearly show that crowd-out is significant," with a crowd-out rate of about 60 percent.[114]

Reducing the un-insurance gap is important. However, the magnitude of the problem is less dramatic than proponents claim. The reason: Many of the uninsured are, in fact, eligible for coverage either with generous federal subsidies or coverage under other government health programs, such as Medicaid.[115] And yet, these public option proposals would undermine the existing coverage arrangements that the majority of Americans have today.

2. **Compel Provider Participation in the Government Plan.** In an attempt to prevent an exodus of health care providers unwilling to accept government payment rates, all the public option proposals, either explicitly or implicitly, would compel providers in existing government programs to also participate in the new government plan.

   The Medicare for America Act,[116] the Medicare-X Act,[117] and the CHOICE Act[118] would compel existing providers in Medicare and Medicaid to participate in the new government health plan. The Choose Medicare Act (Part E)[119] and the Medicare at 50 Act[120] would depend on existing Medicare providers, and the State Public Option Act[121] would depend on existing Medicaid providers.

   While the Medicare X Act[122] and CHOICE Act[123] would theoretically provide an opt-out for providers, the HHS Secretary would be in charge of establishing such an opt-out process for physicians who might prefer to not participate.[124] The Secretary, in other words, would be given the legal right to act like judge in his or her own cause, whether or not a physician or class of physicians can opt out of the Secretary's administered program.

   Armed with the power to determine conditions of participation, the federal government would obviously not be operating on anything resembling a level playing field. By force of law, the public option would have an inherent and unfair competitive advantage in securing provider participation and undermining private provider alternatives for consumers.

3. **Consolidate Enrollment in the Government Plan.** Despite what supporters purport, the public option would not expand choice. By design, the public option would drive out private competition and provide government privileges to the public option over private plans.

There are a variety of ways public option proposals would accomplish this objective. As directed under the Medicare for America Act, the government would simply auto-enroll groups into the government plan over time.[125] Other proposals would boost taxpayer-financed organizations. The Choose Medicare Act would use ACA's Navigators to expand enrollment in the public option,[126] while the Medicare at 50 Act would use "outreach" entities to promote the public option.[127] This, of course, is intended to drive consumers away from private alternatives and toward the public option; in short, deploy additional government resources to tilt the playing field in favor of the government plan. As explicitly noted in the Medicare at 50 Act, these entities are directed "to carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage, enrollment" related to this program.[128]

Other proposals would expand the availability of the government option through the exchanges.[129] Others, as outlined in the Medicare for America Act[130] and the Choose Medicare Act,[131] would expand availability of the public option to employers outside the exchanges. The Medicare at 50 Act and the State Public Options Act would offer new groups access through existing government programs.

Fueled by its unfair advantages, the public option will not increase competition nor increase choice. As private alternatives are driven out by the appearance of lower premiums and generous benefits in the government plan, those left in a rapidly shrinking individual private health insurance market are likely to experience even higher premiums and even fewer health plan choices.[132] Ultimately, it will drive competitors out of the market and enrollees into the government plan.

4. **Shift New Costs to the Federal Taxpayers.** There are a variety of ways the public option proposals would shift costs on to the federal taxpayer. While many of the proposals assume that the government premiums would cover benefits and administrative costs, it is unclear exactly how these proposals would be financially sustained over the long term.

   All the bills foresee new federal spending for the public option. For example, the Medicare for America plan would allocate "such sums as may be necessary" from Treasury funds not otherwise obligated to operate the temporary public option and would authorize future

appropriations "as needed to maintain maximum quality, efficiency and access."[133] The Medicare for America Act would also create an assortment of tax increases borne by federal taxpayers.[134]

The Choose Medicare Act would appropriate $2 million out of Treasury funds not otherwise obligated for initial operations and $30,000,000,000 for its reinsurance program, and would authorize "such sums as may be necessary" for its Navigator program.[135] The Medicare-X Act would appropriate $1,000,000,000 out of funds not otherwise obligated and authorize funding for its reinsurance program.[136] The CHOICE Act would authorize "such sums as may be necessary" for start-up funding, which in theory would be repaid by the Secretary, as well as other funds as may be necessary.[137] The Medicare at 50 Act would appropriate $500,000,000 in grants for outreach entities. The State Public Option Act would have the federal government assume a larger share of the cost to administer the Medicaid program.[138]

In the end, the political dynamics of such an arrangement are predictable: As private competitors leave the market, the public option absorbs more enrollees. Then, the resources to provide the promised benefits become scarce, and demand for more taxpayer dollars will intensify likely through the proverbial back door to keep the government plan afloat.[139]

5. **Shift Other Costs to Providers of Care and Treatments.** These public option proposals create the illusion that the government plan offers a lower cost option. In reality, the true costs are shifted not only to taxpayer but also to providers. All the public option proposals impose non-market, government payment rates as a way to shift costs to providers; and they put patient access to private care and medical treatments at risk.

   Some of the public option proposals would rely exclusively on Medicare payment rates to pay providers or reduce costs. This is the case with the Medicare-X Choice Act,[140] the CHOICE Act,[141] and the Medicare at 50 Act.[142] The Medicare for America Act[143] and the Choose Medicare Act[144] would use a hybrid system based on Medicare, Medicaid, or commercial plans in the ACA exchanges. The State Public Option Act assumes Medicaid payment rates, which are historically even lower than the relatively low Medicare payment rates.[145] In some

cases, the negative impact of these artificial government payment rates would be compounded by the prohibition of private contracting between patients and their physicians, outside of the government program. This restriction on personal freedom and privacy is an explicit feature of the Medicare for America Act[146] and the Choose Medicare Act,[147] and in the Medicare at 50 Act and State Public Option Act.

These public option proposals would also impose non-market, government pricing for prescription drugs. Virtually all of these bills would authorize the Secretary to "negotiate" directly with drug manufacturers and establish a government payment rate for prescription drugs. Some of the proposals go even further by creating a government fallback rate, as outlined in the Medicare for America Act, the Choose Medicare Act, and the CHOICE Act. Such triggers only make the "negotiations" even more one-sided, with the government threatening the power of a fallback payment.

Government "negotiation" over payment rates or prices does not normally resemble the kind of "give and take" negotiations that regularly take place between buyers and sellers within the private sector. Indeed, such government "negotiations" mean little when the main, or sole, purchaser of medical benefits and services *is* the government.

Government payment setting or price fixing, moreover, can also weaken patient access to care. The Veterans Administration's government pricing model for pharmaceuticals offers an example of how government rate setting affects patient access. A recent report by Avalere, a national research firm, found that "24 of the top 50 non-vaccine [Medicare] Part B drugs are not on the U.S. Department of Veterans Affairs' National Formulary."[148]

The government payment setting in Medicare also raises access concerns. The CMS Office of the Actuary and Medicare Trustees have repeatedly stressed that keeping even the current Medicare payment rates is on track to undermine access to care and the quality of care that would be available to senior citizens. As the 2019 Medicare Trustees report states:

> By 2040, simulations suggest approximately 40 percent of hospitals, roughly two thirds of skilled nursing facilities, and nearly 80 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries.[149]

Government-set payment rates have also led to access issues for patients in the Medicaid program. A 2019 study by MACPAC found that health care providers were less likely to accept new Medicaid patients than those privately insured.[150] Specifically, only 68 percent of general practice physicians accept new Medicaid patients, while 91 percent of general practice physicians accept new privately insured patients; only 37 percent of psychiatrists accept new Medicaid patients, while 62 percent accept new, privately insured patients; and 78 percent of pediatricians accept new Medicaid patients compared to 91 percent who accept new, privately insured patients.

Adopting a universal government price-setting model might make the public option plans appear less costly than private plans, but similar experience shows that it would undoubtedly have a negative effect on patient access to, and quality of, care.

The End Game: Government-Controlled Health Care for All

The original architects of the "public option" were clear in their objective: to deploy a government health plan in competition with private health plans in order to ultimately secure a single payer system of government-controlled health care.[151]

These proposals use measures that would drive out private competition, reduce choice, and increase costs for taxpayers.

As the government plan, with its statutory and regulatory advantages, consolidates enrollment and pushes out private competitors, the demand to keep the public option afloat will intensify. Rather than recognizing the failure of the public option to increase choice and competition, champions of more government control would likely pursue an even more robust, government-run a single payer model.

Public option proposals are gaining interest in Congress, and they are often presented as a less radical approach to single payer. While these proposals are sold as merely a government "option," in reality, these public option proposals lay the groundwork for a single payer system on the installment plan.

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Endnotes

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5. See Nina Owcharenko Schaefer and Robert E. Moffit, "The Obama Health Care Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, https://www.heritage.org/health-care-reform/report/the-obama-health-care-plan-more-power-washington.
6. Quoted in Conn Carroll, "Still Not Convinced the Public Option Is a Trojan Horse for Single Payer?" The Daily Signal, August 3, 2009, https://www.dailysignal.com/2009/08/03/still-not-convinced-the-public-option-is-a-trojan-horse-for-single-payer/.
7. Even former Vice President Joseph Biden and House Speaker Nancy Pelosi (D–CA) endorsed this approach, although generally speaking, the public option would undermine employer-based health insurance, as well as the few private options available in the non-group market under the ACA. See Joseph Antos and James C. Capretta, "The Heavy Hand of the Public Option," RealClearPolicy, June 18, 2019, https://www.realclearpolicy.com/articles/2019/06/18/the_heavy_hand_of_the_public_option_111222.html (accessed December 4, 2019), and James C. Capretta, "A Public Option Would Cause More Problems for Obamacare's Private Insurers, and That's Probably the Point," *National Review*, August 25, 2016, https://www.nationalreview.com/2016/08/obamacare-public-option-fix-will-further-undermine-private-insurance/ (accessed December 4, 2019).
8. The Medicare for America Act of 2019, H.R. 2452, 116th Cong., 1st Sess.
9. Co-sponsors as of this writing.
10. Ibid., Title I, Subtitle A, § 101, and § 102.
11. Ibid., Title I, Subtitle A, Sec. 103.
12. The Medicare for America Act of 2019, H.R. 2452, 116th Congress, 1st Sess., Title I, Subtitle A, § 104.
13. Ibid., § 105 (a).
14. Ibid., § 105.
15. Ibid., § 105 (b)(3). In short, the government would compel doctors and other medical professionals to provide medical procedures that many, if not most, Americans would consider unethical or immoral.
16. Ibid., § 106.
17. Ibid., § 106 (d).
18. As defined in CFR Title 45, § 152.2.
19. The Medicare for America Act of 2019, H.R. 2452, 116th Cong., 1st Sess., Title I, Subtitle B, Part A, § 2202 (a).
20. In 2025, individuals enrolled in both Medicare and Medicaid would also be transferred to the government plan. Ibid., § 2202 (b)(2).
21. Ibid., § 2202 (b)(3).
22. Medicare Advantage for America plans would be available under new rules. See ibid., Title I, Subtitle B, Part C.
23. Ibid., Title I, Subtitle B, Part C, § 112 (b)(4). See also, Title I, Subtitle B, Part C, § 112.
24. For example, new rules on defining "qualified" employer-based coverage include requiring that the plan cover 80 percent of the actuarial value of Medicare, provide at least a 70 percent premium contribution, and cover dental, vision, and hearing benefits. For new rules on qualified employer coverage, see Targeted Reforms, ibid., Title I, Subtitle C, § 126.
25. Ibid., Title I, Subtitle B, Part C, § 112 (b)(4).
26. Ibid., § 2202 (b)(3).
27. Ibid. § 2202(b)(1).
28. Ibid., Title I, Subtitle B, Part A, § 2203 (a).
29. Ibid., Title I, Subtitle B, Part A, § 2203 (d).
30. Ibid., Title I, Subtitle B, Part A, § 2204.

31. Ibid., Title I, Subtitle C, § 134.
32. Ibid., Title I, Subtitle B, Part A, § 2205.
33. Ibid., Title I, Subtitle B, Part A, § 2206 (b).
34. Ibid., Title I, Subtitle B, Part A, § 2205 (e) and (f).
35. Ibid., Title I, Subtitle B, Part A, § 2206 (c).
36. Ibid., Title I, Subtitle B, Part A, § 2206 (d).
37. Ibid., Title III.
38. A maintenance of effort requirement would be set by the states. See ibid., Title I, Subtitle B, Part A, § 2209.
39. Ibid., Title I, Subtitle B, Part A, § 2207.
40. Ibid., Title I, Subtitle B, Part A, § 2208.
41. Ibid., Title I, Subtitle B, Part C.
42. Ibid., Title I, Subtitle C.
43. Ibid., Title I, Subtitle B, Part B.
44. Ibid., Title II.
45. Choose Medicare Act, S. 1261, 116th Cong., 1st Sess., and Choose Medicare Act, H.R. 2463, 116th Cong., 1st Sess.
46. Co-sponsors as of this writing.
47. Ibid., § 2 (c)(2).
48. Ibid., § 2 (b).
49. Ibid., § 9.
50. Ibid., § 10.
51. Ibid., § 2 (b).
52. Ibid., § 2 (c)(3).
53. Ibid., § 3.
54. Ibid., § 2 (d).
55. Ibid., § 6 and § 7.
56. Ibid., § 2 (e)(2). The bill also places emphasis on alternative payment models. See § 2 (f).
57. Ibid., § 5 and § 2 (g).
58. Ibid., § 2 (e)(3).
59. Ibid., § 2 (e)(4).
60. Ibid., § 8.
61. Ibid., § 2 (h).
62. Ibid., § 11.
63. Medicare-X Choice Act of 2019, S. 981, 116th Cong., 1st Sess., also Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess.
64. Co-sponsors at the time of this writing.
65. Ibid., § 2202.
66. Ibid., § 2201 (a)(2).
67. Ibid., § 2203. The Secretary would also set rates for additional services not covered by Medicare, and the Secretary may adopt innovative payment models for services provided under Medicare-X.
68. Ibid., § 2206.
69. Ibid., § 2206.
70. Ibid., § 4.
71. Ibid., § 2207. The bill also puts emphasis on "innovative payment models." See § 2209.
72. See Sec. 5 for new Medicare Part D authority.
73. Ibid., § 2208.

74. Ibid., § 2201.
75. Ibid., § 3.
76. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., and Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, H.R. 2085, 116th Cong., 1st Sess.
77. Co-sponsors at the time of this writing.
78. Ibid., § 2795 (b)(1).
79. Ibid., § 2795 (c)(1).
80. Ibid., § 2795 (b)(3).
81. Ibid., § 2795 (c)(2).
82. Ibid., § 2795 (c)(3).
83. Ibid., § 2795 (d)(1).
84. Medicare at 50 Act, S. 470, 116th Cong. H.R. 1346 establishes a similar Medicare buy-in program as well as other provisions related to reinsurance, risk corridors, and cost-sharing enhancements.
85. Co-sponsors at the time of this writing.
86. Ibid., § 1899C (a).
87. Ibid., § 1899C (g)(4).
88. Ibid., § 1899C (h).
89. Ibid., § 1899C (c).
90. Ibid., § 1899C (f).
91. Ibid., § 3.
92. Explicitly excludes health insurance issuers and any entity that directly or indirectly receives consideration from an insurance issuer.
93. Ibid., § 1899C (j).
94. Ibid., § 1899C (i).
95. Ibid., § 1899C (d).
96. State Public Option Act, S. 489, 116th Congress, 1st. Sess., and State Public Option Act, H.R. 1277, 116th Cong., 1st Sess.
97. Co-sponsors as of this writing.
98. Ibid., § 2 (a).
99. Ibid., § 2 (b).
100. Ibid., § 6.
101. Ibid., § 2 (e).
102. Ibid., § 2 (d)(1). See also, Patient Protection and Affordable Care Act of 2010, Public Law No. 111-148, Title I, Subtitle C, Part I, § 2701.
103. If an individual is enrolled in the Medicaid buy-in program but is eligible through another route, the state may only impose premiums or cost sharing based on traditional Medicaid requirements. See Ibid., § 2(d)(3).
104. Ibid., § 2 (d)(4).
105. Ibid., § 4.
106. Ibid., § 5.
107. Ibid., § 2 (c)(1).
108. Ibid., § 3.
109. This number represents 178,350 with employer based coverage and 34,846 with direct purchase coverage. See U.S. Census Bureau, "Health Insurance Coverage in the United States: 2018," November 2019, Table 1, https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.
110. "Medicare Extra: Universal Coverage for Less Than $3 Trillion and Lower Health Care Costs for All," Center for American Progress, July 23, 2019, https://www.americanprogress.org/issues/healthcare/reports/2019/07/23/472520/medicare-extra/.
111. Lane Koenig et al., "The Impact of Medicare-X on Coverage Healthcare Use and Hospitals," KNG Health Consulting, March 12, 2019, p. ii, https://www.aha.org/guidesreports/2019-03-11-impact-medicare-x-choice-coverage-healthcare-use-and-hospitals (accessed December 5, 2019).

112. See scenarios 4–6 in Linda Blumberg et al., "From Incremental to Comprehensive Health Insurance Reforms: How Various Reform Options Compare on Coverage and Cost," Urban Institute, October 2019, https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf (accessed December 5, 2019).
113. Scott Atlas, "Public Option Kills Private Insurance," *The Wall Street Journal*, July 16, 2019, https://www.wsj.com/articles/public-option-kills-private-insurance-11563309118 (accessed December 5, 2019).
114. Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research *Working Paper* No. 12858, January 2007, https://www.nber.org/papers/w12858.pdf (accessed December 5, 2019).
115. Doug Badger and Jamie Bryan Hall, "Why Millions Are Still Uninsured Despite Government Intervention," The Daily Signal, October 28, 2019, https://www.dailysignal.com/2019/10/28/why-millions-are-still-uninsured-despite-government-intervention/.
116. Medicare for America Act, H.R. 2452, 116th Cong., 1st Sess., Title I, Subtitle B, § 2206 (c)(1).
117. Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2208 (a) and (b).
118. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (d).
119. Choose Medicare Act, S. 1261, 116th Cong., 1st Sess., § 2201 (e)(3).
120. Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (a)(2).
121. State Public Option Act, S. 489, 116th Cong., 1st Sess., § 2 (a)(1)(A).
122. Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2208.
123. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (d).
124. Other proposals offer no explicit opt-out.
125. Medicare for America Act, H.R. 2452, Title I, Subtitle B, § 2202 (b)(2)(B) and (C).
126. The "navigator" described in the Choose Medicare Act, H.R. 6117, 115th Cong., 1st Sess., § 3 refers to navigators from the ACA, or individuals who "conduct public education activities to raise awareness of the availability of qualified health plans," from the Patient Protection and Affordable Care Act 42 U.S. Code 18031 § 1311 (i)(3)(A).
127. The Medicare at 50 Act seeks to "carry out outreach, public education activities, and enrollment activities to raise awareness of, and encourage, enrollment under this section." Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (j)(1)(A).
128. Ibid.
129. For example, the Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2203, and Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (b)(1)(D) would require the government plans to operate at both silver and gold levels.
130. Medicare for America Act of 2019, H.R. 2452, Title I, Subtitle B, § 2202 (b)(3)(C).
131. Choose Medicare Act, S. 1261, § 2201 (a).
132. Says CMS Administrator Seema Verma, "Access will be compromised for patients, and reimbursement cuts in the public plan will shift more pressure to employer sponsored plans to make up the difference, driving up costs for 180 million Americans with private insurance." Cited in Nathaniel Weixel, "Trump Health Officials Bash Public Option as No Better than Medicare for All," *The Hill*, July 22, 2019, https://thehill.com/policy/healthcare/454145-verma-bashes-public-option-as-no-better-than-medicare-for-all (accessed December 5, 2019). Also see Seema Verma, "I'm the Administrator of Medicare and Medicaid. A Public Option Is a Bad Idea," *The Washington Post*, July 24, 2019, https://www.washingtonpost.com/opinions/a-public-option-for-health-insurance-is-a-terrible-idea/2019/07/24/fb651c1a-ae2e-11e9-8e77-03b30bc29f64_story.html (accessed December 4, 2019).
133. Medicare for America Act of 2019, H.R. 2452, Title I § 106, and Subtitle B, § 2207.
134. Ibid., Title II.
135. Choose Medicare Act, S. 1261, § 2(h).
136. Medicare-X Choice Act of 2019, H.R. 2000, § 2201(b).
137. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, H.R. 2085, 116th Cong., 1st Sess., § 2(c)(3).
138. For example, the bill would create a 90 percent enhanced match rate for administration costs of the new Medicaid buy-in program and extend the ACA enhanced match rate for expansion states. See State Public Option Act, S. 489, 116th Cong., 1st Sess., § 4 and § 5. See also Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (j)(4).
139. "Unlike a private Insurance plan, there's no particular reason why a publicly run product couldn't experience ongoing losses, so long as the law provided for direct or indirect taxpayer subsidization." Capretta, "A Public Option Would Cause More Problems for Obamacare's Private Insurers, and That's Probably the Point."
140. Medicare-X Choice Act of 2019, S. 981, 116th Cong., 1st Sess., § 2207 (b).

141. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, § 2795 (c)(2).
142. Medicare at 50 Act, S. 470, 116th Cong., 1st Sess. § 1899C (2).
143. Medicare for America Act, H.R. 2452, Title I, Subtitle B, § 2206 (b).
144. Choose Medicare Act, S. 1261, § 2201 (e)(2).
145. In 2016, Medicaid reimbursement rates were an average of 72 percent of Medicare payment rates. See Kaiser Family Foundation, "Medicaid-to-Medicare Fee Index," https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed December 13, 2019).
146. Medicare for America Act of 2019, H.R. 2452, Title I, Subtitle B, § 2205.
147. Choose Medicare Act of 2019, S. 1261, Sec. 2 (e)(4).
148. Milena Sullivan and Ekemini Isaiah, "The VA National Formulary for Top Medical Benefit Drugs Is Narrower than Current Medicare Part B Drug Coverage," Avalere, August 13, 2019, https://avalere.com/insights/the-va-national-formulary-for-top-medical-benefit-drugs-is-narrower-than-current-medicare-part-b-drug-coverage (accessed December 5, 2019).
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150. Kayla Holgash and Martha Heberlein, "Physician Acceptance of New Medicaid Patients," Medicaid and CHIP Payment and Access Commission, January 2019, https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf (accessed December 5, 2019).
151. Halpin, "Getting to a Single Payer System Using Market Forces: The CHOICE Program."

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Changes In Health Insurance Coverage, Access To Care, And Income-Based Disparities Among US Adults, 2011–17

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ABSTRACT **The Affordable Care Act increased insurance coverage and access to care, according to numerous national studies. However, the administration of President Donald Trump implemented several policies that may have affected the act's effectiveness. It is unknown what effect these changes had on access to care. We used survey data for 2011–17 from the Behavioral Risk Factor Surveillance System to assess changes access to care among nonelderly adults from before to after the change in administration in 2017. We found that the proportion of adults who were uninsured or avoided care because of cost increased by 1.2 percentage points and 1.0 percentage points, respectively, during 2017. These changes were greater among respondents who had household incomes below 138 percent of the federal poverty level, resided in states that did not expand eligibility for Medicaid, or both. At the population level, our findings imply that approximately two million additional US adults experienced these outcomes at the end of 2017, compared to the end of 2016.**

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The year 2017 marked an important transition period for the Affordable Care Act (ACA). Republicans controlled both houses of Congress and the White House for the first time in more than a decade, and they ushered in several policy changes that affected key features of the ACA. These included, in 2017, the cancellation of cost-sharing reduction payments to insurers[1] and reduced outreach and a shorter enrollment period for most ACA Marketplaces and, in 2018, greater access to short-term insurance options that are not required to include many of the ACA's consumer protections.[2] Congress also repealed the individual insurance mandate penalty (effective in 2019) and came within one vote of full ACA repeal, which led many voters to believe that the law was no longer in effect.[3,4] At the same time, insurer competition within the ACA Marketplaces declined, and insurance premiums continued to rise.[5,6] Uncertainty over the ACA's future was implicated in some of these insurer exits.[7]

The first three years following implementation of the ACA's major provisions such as Medicaid expansion and the creation of individual insurance Marketplaces (2014–16) resulted in large improvements in health care access and reductions in racial, socioeconomic, and urban-rural disparities in access.[8–10] For instance, the uninsurance rate for households earning less than $25,000 per year fell by 15.0 percentage points from 2013 to 2015 in states that expanded eligibility for Medicaid under the ACA and by 5.3 percentage points in nonexpansion states.[11] Some early reports have suggested potential declines in health care coverage under the administration of President Donald Trump,[12,13] although these studies relied on nongovernmental surveys with low response rates. Meanwhile, 2017 coverage estimates from the Census Bureau[14] and the National Center for Health Sta-

tistics[15] showed a nonsignificant increase in uninsurance. However, Census Bureau reports do not include trends by month or quarter. Using high-quality survey data from the nationally representative Behavioral Risk Factor Surveillance System (BRFSS), we examined trends in access to care and insurance coverage disparities during 2017. BRFSS surveys are conducted as a continuous random sample, and survey dates are published in the public-use data—which allowed us to study changes on a quarterly basis. We assessed changes in health care access outcomes in the overall nonelderly US adult population and stratified by state Medicaid expansion status and household income. Because of the observational nature of our study design, our results should be considered descriptive; they do not enable us to make any direct connection between specific policy interventions and the study outcomes.

Study Data And Methods

DATA Data for this study are from the 2011–17 BRFSS. The BRFSS is a nationwide, repeated cross-sectional telephone survey that has included both land-line and mobile phones since 2011; its sampling methodology and respondent characteristics have been described elsewhere.[16,17] Our sample included adults up until the age of Medicare eligibility—that is, ages 18–64—who resided in the US (not including its territories).

MEASURES Our outcome variables included three self-reported measures of health care access: whether respondents had any kind of health care coverage, whether they had one person they thought of as their personal doctor or health care provider, and whether there was a time in the past twelve months when they had needed to see a doctor but could not because of cost. These measures have been validated in several previous works.[18] For instance, Lorelei Mucci and coauthors interviewed BRFSS respondents to validate their health insurance status and found that 93 percent of the respondents who reported that they had insurance were able to produce their insurance cards.[19] We also extracted data on a variety of demographic characteristics: race, household income, sex, home ownership, educational attainment, age, veteran status, rurality (using BRFSS metropolitan status codes), household size, and whether children were present in the household. We calculated an imputed percentage of the federal poverty level, which was then used to categorize respondents by household income: less than 138 percent of poverty (the income eligibility threshold under the Medicaid expansion), 138–400 percent of poverty (corresponding to subsidy eligibility limits in the ACA Marketplaces), and more than 400 percent of poverty (eligible for neither Medicaid nor Marketplace subsidies). For a summary of this process, see the online appendix[20] or an earlier article by Benjamin Sommers and coauthors.[21] We used hot-deck imputation to replace the small number of missing answers to specific survey questions (less than 1 percent), which reduced the potential for nonresponse bias in our models.[22]

ANALYTIC APPROACH We first assessed quarterly trends in the three measures of health care access in the period 2011–17, stratified by household income and state Medicaid expansion status. Since our study focused on changes in 2017, states were treated as having expanded Medicaid if they had implemented the Medicaid expansion by the end of 2016. We then used an interrupted time-series approach to estimate the adjusted changes in access for each quarter in the period 2014–17, relative to what would have been expected had trends at baseline (2011–13) for each state continued. Wald tests were used to check whether the regression coefficients for each quarter of 2017 were significantly different from those of the fourth quarter of 2016. In sensitivity analyses we examined annual instead of quarterly changes in access. All regressions were estimated as linear probability models using BRFSS sampling weights. The results were highly comparable when we used logistic models and changes in average predicted probabilities. Models were adjusted for the demographic covariates listed earlier, survey quarter, and state-specific pre-ACA time trends.

Lastly, we assessed changes in absolute income-based disparities in avoided care because of cost from 2013–16 to 2016–17, again stratified by state expansion status. Absolute disparities were calculated as the adjusted differences in average regression predictions for households with incomes less than 138 percent or more than 400 percent of poverty, with covariates standardized to the final quarter of 2013. The study methodology is discussed in more detail in the appendix.[20] Analyses were conducted using Microsoft R Open, version 3.5.1.

LIMITATIONS Our study had several limitations. First, it had many of the standard limitations of survey-based designs, such as the potential for nonresponse bias and the reliance on self-reported outcomes. However, the BRFSS generally has a high response rate for telephone surveys (nearly 50 percent each year),[17] responses were reweighted to reflect state-level demographics, and hot-deck imputation was used to replace missing answers to specific questions.[22] In previous work, the measures of health care access that we examined have been found to have high levels of validity and reliability.[18]

Second, income measurement in the BRFSS is quite imprecise, and our imputed household income measure was only a rough proxy for the family income measure used to determine eligibility for Medicaid and Marketplace subsidies.

Third, the BRFSS does not include an assessment of different coverage types in its core survey, which meant that we could not directly assess whether the coverage losses in 2017 reflected changes in Medicaid, Marketplace insurance, or some other type of coverage. However, the Centers for Medicare and Medicaid Services (CMS) reported that enrollment in the individual Marketplaces fell by 10 percent from 2016 to 2017 and continued to decline in 2018.[23] These declines have been strongly concentrated among people ineligible for premium subsidies. Total nonsubsidized enrollment fell from approximately 6.27 million in 2016 to 3.77 million in 2018, a decline of 40 percent. It's unclear how much of the enrollment decline reflected a net loss of coverage versus substitution for non-Marketplace plans. Meanwhile, total subsidized enrollment among eligible people showed a modest increase of 1.3 percent, from 8.25 million to 8.36 million.[24]

Fourth, the BRFSS does not include questions about citizenship status. This precluded analyses of changes in access for immigrant populations, whose members may be disproportionately affected by recent policy changes.

Finally, because of the observational nature of our study design, our estimates should be interpreted only as associations. We were unable to directly attribute changes in access from 2016 to 2017 to specific changes in the policy environment.

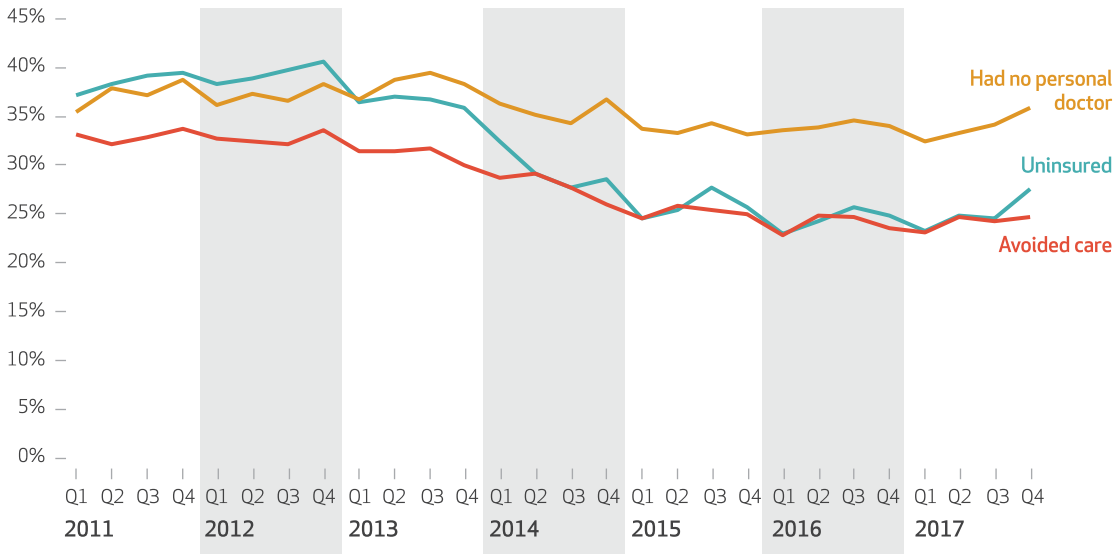
Study Results

Our final sample included nearly 2.2 million respondents (sample characteristics are in appendix exhibit A1).[20] Respondents in states that chose to expand Medicaid were less likely to be black, and they had higher household incomes and a higher rate of college graduation, but they were similar in terms of employment and other covariates compared to respondents in states that did not expand Medicaid.

The uninsurance rate for low-income respondents fell to 23.2 percent in the first quarter of 2017 (exhibit 1). However, it rose to 27.5 percent by the end of the year, its highest point since the third quarter of 2015. The proportion of respondents who reported having no personal doctor reached its nadir during the first quarter of 2017 (32.5 percent), when the proportion who reported having avoided care fell to 23.1 percent. However, both measures also rose during 2017. These data are available for other income groups and for the entire sample in appendix exhibit A2.[20] In the subsequent sections of this article, we focus on results from adjusted models (unadjusted results are in appendix exhibit A3).[20]

EXHIBIT 1

Percent of low-income households that were uninsured, had no personal doctor, or avoided care because of cost, 2011–17



SOURCE Authors' analysis of data for 2011–17 from the Behavioral Risk Factor Surveillance System (BRFSS). **NOTES** All lines show unadjusted proportions of those households with incomes of less than 138 percent of federal poverty level, accounting for BRFSS sampling weights. In each year, respondents were asked whether they had experienced these outcomes in the past twelve months.

CHANGES IN ACCESS, OVERALL AND BY HOUSEHOLD INCOME From the end of 2013 through the end of 2016, uninsurance rates declined by 7.1 percentage points (exhibit 2) (95% confidence interval: 6.6, 7.7), the proportion of respondents without a personal doctor declined by 6.3 percentage points (95% CI: −6.9, −5.7), and the proportion that avoided care because of cost declined by 4.0 percentage points (95% CI: −4.5, −3.4). Starting in the second quarter of 2017, all of these coverage gains were partially reversed. From the end of 2016 through the end of 2017, the overall proportion of adults without health insurance rose 1.2 percentage points (95% CI: 0.7, 1.5), and this increase was concentrated among respondents with household incomes below 138 percent of poverty (1.6 percentage points; 95% CI: 0.7, 2.5). In contrast, the proportion without a personal doctor decreased slightly (−0.8 percentage points; 95% CI: −1.3, −0.5), led by changes in middle-income households (−1.2 percentage points; 95% CI: −1.9, −0.5). The rate of avoiding care because of cost worsened (1.0 percentage points; 95% CI: 0.6, 1.4), with the greatest increases seen in the lowest-income group (1.3 percentage points; 95% CI: 0.4, 2.2).

The 2017 declines in insurance coverage and affordability were concentrated in nonexpansion states (exhibit 3). Uninsurance increased by 2.1 percentage points overall in nonexpansion states from the fourth quarter of 2016 through the fourth quarter of 2017 (95% CI: 1.4, 2.8), primarily as a result of changes in the group with incomes below 138 percent of poverty (3.4 percentage points; 95% CI: 1.8, 5.0). Smaller increases in uninsurance rates were observed during this period in Medicaid expansion states (0.6 percentage points; 95% CI: 0.1, 1.1). Overall changes from the fourth quarter of 2016 to the fourth quarter of 2017 in the proportion of respondents without a personal doctor were similar in expansion and nonexpansion states, but there was significant variation by subgroup. In expansion states there was a decrease in the proportion of respondents in the lowest income group who had no personal doctor (−1.7 percentage points; 95% CI: −2.9, −0.5). In nonexpansion states there was an increase instead (2.0 percentage points; 95% CI: 0.4, 3.6), but this was offset by declines in the other income groups. Rates of avoiding care because of cost increased by 2.1 percentage points in nonexpansion states (95% CI: 1.4, 2.8), and estimates for subgroups were roughly similar. Increases in the rates were smaller in magnitude for expansion states and were significant only for the highest income group (0.8 percentage points; 95% CI: 0.2, 1.4).

EXHIBIT 2

Adjusted percentage-point changes from 2013 to 2017 in households that were uninsured, had no personal doctor, or avoided care because of cost, by household income group

		Compared to 2016 Q4[a]			
Household income (% FPL)	2016 Q4[b]	2017 Q1	2017 Q2	2017 Q3	2017 Q4
UNINSURED					
Less than 138%	−10.9****	−0.8	0.3	0.3	1.6****
138–400%	−4.3****	−0.2	0.7**	0.8***	1.0****
More than 400%	−0.9**	0.5	0.7**	1.2****	1.1****
All	−7.1****	0.0	0.5**	0.8****	1.2****
HAD NO PERSONAL DOCTOR					
Less than 138%	−6.6****	−1.6***	−2.5****	−1.2**	−0.4
138–400%	−6.6****	0.6	0.5	0.1	−1.2****
More than 400%	−1.9****	−0.3	−0.1	0.0	−0.5
All	−6.3****	−0.2	−0.7***	−0.3	−0.8****
AVOIDED CARE BECAUSE OF COST					
Less than 138%	−6.8****	−0.4	1.2**	1.6***	1.3***
138–400%	−1.0***	0.3	0.9***	0.9***	1.1****
More than 400%	−0.3	1.2****	1.6****	1.9****	1.1****
All	−4.0****	0.4*	1.1****	1.4****	1.0****

SOURCE Authors' analysis of data for 2011–17 from the Behavioral Risk Factor Surveillance System (BRFSS). **NOTES** Models are adjusted for state-level time trends; survey quarter; and respondent demographic characteristics, including race, household income, sex, home ownership, educational attainment, age, veteran status, rurality, household size, and whether children were present in the household. In each year, respondents were asked whether they had experienced these outcomes in the past twelve months. For additional details on our regression specifications, see the appendix (note 20 in text). FPL is federal poverty level. [a]Wald test for the difference between two regression coefficients. [b]Counterfactual estimates of changes from the fourth quarter of 2013. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

ANNUALIZED CHANGES IN HEALTH CARE ACCESS As a robustness check, we repeated our analyses, looking at annual instead of quarterly changes in access from 2013 to 2017. The annual estimates of changes in access from 2016 to 2017 were generally similar to our quarterly estimates and also highly significant, although slightly attenuated. For instance, the overall change in the proportion of adults without health insurance from 2016 to 2017 was 0.9 percentage points (95% CI: 0.6, 1.2), and the proportion who avoided care because of cost rose by 0.8 percentage points (95% CI: 0.6, 1.0). These results are in appendix exhibits A4 and A5.[20]

CHANGES IN COVERAGE DISPARITIES Income-based disparities in avoided care because of cost decreased from the end of 2013 to the end of 2016 in both expansion and nonexpansion states. For instance, the disparity in rates of avoided care between the high- and low-income groups declined by 8.5 percentage points (95% CI: 7.2, 9.7) in expansion states (exhibit 4). However, disparities began to rise in 2017 for respondents in nonexpansion states. From the fourth quarter of 2016 to the fourth quarter of 2017, the absolute disparity in avoided care between rich and poor increased from 23.4 percentage points to 26.0 percentage points in nonexpansion states

EXHIBIT 3

Adjusted percentage-point changes from 2013 to 2017 in households that were uninsured, had no personal doctor, or avoided care because of cost, by household income group and whether or not states expanded eligibility for Medicaid

		Compared to 2016 Q4[a]			
Household income (% FPL)	**2016 Q4[b]**	**2017 Q1**	**2017 Q2**	**2017 Q3**	**2017 Q4**
NONEXPANSION STATES					
Uninsured					
Less than 138%	−6.1****	0.7	1.8**	−0.3	3.4****
138–400%	−4.2****	−1.0*	1.6***	1.9****	1.3***
More than 400%	−0.5	0.5	1.1*	2.6****	0.9*
All	−5.7****	0.4	1.7****	1.5****	2.1****
Had no personal doctor					
Less than 138%	−6.1****	0.2	0.1	−0.2	2.0**
138–400%	−5.7****	1.0	−0.2	−0.1	−2.3****
More than 400%	−1.5	−1.4*	−1.7**	−1.4*	−2.5****
All	−5.8****	0.5	−0.3	−0.3	−0.7*
Avoided care because of cost					
Less than 138%	−3.2***	1.1	2.9****	1.7*	2.3***
138–400%	−1.0	1.2**	1.7***	2.0****	2.0****
More than 400%	−2.0***	1.7***	2.3****	2.6****	1.7***
All	−3.3****	1.7****	2.5****	2.1****	2.1****
EXPANSION STATES					
Uninsured					
Less than 138%	−13.8****	−2.0***	−0.8	0.6	0.4
138–400%	−4.4****	0.1	−0.1	0.1	0.8**
More than 400%	−1.1**	0.4	0.3	0.4	1.3****
All	−7.8****	−0.5*	−0.4	0.3	0.6**
Had no personal doctor					
Less than 138%	−6.8****	−2.7****	−4.3****	−1.8***	−1.7***
138–400%	−7.0****	0.1	0.7	0.0	−0.7*
More than 400%	−1.9***	0.1	0.5	0.5	0.5
All	−6.4****	−0.8**	−1.1****	−0.4	−0.9***
Avoided care because of cost					
Less than 138%	−9.0****	−1.5**	−0.1	1.5**	0.7
138–400%	−1.1**	−0.2	0.4	0.4	0.6
More than 400%	0.7	0.9**	1.2***	1.5****	0.8**
All	−4.3****	−0.4	0.2	1.0****	0.4*

SOURCE Authors' analysis of data for 2011–17 from the Behavioral Risk Factor Surveillance System. **NOTES** Models are adjusted for the factors listed in the notes to exhibit 2. In each year, respondents were asked whether they had experienced these outcomes in the past twelve months. For additional details on our regression specifications, see the appendix (note 20 in text). FPL is federal poverty level. [a]Wald test for the difference between two regression coefficients. [b]Counterfactual estimate of changes from the final quarter of 2013. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

(a relative increase of 11 percent), while falling from 14.3 percentage points to 13.3 percentage points in expansion states (a relative decrease of nearly 7 percent).

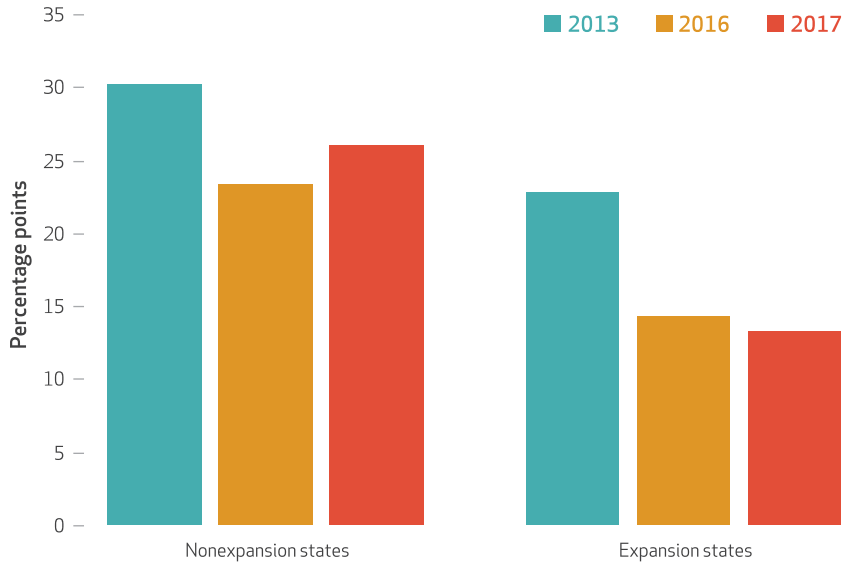
Discussion

Consistent with a large body of evidence on the ACA's impacts,[9,11,25] we observed substantial improvements in health care access from 2013 through 2016. These gains were concentrated among respondents who had household incomes under 400 percent of poverty, resided in states that chose to expand Medicaid, or both. These trends reversed in 2017, and gains in health care access began to erode. We also observed sizable reductions in income-based disparities in avoided care because of cost from 2013 through 2016, although these disparities increased in 2017 for Medicaid nonexpansion states.

Nationally, we estimated that uninsurance rates fell by 7.1 percentage points from 2013 to 2016 but rose by 1.2 points during 2017. Thus, roughly 17 percent of the adjusted change in coverage from the ACA's early years had been reversed by the end of 2017. On the population level, our findings of an increase of approximately 1 percentage point in the rates of uninsurance and avoided care because of cost imply that nearly two million additional US adults ages 18–64 experienced each of these outcomes at the end of 2017, compared to the end of 2016. These recent declines were primarily concentrated among

EXHIBIT 4

Differences between rich and poor households in rates of avoided care because of cost in the fourth quarters of 2013, 2016, and 2017, by whether or not states expanded eligibility for Medicaid



SOURCE Authors' analysis of data for 2013–17 from the Behavioral Risk Factor Surveillance System. **NOTE** Absolute disparities are calculated as the percentage-point differences in average regression predictions for poor households (those with incomes below 138 percent of the federal poverty level) and rich households (those with incomes above 400 percent of poverty), with covariates standardized to the fourth quarter of 2013.

people who were poor, resided in nonexpansion states, or both. As a result, income-based disparities in avoided care because of cost began to increase in nonexpansion states during 2017.

The nature of our study design did not allow us to causally link changes in health care access with specific policy interventions. For instance, it is unclear whether the observed protective effects of Medicaid expansion are due to expansion per se or to other related state policies and activities. Expansion states were more likely to establish and operate state-based Marketplaces, provide more generous funding for Marketplace navigators, and have a greater volume of advertising promoting ACA open enrollment periods.[5,26,27] Notwithstanding this limitation, the observed changes were concurrent with important policy developments under the Trump administration, which took office in January 2017. The declines in coverage coincided with the implementation of federal policies that shortened enrollment periods and reduced advertising and outreach, as well as with general confusion about the ACA's status after the repeal debate.[5,13,28,29] Given that these changes also occurred during a time of low unemployment and that our model directly adjusted for demographic factors such as employment and income, it is less likely that the economy or population changes accounted for these results. The observed changes in health care access may in fact understate the effects of the above-mentioned policy changes. Furthermore, the fact that the negative impacts in 2017 were concentrated in nonexpansion states suggests that state policies are important drivers of coverage and access. Misinformation may also have played a role; a 2017 Morning Consult/Politico survey found that nearly one in four Americans incorrectly believed that the ACA had been partially repealed, while 15 percent believed that it had been totally repealed.[4] Our results on insurance coverage are largely consistent with findings from the Gallup Well-Being Index.[13] To our knowledge, however, ours is the first study to use a validated government data source to document significant changes in coverage, as well as the first to show an associated change in access to care.

It is unclear whether these trends continued into 2018 and 2019, and the conflicting results from alternative data sources add more uncertainty to the implications of these findings. For instance, the uninsurance rate for adults ages 18–64 increased from 11.9 percent in 2016 to 12.1 percent in 2017, according to the Current Population Survey,[14] and from 12.4 percent to 12.8 percent, according to the National Health Interview Survey.[15] The Commonwealth Fund's Biennial Health Insurance Survey showed no change in the uninsurance rate from

2016 to 2018 (it remained 12 percent), although these estimates were rounded to the nearest integer.[30] Meanwhile, Gallup recently reported a large uptick in the uninsurance rate in 2018,[31] though given a large-scale redesign in that data source at the end of 2017, it is unclear whether the revised survey provides valid estimates of coverage trends over time.[32] Lastly, recent results from the Current Population Survey showed a slight uptick in the uninsurance rate from 2017 (7.9 percent) to 2018 (8.5 percent).[33] It is possible that our results are early indicators of concerning trends that may become more apparent over time and across other data sources. It is also possible that idiosyncrasies in the BRFSS (and Gallup data) may be responsible for our findings. Future research with multiple data sources will be critical to evaluating these points.

Ongoing policy changes such as the elimination of the individual insurance mandate penalty in 2019, reductions in CMS's budget for ACA marketing and navigator programs,[28] temporarily halting risk-adjustment payments to insurers,[34] and shortening the open enrollment period on the ACA's insurance Marketplaces may further erode access gains.[29] On the other hand, Virginia's and Maine's Medicaid expansions became effective in January 2019, and expansions were approved by voters in Idaho, Nebraska, and Utah in 2018 but have not yet been implemented.[35,36] As we approach the ten-year anniversary of the passage of the ACA, further monitoring of these national trends with high-quality data will be critical to informing policy discussions regarding the act's future. ■

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CMS Guidance Authorizes Medicaid Demonstration Applications That Cap Federal Funding: Implications for States

Authored by Manatt Health

STATE Health & Value STRATE I | *Driving Innovation Across States*

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I. Introduction

The Centers for Medicare & Medicaid Services (CMS) issued a long-anticipated State Medicaid Director Letter (SMDL)[1] on January 30, 2020 inviting states to apply for Section 1115 demonstration projects that would impose caps on federal Medicaid funding for the adult expansion and some other adult populations in exchange for new programmatic flexibility. Referred to as "Healthy Adult Opportunity" by CMS, these demonstrations would allow states to choose between two types of capped funding arrangements: a per capita cap or an aggregate cap (i.e., a block grant). CMS also released with the SMDL an application template[2] for use by states interested in requesting a capped funding demonstration.

The SMDL is a major shift from Medicaid's current structure as a statutory entitlement, in which the federal government matches all eligible state expenditures *without* any cap. Previous proposals to shift Medicaid federal funding models to a cap were included in the repeal and replace legislation of 2017, which were not passed by Congress. Those bills would have replaced traditional Medicaid spending for *all* states with a per capita cap, and some would have imposed a block grant for Affordable Care Act (ACA) expansion groups. Under CMS' new guidance, each state may decide for itself whether to apply for a Section 1115 demonstration that would cap federal financial participation (FFP) for certain Medicaid populations, subject to the parameters set out in the guidance.

As explained in the SMDL and application template, CMS uses "expenditure" authority under Section 1115(a)(2) to allow coverage that can be designed without regard to key provisions in the Medicaid statute, including certain standard beneficiary protections that today apply to all Section 1115 Medicaid demonstrations.[3] The capped funding model thus offers states new programmatic flexibility with respect to enrollment procedures, covered benefits, and federal oversight in exchange for reduced federal funding and substantial financial risk. Given the extent and nature of the financial and programmatic changes that would be permitted pursuant to

Key Considerations for States

As states weigh whether to pursue a capped funding demonstration, they will want to consider key features and implications of the guidance, as described in more detail throughout this issue brief:

- **Loss of Federal Funds.** Caps on federal funding shift financial risk to the states. That risk is particularly great under the model described in the SMDL, given that the caps are designed to constrain the growth in Medicaid spending.
- **Limited New Flexibilities.** The SMDL describes various forms of program flexibility that states may request, many of which are already available to states outside the context of a capped demonstration. Notable policy options that have not previously been approved include: access to "shared savings," some of which may be spent on services outside of Medicaid; eliminating hospital presumptive eligibility; implementing a closed prescription drug formulary for populations beyond the ACA expansion group; proposing alternative approaches to complying with federal standards for access and managed care oversight; and modifying certain program elements during the demonstration without the need for federal approval.

Continued on page 2

1 Centers for Medicare & Medicaid Services. State Medicaid Director Letter, Healthy Adult Opportunity (SMDL # 20-001). Washington: Centers for Medicare & Medicaid Services; 2020. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf. Accessed January 30, 2020.

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3 Rather than using its traditional 1115(a)(1) "waiver" authority to construct capped funding allotments, CMS' new guidance relies heavily on 1115(a)(2) of the Social Security Act to grant expenditure authority for costs that are not otherwise matchable. By relying on this 1115(a)(2) authority, CMS asserts that otherwise applicable Medicaid requirements need not apply to the demonstration population.

the SMDL, demonstrations approved under the guidance are also at high risk of litigation.

This issue brief describes key features of the CMS guidance and provides an overview of potential implications for states that pursue these capped funding demonstrations. As discussed in greater detail below, CMS is open to approving certain new program flexibilities for states that accept a cap on their federal Medicaid funding. These capped funding arrangements will be designed to constrain federal Medicaid spending; states that adopt them will be subject to new pressure (in addition to the fiscal imperative to constrain Medicaid costs that states always face) to reduce Medicaid expenditures in order to keep spending below the self-imposed caps. Manatt Health is continuing to review the guidance, and an analysis of its fiscal impact on states is forthcoming. This analysis focuses on considerations for states rather than the potential implications for beneficiaries, Medicaid providers, and health plans that could result from these demonstrations.

II. Key Features of Capped Funding Demonstrations

This section describes CMS' vision for capped funding demonstrations, as laid out in the SMDL. The demonstration's core features including the following:

- Populations that may be covered under the funding cap include the ACA adult expansion group as well as "optional" non-elderly, non-disabled adults, including groups that have not previously been covered in the state.[4]
- Federal funding caps may be imposed on either a per capita or an aggregate basis and will grow more slowly than projected Medicaid spending. States will continue to receive federal funding to match state spending but only up to the cap, leaving the state responsible for costs above the cap.
- Shared savings may be available under the aggregate cap model to a state that spends *less than* the annual cap and meets certain performance benchmarks. States that qualify can divert some of the unspent federal Medicaid funds to health-related initiatives outside the Medicaid program.
- Program flexibility articulated in the guidance includes changes that CMS has already permitted in demonstrations without funding caps as well as policies that CMS has not previously approved. The guidance does not, however, permit partial expansions [e.g., up to 100% of the Federal Poverty Level (FPL)] or enrollment caps for the expansion population.
- Federal oversight for capped demonstrations includes monitoring and reporting obligations beyond those typically required under an 1115 demonstration. Although CMS indicates it will loosen other forms of oversight (i.e., forgoing

Key Considerations for States

Continued from page 1

- **Risks for Medicaid Beneficiaries and Other Stakeholders.** States that experiment with altering Medicaid program standards may end up reducing beneficiaries' access to care, constricting provider reimbursement to unsustainable levels, or squeezing managed care capitation rates to an extent that makes it unfeasible for plans to meet their obligations.
- **Quality and Monitoring Obligations.** A capped funding demonstration comes with monitoring and reporting obligations that go beyond the typical 1115 demonstration requirements.
- **Administrative Challenges.** A capped funding demonstration that departs substantially from the state's existing Medicaid coverage model will mean that the state is essentially running a new, separate program alongside existing coverage for other populations (such as children and disabled or elderly adults).
- **Litigation Risk.** States can expect legal challenges to any approved demonstration that includes capped federal funding.

4 The ACA required all states to expand their Medicaid programs to include all adults up to 133 percent of the FPL. The Supreme Court made this voluntary for states, however, with its 2012 decision in *National Federation of Independent Business v. Sebelius*.

prospective managed care contract review), CMS also acknowledges that it could require retrospective adjustments if it later deems a state to have been out of compliance.

A. Covered Populations

The SMDL states that the capped funding model is focused on "optional" nonelderly, nondisabled adults. States that apply for a capped funding demonstration may request to cover new populations for the first time, and also to transfer in some of their existing Medicaid populations, including adults currently covered as part of the Medicaid expansion, an "optional" state plan group, or an existing 1115 demonstration. At this time, states will not be permitted to pursue block grant demonstrations for children, the elderly, and people eligible based on a disability, nor for the lowest-income (i.e., "mandatory") parents and pregnant women. Note that many states have expanded coverage for low-income parents and pregnant women above the mandatory income levels and could apply for capped funding demonstrations that would cover optional parents and pregnant women, with or without adding the ACA expansion adult population.

B. Capped Funding Financing Models: Per Capita Cap and Aggregate Cap

The SMDL leaves Medicaid's federal matching structure in place; congressional action would be needed to convert Medicaid to a block grant model that provides lump-sum federal payments without a state match or state spending requirement, as exist in some block grant programs. Under a capped funding demonstration, the federal government would contribute FFP at the usual matching rate given the population and services covered until the cap is reached; at that point, the federal government would stop contributing a federal match, leaving the state solely responsible for all remaining program costs that year.

The guidance generally allows states to elect to cap their federal funding on either a per capita or an aggregate basis. If, however, a state uses a capped demonstration to extend coverage to a new population, the state must use a per capita cap until sufficient data is available to calculate an aggregate cap, as explained below. Under a per capita cap, the federal government will spend up to a certain amount *per enrolled beneficiary each year*. Under an aggregate cap, by contrast, the amount of the cap is fixed, meaning it is not adjusted to account for any changes in actual enrollment during the demonstration. Both types of caps shift financial risk to the states for unexpected increases in the cost per enrollee (due to, for example, an expensive new drug). The aggregate cap—but not the per capita cap—also shifts risk to the state for increased enrollment (due to, for example, an economic downturn).[5]

Calculating the Cap Amounts

For both the aggregate cap and the per capita cap models, CMS will calculate "base year" expenditures using the most recent two years of expenditures (state and federal) for the populations and services that will be covered under the demonstration.[6] If a proposed capped funding demonstration will extend coverage to new populations for the first time, the SMDL requires that the state start the demonstration period with a per capita cap for those populations,[7] with a base amount calculated using the best available state and national data. After two years—or once sufficient baseline data is available—states may transition to a rebased aggregate cap.

To determine the cap amount for each year of the demonstration, CMS will trend the base amount forward. For a state with a per capita cap, the trend factor will be the lower of the medical care component of the Consumer Price

5 CMS has previously approved two demonstrations with aggregate caps, one in Vermont in 2005 and a second in Rhode Island in 2009. In contrast to the approach taken in the SMDL, both Vermont and Rhode Island secured generous federal caps and, so, received more federal dollars than their projected federal contributions without the demonstration. For more information on these waivers, see Jocelyn Guyer, *Vermont's Global Commitment Waiver: Implications for the Medicaid Program*, Kaiser Family Foundation (April 2006), https://www.kff.org/medicaid/issue-brief/vermonts-global-commitment-waiver-implications-for-the/, and Edward Alan Miller et al., *Medicaid Block Grants: Lessons from Rhode Island's Global Waiver*, State Health Access Reform Evaluation, Robert Wood Johnson Foundation (June 2013), https://www.shadac.org/sites/default/files/publications/RI_Global_Waiver_Brief_FINAL.pdf.

6 If the state's quarterly CMS-64 expenditure reports do not permit CMS to separate out the specific populations and services that will be covered under the demonstration, the state will need to submit two years' worth of auditable expenditure data that ties to the expenditures reported on the CMS-64.

7 The guidance is unclear about whether a state could request a demonstration that applies a per capita cap for newly covered populations while simultaneously applying a block grant for other populations that were already covered.

Index (CPI) or the state's historical spending growth rate over the past five years.[8] For aggregate caps, CMS will use the lower of the medical CPI plus half a percentage point or the average state growth rate.[9] Anchoring the trend rate in the medical CPI is designed to constrain state spending relative to current levels: A recent publication from the CMS Office of the Actuary estimated that average annual Medicaid spending growth for the period 2017 to 2026 will consistently exceed the medical CPI.[10]

The annual cap amounts will be set at the time the demonstration is approved (using projections of the medical CPI available at that time); however, certain circumstances may prompt CMS to adjust the cap amounts during the demonstration period. States may request to renegotiate the demonstration's terms and conditions to account for unforeseen circumstances outside the state's control, such as public health emergencies or major economic events. Meanwhile, CMS may adjust the cap if a state requests a policy change that "has the potential to substantially impact enrollment" (p.36). The SMDL does not define "substantial impact" or offer specific examples, but potentially applicable policies might include, for example, community engagement requirements (commonly referred to as work requirements).

If a state seeks to renew a capped funding demonstration at the end of the five-year demonstration period, CMS will rebase the caps using the same procedures outlined above.[11]

Included and Excluded Spending Under the Cap

The federal funding cap will apply to almost all of a state's Medicaid spending on covered populations. The SMDL defines a limited set of exclusions for administrative expenditures, spending on public health emergencies, spending on services received through the Indian Health Service, and spending that is not readily attributable to individual enrollees, such as Disproportionate Share Hospital (DSH) payments and certain temporary supplemental and pool payments made under 1115 authority.[12] The cap will, however, include standard fee-for-service (FFS) supplemental payments and managed care pass-through payments; these supplemental payments would be allocated to the demonstration population based on the population's share of *non*-supplemental payments.[13]

Consequences of Exceeding the Cap

As the capped funding methodology is designed to constrain spending, and given the projected growth rate in Medicaid costs, states may find it challenging to stay within their spending limits, and if a state spends above the cap in a given year, the excess payments are ineligible for FFP. Any FFP provided to a state based on spending above the cap will be disallowed using standard procedures.

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8 Note that, although the per capita cap amount is calculated on a per-enrollee basis, CMS will not assess state spending at the enrollee level. Rather, after each year of the demonstration, CMS will calculate an overall spending cap by multiplying the predetermined per enrollee cap amount by the number of enrolled beneficiaries.

9 Basing the trend factor on the medical CPI raises a question about timing: The SMDL states that the cap amounts "will be determined prior to approval of the demonstration" (p.16), but the Bureau of Labor Statistics publishes CPI figures each month based on actual data and does not forecast the medical CPI for future years. CMS may thus intend to rely on the medical CPI projections issued by the CMS Office of the Actuary. Alternatively, CMS may intend to apply the current medical CPI at the time of demonstration approval, locking in that rate for the demonstration's entire five-year period.

10 CMS Office of the Actuary. *2017 Actuarial Report on the Financial Outlook for Medicaid*. Washington: CMS Office of the Actuary; 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf. Accessed January 30, 2020.

11 This approach is consistent with 2018 guidance preventing states from "rolling over" unlimited savings from one demonstration project to the next. Centers for Medicare & Medicaid Services. State Medicaid Director Letter, Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects (SMDL # 18-009). Washington: Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf. Accessed January 30, 2020. Under CMS' current approach to budget neutrality, states are permitted to roll over accumulated budget neutrality savings only from the most recently approved five-year demonstration period.

12 The SMDL lists examples of excluded payments including Designated State Health Program (DSHP) payments, Delivery System Reform Incentive Payments (DSRIP), and Uncompensated Care Cost (UCC) payments.

13 To allocate inpatient hospital supplemental payments, for example, CMS will examine the state's base payments for inpatient services and determine what percentage of those payments were attributable to services for the demonstration population.

Capped Funding Models Are More Restrictive than Standard 1115 Demonstration Budget Neutrality

CMS requires that all 1115 demonstrations be "budget neutral" to the federal government, meaning that federal spending under the demonstration must be no greater than what the federal government would have spent in the absence of the demonstration. As with a cap under the SMDL, CMS determines the budget neutrality limit by calculating the state's base year expenditures and trending that amount forward over the life of the demonstration. However, the SMDL takes a stricter approach to limiting federal spending.

- **Annual Spending Limits.** In a standard 1115 demonstration, the budget neutrality limit applies over the life of the entire demonstration. States can thus balance a budget overrun in one year against a surplus in the next, which allows for policy changes that may take upfront investment before generating longer-term savings. In a capped funding demonstration, by contrast, the caps apply on an annual basis. A state that exceeds its cap in any given year must repay the "excess" FFP the following quarter. (As discussed below, under an aggregate cap—but not a per capita cap—states may apply "unused" spending under the cap in one year against excess spending in future years; unlike budget neutrality, this rebalancing is limited to a *prospective* three-year period, so spending reductions late in the demonstration cannot make up for excess spending in the early years.)
- **Less Flexible Trend Factor.** When selecting a trend factor for budget neutrality in other Section 1115 demonstrations, CMS uses the lower of historical state spending or the President's Budget trend rate projections for Medicaid cost growth. Both figures are specific to Medicaid spending on populations covered by the demonstration. In a capped demonstration, by contrast, CMS will compare historical state spending against the medical CPI, a general inflation figure for people with all types of health coverage.

Provisions Specific to the Aggregate Cap: Retaining Unused Funding and Shared Savings

Certain additional financing features apply specifically to the aggregate cap model. The SMDL explains that these features, like the 0.5 percent boost to the trend rate, reflect the "added risk states will assume under an aggregate cap model" as compared with the per capita cap (p.18).

The aggregate cap itself creates strong pressure on states to keep total spending from exceeding the cap, but the SMDL goes a step further by defining two policies that could further drive states to reduce spending below the cap. First, a state that underspends in a given year may hold the "unused" spending for up to three years. If the state exceeds its cap during that three-year period, the state may offset the overspending in an amount equal to the unused funds.

Alternatively, a state may request to convert a portion of its unused spending into a "shared savings" payment. CMS will calculate the amount of potential FFP associated with the unused spending and will designate 25 to 50 percent of that unused FFP as shared savings that may be used by the state, contingent on the state maintaining or improving its performance on certain quality benchmarks.[14]

The shared savings are not returned to the state as a simple cash grant. Rather, shared savings payments operate as a form of flexible FFP, which the state may access by spending state funds, then drawing down the shared savings FFP at the state's usual federal match rate.[15] These shared savings may, at CMS' discretion, be spent on health-related state programs that are not otherwise FFP eligible but that promote Medicaid objectives. The SMDL lists potentially eligible initiatives such as prevocational services for Medicaid beneficiaries, a tobacco cessation program that serves (but is not limited to) Medicaid beneficiaries, or providing Medicaid services for populations not currently covered by the state's Medicaid program. The state spending required as a match does not have to

14 CMS will calculate shared savings as follows: First, a state must establish a comprehensive set of baseline quality metrics (tied to the CMS Adult Core Set metrics listed in SMDL Appendix D) for the demonstration population; thereafter, if the state maintains access and quality metrics at baseline levels, the state qualifies for shared savings consisting of 25 percent of unused FFP. The state may increase its shared savings percentage to 37.5 percent by showing either a 3 percent improvement or performance at the 75th percentile with respect to at least seven of the 25 Adult Core Set performance benchmarks. If the state can make that showing for 13 or more benchmarks, the savings percentage increases to 50 percent.

15 The match rate for these shared savings funds is likely to be lower than the block grant demonstration population match rate assuming the demonstration population includes the ACA expansion group.

be new state spending in all cases: up to 30 percent of a state's federal shared savings dollars may be spent on existing state programs, and although these dollars may not be used to supplant existing *federal* funding, they can replace existing *state* spending on health programs (as long as the match requirement is met), thereby freeing state dollars for other uses.

The SMDL combines these opportunities with a "maintenance of effort." Each year, states with an aggregate cap must spend at least 80 percent of their cap amount (combined state and federal shares) on Medicaid expenditures for the block grant population or CMS will reduce their cap amount going forward.

Limitations on Shared Savings

Although proponents of block grant models tout shared savings as a main selling point, a number of factors in the capped funding guidance may stand in the way of states qualifying for, or benefiting from, shared savings.

- **Data Limitations.** To qualify for shared savings, states must establish a comprehensive set of baseline quality metrics for the demonstration population. States in the early phases of implementing data collection infrastructure may face challenges in establishing a quality baseline or demonstrating improvement. The variability in Medicaid data may complicate comparisons across state lines, which may hamper CMS' efforts to apply percentile-based performance benchmarks.
- **Timing Limitations.** States may be categorically ineligible in the early years of their demonstration, whether because of insufficient financial baseline data, as described above, or because they used the demonstration to cover a new population and were thus required to implement a per capita cap demonstration for at least two years before transitioning to a block grant. Moreover, states are not eligible for shared savings in the final year of a demonstration unless CMS approves a demonstration renewal.[16] Thus, some states may be eligible for shared savings in only two of the five demonstration years.
- **The Federal Government Will Retain the Majority of Shared Savings.** If a state qualifies for a portion of the shared savings, the state must spend its own funds to "draw down" the federal shared savings dollars. Even if a state uses a capped funding demonstration to cover the ACA expansion population, which carries an enhanced match rate of 90%, shared savings must be drawn down at the state's regular match rate; those rates currently range from 50% to 77%.

C. States Entering Capped Funding Demonstrations Will Trade Funding Reductions for Program Flexibility

The guidance proposes a trade-off for states: accept a cap on federal funding in exchange for flexibility in program design and administration. The per capita cap—unlike the aggregate cap—offers no opportunity for shared savings, such that program flexibility would be the primary benefit to states entering these arrangements. The SMDL "encourages states to apply for all flexibilities that have been previously approved in other demonstrations" with respect to program features such as eligibility, enrollment, covered benefits, and health system delivery reform (p.2). In addition, the SMDL expressly authorizes certain policy options that have not previously been approved and invites states to "request additional flexibilities" beyond those addressed in CMS' guidance (p.15). And as discussed in later sections of this issue brief, states may exercise these flexibilities in an environment of relaxed federal oversight. Consistent with current Section 1115 demonstration policy, states will have to develop, and submit for CMS approval, an implementation plan to provide "detailed information" about the state's approach to implementation; CMS will provide a template for the implementation plan, as the agency did for work requirement demonstrations (p.35).

16 As noted above, CMS intends to rebase the caps upon capped funding demonstration renewal. While the guidance is not clear about how spending reductions would factor into the baseline, a state that substantially reduces spending and qualifies for shared savings during an initial demonstration may, upon renewal, receive a reduced baseline cap for the new demonstration period.

Eligibility and Enrollment

As under existing Medicaid Section 1115 demonstrations, states may impose various restrictions on the demonstration population as well as on when and how they may enroll in Medicaid, including by:

- Imposing additional conditions on eligibility, such as work requirements or health assessments.
- Restricting the duration of effective Medicaid coverage by:
  - Eliminating retroactive eligibility; or
  - Imposing a waiting period (or payment of a premium) before enrollment becomes effective.
- Imposing coverage lockout periods for beneficiaries who fail to satisfy program requirements (such as work requirements or premiums).

The guidance also indicates openness to eliminating hospital presumptive eligibility (which CMS has not approved to date) as well as the prohibition on asset tests (subject to certain limitations with respect to the ACA expansion population).[17]

The SMDL specifies that the annual spending cap will take into account program features that "significantly affect enrollment" so that "states do not achieve savings from disenrolling individuals" (p.24). And the guidance notes that certain federal requirements for enrollment procedures will continue to apply, including rules regarding timely eligibility determinations, electronic verification, streamlined renewal, and coordination of eligibility determinations with the Marketplaces.

Covered Services

The SMDL explains that states will not be subject to the Alternative Benefit Plan (ABP) coverage requirements with respect to these demonstration populations. Rather, states will generally be expected to align capped funding demonstration coverage with the essential health benefits (EHB) available under private health plans in the Marketplace.[18] In this way, states will be able to opt out of otherwise mandatory Medicaid benefits such as:

- Nonemergency medical transportation (NEMT)
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for individuals aged 19 or 20
- Medicaid's enhanced reimbursement rate and other provisions regarding Federally Qualified Health Centers (FQHCs) if in the context of a value-based payment arrangement[19]

In addition, states may request to add benefits under a capped funding demonstration, consistent with CMS' existing guidance and prior demonstration approvals. The SMDL lists examples including services to address social determinants of health, such as enhanced case management, and services provided at Institutions for Mental Diseases (IMDs) for substance use disorders or serious mental illness. Under a cap, however, new services may displace funding for traditional health care services. For example, if a state applies for a demonstration that adds housing supports not otherwise eligible for FFP, the state's historical expenditure data—and therefore the state's annual cap amount—would not reflect those services.

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17 Federal law generally prohibits states from applying asset tests to populations that qualify for Medicaid eligibility based on modified adjusted gross income. This prohibition is not waivable under Section 1115(a)(1), but the SMDL indicates that CMS may use its 1115(a)(2) expenditure authority to permit otherwise unallowable asset tests. The SMDL cautions, however, that the enhanced federal match rate for the expansion population is available only if the state expands coverage all the way to 133 percent of the FPL *without* imposing an asset test.

18 Marketplace plans must cover services in each of the 10 categories of EHB: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, behavioral health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.

19 If a state elects to cover FQHC services as part of a value-based payment reform, the state may opt out of the Medicaid requirements for FQHC prospective payment or alternative payment methodologies, and may instead comply with the "Essential Community Provider" requirements at 45 C.F.R. § 156.235. This authority is precedent-setting as CMS has generally declined to waive FQHC requirements.

Implications of Importing the Essential Health Benefits (EHB) Standard into Medicaid

- The ability to align Medicaid benefits with EHB coverage magnifies the impact of recent federal efforts to relax the EHB standard by, for example, allowing states to incorporate elements of other states' EHB standards or limiting states' ability to supplement the EHB standards with benefits that were not already included as of the 2017 plan year.[20] In some states, these dynamics may contribute to a more limited benefit for Medicaid beneficiaries covered under capped funding demonstrations.
- The SMDL does not discuss "medically frail" individuals, who are currently exempt from being placed in the ABP applicable to the adult exchange group. Unlike Medicaid, the EHB standard does not require coverage of nursing homes and certain other options for long-term care. It thus appears that states may require medically frail individuals to enroll in the ABP with no right to opt in to comprehensive Medicaid coverage. A decision along these lines may drive an increase in the number of medically frail individuals who seek a disability determination,[21] which would likely remove them from the population targeted by the SMDL (in addition to qualifying them for other benefits and safeguards).

Prescription Drugs

The SMDL authorizes states to implement a closed prescription drug formulary without sacrificing manufacturer rebates under the Medicaid Drug Rebate Program (MDRP). Although CMS frames this policy as a major new flexibility, states have had similar authority to limit covered prescription drugs (while retaining MDRP rebates) for the ACA expansion population under the ABP. Relatively few states have pursued this approach. The key change, then, seems to be for medically frail individuals in the expansion population (who currently have a right to opt out of ABP coverage, as explained in the text box), as well as optional, nondisabled adult populations (who are currently covered under the state plan). For their state plan populations, states may already implement preferred drug lists that trigger a prior approval process for drugs not on the list, but CMS has been unwilling to approve a true closed formulary unless a state agreed to give up MDRP rebates.

Under a capped funding demonstration, however, a state may implement a closed formulary (in accordance with the EHB requirements that already apply to the ACA expansion population), retain MDRP rebates, and negotiate supplemental rebates with manufacturers as long as the state:

- Covers substantially all antiretroviral drugs and drugs for mental health, consistent with Medicare Part D coverage.
- Covers all FDA-approved drugs to treat opioid use disorders for which there are MDRP rebate agreements in place.
- Adheres to requirements for drug utilization review, state reporting, and program integrity "generally consistent" with Section 1927 of the Social Security Act (p.9).

Because these protections apply over and above EHB prescription drug requirements, states designing a closed formulary under a capped funding demonstration may need to cover more drugs than would otherwise be required under ABP rules for the expansion population.

20 These and other EHB details are discussed in SMDL Appendix C, and also in 2019 guidance from CMS that discusses the relationship between the ABP and EHB standards. Centers for Medicare & Medicaid Services. New State Flexibilities and Requirements regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB), CMCS Info. Bulletin. Washington: Centers for Medicare & Medicaid Services; 2019. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib080819-1.pdf. Accessed January 30, 2020.

21 Following passage of the ACA, studies have observed a decline, in expansion states, in the number of low-income non-elderly adults seeking disability determinations through the Supplemental Security Income (SSI) program. See, e.g., A. Soni, et al., *Medicaid Expansion and State Trends in Supplemental Security Income Program Participation*, Health Affairs 36, No. 8 (2017): 1485-1488. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1632. Accessed January 30, 2020.

Premiums and Cost Sharing

States will be able to increase premiums and cost-sharing fees under a capped funding demonstration, subject to certain limitations. The authority relating to copayments is new; CMS is offering this option notwithstanding a provision in federal law that constrains CMS' waiver authority relating to copayments.[22] States must continue to limit beneficiaries' aggregate out-of-pocket costs to 5 percent of the beneficiary's household income, and must retain current protections for beneficiaries who qualify for services through the Indian Health Service, or who are receiving treatment for mental health conditions, substance use disorders, or HIV. Although not specifically noted, CMS' broad statement (p.10) that current regulatory and statutory restrictions on premiums and cost sharing need not apply suggests that CMS would entertain states' requests to deny services to individuals below 100 percent of the FPL who cannot pay required copayments.

Delivery System and Managed Care

Under a capped funding demonstration, states would continue to have the flexibility they do today to deploy a combination of FFS and managed care delivery system structures. They may also use Medicaid dollars to assist beneficiaries in securing private coverage or propose other coverage arrangements in connection with a State Innovation Waiver under Section 1332 of the ACA.

Although states with capped funding demonstrations will be required to monitor and report on beneficiaries' access to care, CMS will allow states to opt out of the current federal access standards in both FFS and managed care; states may propose alternative approaches to defining and measuring access to care and other standards for managed care contracts.[23] With respect to the requirement that managed care capitation rates be actuarially sound, for example, the guidance notes that states may forgo CMS review and instead submit their own independent actuarial certifications. In addition, although states must continue to submit managed care contracts for CMS review and approval, a state need not seek CMS approval for contract *amendments* that are consistent with the demonstration special terms and conditions (STCs).[24] The guidance cautions that if a state forgoes prior review and approval for amendments or rates, the state might be at risk if CMS later determines it is out of compliance.

D. CMS Oversight of Capped Funding Demonstrations

The guidance imposes a number of monitoring and reporting obligations for capped funding demonstrations that are over and above the standard monitoring, evaluation, and oversight requirements for 1115 demonstrations.

Preapproval for Mid-Demonstration Policy Changes

States that apply for a capped funding demonstration can seek approval of potential policy changes that may then be adopted at a later time during the course of the demonstration. States may propose, for example, a range of potential cost-sharing levels or a list of optional benefits that the state may or may not cover. CMS will incorporate all approved options into the STCs, allowing states to exercise those policy options as they see fit to manage costs during the demonstration period, with minimal CMS oversight.

During the demonstration period, the state would need to provide CMS with at least 60 days' advance notice before implementing a preapproved policy, but need not submit a formal demonstration amendment or wait for

22 Section 1916(f) of the Social Security Act establishes that the Secretary of Health and Human Services cannot waive cost-sharing requirements otherwise established by federal law unless multiple criteria are met, including that the waiver will test a unique and previously untested use of copayments; is limited to a period of not more than two years; will provide benefits to recipients of medical assistance that can reasonably be expected to be equivalent to the risks to the recipients; is based on a reasonable hypothesis that the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and is voluntary or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation. States have not typically pursued cost-sharing waivers and CMS has granted only one such waiver, which the state opted not to renew.

23 States remain obligated to meet the *statutory* requirements in sections 1903(m) and 1932 of the Social Security Act, but may propose alternatives to CMS' more detailed *regulatory* standards at 42 C.F.R. Part 438.

24 The SMDL does not address a scenario in which a state hopes to rely on managed care models for both demonstration and non-demonstration populations. It is not clear, for example, whether a state would need to execute separate contracts with separate managed care entities or whether the state could have a single managed care contract that defines separate rates and standards for each population, and where the amendment process would perhaps vary depending on which populations would be affected by the amendment.

federal approval. The state would need to reflect any such changes in the state's implementation plan. The state would, in addition, need to comply with procedures for public notice and comment and for tribal consultation, except with respect to administrative changes with only a minimal impact on Medicaid beneficiaries, providers, and plans. If a state opts to adopt a preapproved policy change that is likely to substantially impact enrollment, CMS would reexamine, and might adjust, the annual caps.

Additional Reporting Obligations

As compared with other 1115 demonstrations, these new capped funding demonstrations would require states to monitor and report on a greater array of quality and spending metrics, as described in SMDL Appendices D through H. The state must implement a demonstration-specific quality strategy and submit quarterly and annual reports addressing, among other things, 13 sets of continuous performance indicators regarding access, enrollment, appeals, and financing elements; 25 quality and access measures drawn from the Adult Core Set; financial reporting to assess whether spending has reached the annual cap; and the state's progress against the demonstration implementation plan.

These additional monitoring and reporting obligations suggest CMS' awareness that the capped funding model, with its incentives to reduce spending, may have an adverse effect on beneficiaries' access to high-quality care. The SMDL cautions that a change in the reported metrics "signals the need for CMS to engage with the state to determine the cause(s) of the change and whether corrective action is needed" (p.32). These reporting requirements are likely to prove significantly more burdensome for states as compared with existing procedures.

III. Conclusion: Key Considerations for States

The new capped funding model may hold interest for states that seek particular types of program flexibility that have not previously been approved, notably including the ability to:

- Qualify for shared savings if the state underspends its block grant while maintaining or improving quality. These shared savings payments can potentially be spent on services outside the capped funding demonstration or outside the Medicaid program (subject to a state match requirement).
- Eliminate hospital presumptive eligibility.
- Implement a closed prescription drug formulary even for optional non-expansion populations previously covered under the Medicaid state plan.
- Propose alternative approaches to complying with federal standards for access and managed care oversight.
- Modify certain program elements during the demonstration without the need for federal approval.

At the same time, the capped funding demonstration model also presents a number of potential drawbacks for states, including the following:

- **Loss of Federal Funds.** Caps on federal funding shift financial risk to the states. That risk is particularly great under the model described in the SMDL, given that the caps are designed to constrain the growth in Medicaid spending.
  - States would face difficult choices if capped funding falls short of actual need: either further curtail demonstration spending or use state dollars to replace FFP for all spending above the cap, thereby displacing other state spending (potentially including spending on Medicaid populations outside the demonstration).
  - Because the penalty for exceeding the cap means a loss of FFP, the consequences for exceeding the cap are most acute for states with high federal match rates. As compared with a state with a 50 percent match rate, a state with a 75 percent rate will lose an extra 25 cents of FFP on each dollar above the cap. The ACA expansion population, moreover, receives a 90 percent federal match rate (as long as the state covers the

entire expansion population up to 133 percent of the FPL). A state that exceeds its spending cap for this population could suddenly face a tenfold increase in its financial liability for each dollar spent.[25]

- Although the guidance offers the opportunity for shared savings under the aggregate cap model, this opportunity may not be meaningful in practice, given the various limitations in terms of timing, data, and program quality.

› **Risks for Medicaid Beneficiaries and Other Stakeholders.** CMS' guidance indicates that it will generally allow states that adopt a capped funding demonstration to remove or reduce current federal protections. States that experiment with altering Medicaid program standards may end up reducing beneficiaries' access to care, constricting provider reimbursement to unsustainable levels, or squeezing managed care capitation rates to an extent that makes it unfeasible for plans to meet their obligations.

› **Quality and Monitoring Obligations.** A capped funding demonstration comes with monitoring and reporting obligations that go beyond the typical 1115 demonstration requirements. States that pursue these demonstrations may need to invest considerable resources in implementing their quality strategies and satisfying reporting requirements.

› **Administrative Challenges.** In addition to the administrative burden associated with monitoring and reporting, as discussed above, states that implement a capped funding demonstration with significant new program flexibility will essentially be running a separate program alongside existing coverage for other populations such as children and disabled or elderly adults. States will need to remain cognizant of differing substantive standards and procedural requirements with respect to, for example, managed care contracting or beneficiary cost sharing. It remains to be seen how much of a lure the promise of somewhat reduced oversight will be, given that states will still be subject to standard Medicaid rules for the bulk of their Medicaid population and enhanced reporting requirements for their capped funding demonstration population. The financial risk of assuming a cap on federal Medicaid funding thus may not be outweighed by promised flexibilities.

› **Litigation Risk.** States can expect legal challenges to any approved demonstration that includes capped federal funding. The recent litigation around work requirements has shown that these types of legal challenges can be costly and time consuming, and can introduce uncertainty into states' implementation efforts. Legal challenges may take several forms, potentially including arguments such as:

- The Secretary of Health and Human Services lacks the authority to alter Medicaid's financing structure in this way, either under Social Security Act Section 1115(a)(1) (because the financing provisions are not listed among the provisions that may be "waived" in a demonstration project) or under Section 1115(a)(2) (because the Secretary's so-called expenditure authority does not permit changes in the financing structure itself).
- Particular changes that disregard fundamental Medicaid protections—such as cost sharing or drug formularies—may be found to exceed statutory authority under 1115(a)(2).
- A demonstration that restricts enrollment or benefits may not meet the requirement that demonstration projects be "likely to assist in promoting the objectives" of the Medicaid program.
- A change of this magnitude should be effectuated through formal rulemaking—which affords opportunities for public comment—rather than through guidance documents or ad hoc demonstration approvals.

25 The guidance does not explain how CMS will assess excess spending in a demonstration that covers multiple populations subject to *different* matching rates—for example, covering the expansion population at a 90 percent match rate as well as certain optional populations at the state's standard rate. The SMDL suggests that CMS will apply a single overall cap by blending weighted spending projections for all covered groups, and so CMS will perhaps take a similar approach with respect to allocating excess spending above the cap (based on, for example, each population's share of *overall* spending that year). Alternatively, CMS could attempt to allocate spending chronologically by determining the point in time at which spending hit the cap amount and disallowing FFP for all expenditures after that date.

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Despite Gains From ACA, Lower Rates of Health Insurance Coverage Persist Among Those Lacking Housing Basics

Deborah Freund, Chengcheng Zhang, Petra W. Rasmussen, Safia Hassan, and Gerald Kominski

Since the passage in 2010 of the Patient Protection and Affordable Care Act (PPACA, most commonly called the ACA), a great deal of literature has emerged showing that states that have embraced the law's Medicaid expansion have seen significant reductions in the number of uninsured, though disparities in coverage persist by race/ethnicity, employment, and other factors.[1-3] Similarly, in recent years, other research has shown that there is an important relationship between housing and health outcomes,[4] and that improving housing quality and safety improves overall health. Individuals experiencing unstable housing and poor housing safety, defined in a variety of ways—including instability, an unsafe environment, water leaks, poor ventilation, and pest infestation—have poorer health.[4] However, there is virtually no literature that focuses on the question of whether having stable and safe housing is related to the likelihood of having health insurance coverage. A study by Carroll et al. in 2017 assessed the extent to which housing instability is linked to insurance status in a preschool population. The study found that preschool-age children residing in unstable housing were 27% more likely than stably housed preschool-age children to have gaps in health insurance.[5]

Using data from the American Community Survey for 2013 and 2018, with responses from almost 3 million individuals, we compared those ages 0-64 who had complete housing amenities with those whose housing lacked one basic necessity. Basic necessities are defined as these:

- bathtub or shower
- sink with a faucet
- stove or range
- refrigerator

We stratified the data based on the following income categories: up to 100% of the federal poverty level (FPL), 100–399% FPL, and 400% FPL or greater. For 2018, 100% FPL was $12,060 for an individual and $24,600 for a family of four; 400% FPL was $48,240 for an individual and $98,400 for a family of four.

Our findings suggest that having housing that lacks at least one basic necessity is associated with being uninsured. Prior to the implementation of the ACA's main coverage provisions, individuals whose housing lacked at least one basic necessity had higher rates of being uninsured than individuals with complete housing. While this disparity still exists after implementation of the ACA, rates of uninsurance have decreased for those whose incomes would qualify them for Medicaid coverage under Medicaid expansion or for individual market subsidies, both for those with complete housing and those whose housing lacks a basic necessity.

Claremont Graduate University

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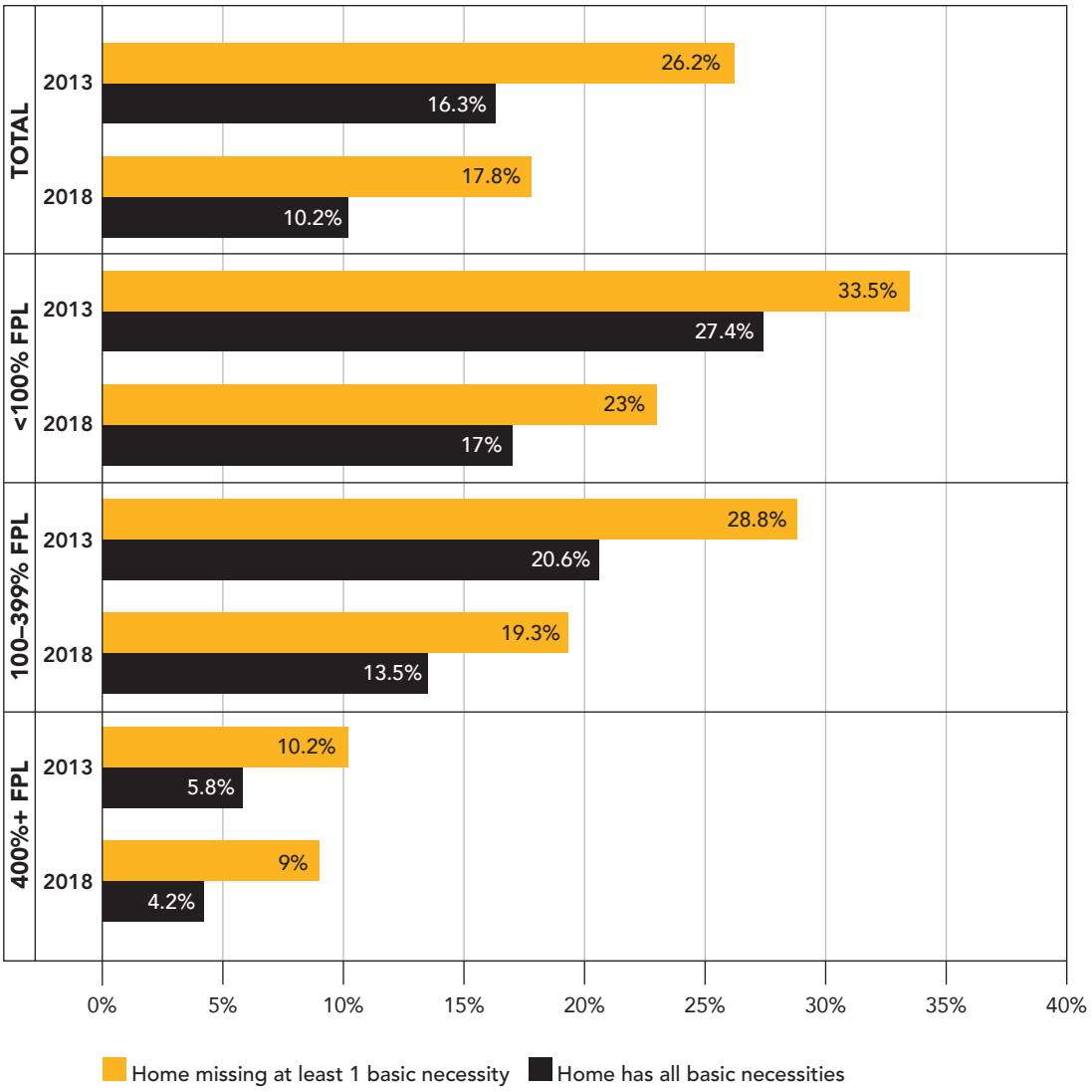
Exhibit 1 **Uninsured Rate by Housing Index, Ages 0-64, 2013 and 2018**



But more importantly, large disparities in coverage persist.

Overall, in a comparison of the pre-ACA implementation (2013) with the most recently available post-ACA implementation year (2018), the reduction in the uninsured rate was dramatic. However, individuals with homes that had all the basic necessities had lower uninsured rates and higher rates of decline in their uninsured rates in comparison to those lacking at least one basic necessity (Exhibit 1). Those having all the basic necessities had much lower rates of being uninsured than those whose housing lacked at least one basic necessity, regardless of income.

Among those living in homes absent one basic necessity, the rate of uninsurance declined from 33.5% to 23% for individuals with incomes below 100% FPL, and from 28.8% to 19.3% among those with incomes of 100–399% FPL. In comparison, those living in homes with all the basic necessities had better coverage rates in 2013, and their coverage rates as a percentage change declined more than the rates for those living without one

basic necessity. Between 2013 and 2018, the insured rate for this group declined from 27.4% to 17% for those with incomes below 100% FPL, and from 20.6% to 13.5% among those with incomes of 100–399% FPL.

Individuals with incomes of 400% FPL or greater started out with much lower rates of being uninsured than the other two income groups, regardless of their housing status. However, among this population, there was not a significant decrease in the uninsured rate: The rate declined only from 5.8% to 4.2 % for those with all the basic necessities, and from 10.2% to 9% for those without at least one basic necessity. Thus, disparities still exist, as not all groups shared equally in the decline, and those that had full housing had lower uninsured rates than those that had a missing basic necessity.

We also compared the rates of being uninsured for each income group in states that expanded Medicaid in 2014 versus states that did not expand. Whether or not the individual or family had all the basic necessities, there was a larger percentage of decline in uninsured rates for all income groups in those states that expanded than in those states that did not take part in the Medicaid expansion.

Housing has been a relatively unexplored topic since the passage of the ACA. Though many health organizations — whether in the private, nonprofit, or government sectors — have begun to discuss and create interventions to tackle the social determinants of health, the role of housing as a variable that puts individuals at greater risk of being uninsured has never been highlighted. Our analyses demonstrate that individuals with housing issues, as measured by the lack of a basic necessity, are more likely to be uninsured than those without housing issues. The reasons why are not clear, though the finding may reflect a higher budgetary priority on housing and food than on health insurance. Further investigation is necessary to determine why individuals whose housing lacked at least one basic necessity and whose income was less than 100% FPL did not see a larger increase in their uninsured rate, as they would be eligible for Medicaid in expansion states. More research will be needed in the future to assess the relationship between insurance and housing.

Data

Data for this fact sheet are from the 2013 and 2018 American Community Survey.

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Leveraging American Community Survey (ACS) Data to Address Social Determinants of Health and Advance Health Equity

Prepared by State Health Access Data Assistance Center at the University of Minnesota

STATE Health & Value STRATE I | *Driving Innovation Across States*

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Introduction

State Medicaid programs are increasingly seeking to understand and address social factors that contribute to poor health—such as food insecurity, unstable housing, and a lack of access to social supports—in order to lower costs, improve outcomes for their members, and advance health equity.[1] Health equity can be defined as when "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[2] To inform this work of addressing the social determinants of health (SDOH) and advancing health equity, states and Medicaid officials need data in order to identify priority areas of unmet social and economic needs, execute SDOH initiatives, and monitor and evaluate the impacts of these programs.

Increasingly, states are leveraging a broad array of data sources to support efforts to address health equity (see Table 1). While those sources closest to the Medicaid program are the most widely used, each has advantages and disadvantages. Data from providers are extremely rich but can be challenging to collect and extract information in a uniform way. Similarly, while data from other state agencies have great depth (e.g., incarceration history, housing history, information on food security), using them may require lengthy data use agreement (DUA) negotiations, and matching individuals across agencies can be complex. Commercial data can provide insights on comparison populations (e.g., those with employer-sponsored insurance) or fill other data gaps (e.g., information on patient or consumer preferences), but it can be expensive to obtain and analyze.

Federal survey data also have important advantages and disadvantages. For example, survey data cannot provide direct information about the service use of people enrolled in Medicaid; however, the data are broad in scope, easy to access, and able to support population-level analysis. In addition, while obtaining complete information on race, ethnicity, and language (also known as "REL" data) continues to be challenging for providers and insurers, federal surveys have adapted a variety of techniques (such as detailed probes and imputations) to improve the reliability and consistency of this information.[3] This makes federal survey data particularly valuable for understanding and developing strategies that address health equity. When used as part of a broader data strategy, federal survey data can be a powerful additional tool for Medicaid programs seeking to measure social determinants of health in ways that can guide efforts to address health equity.

Table 1. Data Sources and Types

Medicaid	Providers/MCOs	Other State Agencies	Commercial Data	Population-Based Surveys
› Administrative/ enrollment/ financials › Claims/encounters	› EHR/clinical data › Patient satisfaction surveys › Targeted screening tools	› Use/access to housing support › Use/access to food supports › Incarceration/justice system involvement	› Claims for non-Medicaid populations › Consumer preference data	› Federal surveys (ACS, CPS, NHIS) › State-administered surveys

In this brief, we focus on how Medicaid programs can use data from one federal survey, the American Community Survey (ACS), to inform and target interventions that seek to address social determinants of health and advance health equity. We focus on the ACS because it contains content relevant to a range of social determinants of health, such as housing, income, and food supports, and has a large sample size that supports estimates for smaller subpopulations

and geographic areas. This brief also highlights relevant examples from states that use SDOH and health equity measures from the ACS, including which measures and what they are used for.

ACS Content Relevant to SDOH and Health Equity

The ACS contains a broad range of content relevant to social determinants of health and health equity. Relevant topic areas are laid out in Table 2. The rich demographic data (such as income, race/ethnicity, and age) available in the ACS also supports stratifying results for key subpopulations, which is crucial for understanding and monitoring efforts to address health equity.

The ACS also provides considerable depth and flexibility for users to select, refine, and combine multiple variables to best meet their analytic purposes. Table 3 provides information about the variables, definitions, and detailed response categories related to race/ethnicity. As the table demonstrates, users can choose between variable coding that is "rolled up" to reflect the most commonly reported responses and much more detailed codes that allow for drilling down to very specific groups. A data dictionary containing similar information for all relevant variables is available in the Excel toolkit.

One way that states can consider using the ACS data is to better understand issues related to health equity and social determinants of health for key subpopulations. For example:

- How do issues of housing stability vary by time in the U.S. for immigrant populations? How could this information be used to better target information and resources about housing supports?
- Do rates of participation in food and income supports differ for populations that are linguistically isolated? What information about primary language is available to better target outreach information for these programs?
- What variation exists on key outcomes by country of origin within a state's Hispanic/Latino population? How could this be used to better target and partner with relevant community resources?

This type of population-level analysis can be operationalized with the ACS microdata, which are data files that contain individual-level information for each survey respondent (see more about accessing and using ACS microdata in the sidebar).

ABOUT THE AMERICAN COMMUNITY SURVEY

The American Community Survey (ACS) is a general household survey conducted by the U.S. Census Bureau. It includes data on income, poverty, disability, marital status, education, employment, travel to work, health insurance coverage, housing, and other factors. ACS data are collected on an ongoing basis using monthly mailings to a sample of approximately 3.5 million U.S. households, yielding about 3.2 million individuals. The ACS collects sample data in all 3,141 counties (or county equivalents) in the United States every year. Participation in the survey is required, and the response rate is high—93.7 percent in 2017.[10]

ACCESSING AND USING ACS MICRODATA

Users can download ACS microdata directly from the ***Census Bureau***, along with code to process the data. Data are updated annually between September and December; the most recent data available now are for 2018.

IPUMS at the University of Minnesota makes harmonized versions of the ACS files, along with enhanced documentation, available to users at no cost. Users can generate extracts for specific years and variables of interest, which, along with the detailed documentation and harmonized variables, can save considerable time in processing and managing the data. IPUMS releases harmonized versions of the ACS after the data are available from the ***Census Bureau***; the most recent data available now are for 2017.

The data dictionary available in the ***Excel toolkit*** is based on documentation from the 2017 ACS file available through IPUMS.

Researchers at SHADAC are also available to provide tailored, one-on-one technical assistance to state analysts working with the ACS microdata.

Table 2. ACS Content Relevant to SDOH and Health Equity

Demographic	Social	Economic	Housing
Race/Ethnicity **Age** **Citizenship** › Place of Birth › Ancestry › Year of Entry **Language** › Spoken at home › English proficiency › Linguistic isolation **Migration** › Moved within same state, from another state, or abroad in past year **Household makeup** › Single-parent families › Multifamily households	**Disability** › VA-related › Type (cognitive, vision, hearing, other physical self-care) **Educational Attainment** **Health Insurance**	**Income/Poverty Status** › Family level › Health insurance unit (to determine eligibility for Medicaid and subsidies) **Employment** › Status › Labor force participation **Other public programs** › Income support › Supplemental Nutrition Assistance Program (SNAP) **Transportation** › Vehicles available › Commuting to work	**Type and occupancy** › Type (multi-unit, mobile home, group quarters) › Owner/renter › Time at address **Housing Costs** › Monthly rent › Monthly ownership costs › Annual heating costs › Annual water costs **Technology/Communication** › Phone › Computers/other devices › Internet connectivity **Housing conditions** › Kitchen facilities › Refrigerator › Plumbing facilities › Bathtub or shower › Piped water › Rooms per person (crowding)

Table 3. ACS Variables Related to Race/Ethnicity

Variable(s)	Definition	Response Categories	Notes
RACE	Self-reported race	› White › Black/African American › American Indian or Alaska Native › Chinese › Japanese › Other Asian or Pacific Islander › Other race › Two major races › Three or more major races	Analysts frequently collapse categories and combine with ethnicity (HISPAN) to create race/ethnicity variables with fewer categories and/or categories that are mutually exclusive. Users can also choose to view the detailed codes, which include up to 252 categories depending on the year.
RACAMIND **RACASIAN** **RACOTHER** **RACBLK** **RACWHT** **RACPACIS**	Bivariate indicator of whether person reported a specific race	› No › Yes	These variables can be used in combination with RACNUM to identify specific race combinations.
RACNUM	Total number of major race groups reported	› One to six	Major race groups include: American Indian, Asian, black, Native Hawaiian or other Pacific Islander, white, and some other race.
HISPAN	Identifies persons of Hispanic/ Spanish/Latino(a) origin and classifies based on country of origin when possible	› Not Hispanic › Mexican › Puerto Rican › Cuban › Other › Not Reported	Users can also choose to view the detailed codes, which include up to 59 categories depending on the year.

Source: SHADAC review and compilation of IPUMS documentation of the 2017 ACS data file.[4]

Strategies and Tools for Examining Smaller Geographies with the ACS

As we discussed above, one of the key advantages of the ACS is its large sample size that supports analysis by key subpopulations such as age, race/ethnicity, income, and educational attainment. ACS microdata can be used to examine estimates for these populations at the state level. However, there may be instances where states would prefer to have information for smaller geographic areas such as counties, ZIP codes, or block groups. Examples of questions and related interventions that may benefit from more granular geographic estimates of content related to SDOH include:

- **Housing:** Which geographic areas contain higher concentrations of populations that spend more than 30 percent of income on rent/housing costs; have high percentages of renters or individuals with short housing tenures; and/or live in housing with incomplete plumbing or in crowded conditions? *This information could be used to target outreach efforts about available housing support and to target resources for more intensive provider screening related to housing*.
- **Transportation:** Which geographic areas contain higher concentrations of individuals that report not owning vehicles? *This information could be used to communicate about Medicaid non-emergency medical transportation benefits and other transportation programs and to target resources for more intensive provider screening related to transportation needs.*
- **Nutrition:** Which geographic areas contain higher concentrations of people who report using food stamps/SNAP, appear to be eligible for SNAP but not receiving it, and/or report incomplete or a lack of kitchen facilities in their housing? *This information could be used to communicate about SNAP and community-based organizations such as food pantries and to target resources for more intensive provider screening related to food insecurity.*
- **Communication needs:** Which geographic areas contain higher concentrations of people who report limited access to computers, internet, and/or phone services (which are essential tools for accessing information about health care and communicating with providers)? *This information could be used to target access to key information in other ways (e.g., in person or by phone) and/or to provide patients and their families information about accessing public spaces with computer resources, such as libraries.*

STATE HEALTH COMPARE

SHADAC's online data tool, ***State Health Compare***, allows users to generate state-level estimates of select SDOH-related factors from the ACS, including:

- The share of children living in poverty
- The percent of rental households that spend more than 30 percent of their income on rent (unaffordable rents)

The child poverty measure can be stratified by detailed race/ethnicity categories, and the unaffordable rents measure can be stratified by income, disability status, metropolitan status, and whether anyone in the household is enrolled in Medicaid.

SHADAC is continuing to add measures to ***State Health Compare*** that relate to SDOH and health equity, and researchers are available to provide one-on-one technical assistance to state analysts who wish to use the ACS to produce additional measures or breakdowns.

In these cases, analysts can leverage pre-tabulated estimates produced by the Census, also known as "summary data." The Census produces summary tables using both single-year and five-year data files. The five-year files are updated annually, with the most recent available file containing data from 2014 to 2018. Certain smaller geographic estimates (such as ZIP codes, census tracts, and block groups) are only available from tables based on five years of data. Table 4 below provides an overview of the substate geographic estimates available from both one- and five-year tables.

Table 4. Substate Geographic Areas Available in ACS One-Year and Five-Year Summary Tables

Geography	Total	One-year	Five-year
Congressional Districts	435	All	All
Metro & Micro Statistical Areas	929	56%	All
Counties	3,220	26%	All
School Districts	13,642	7%	All
Zip Code Tabulation Areas	33,120	None	All
Census Tracts	74,001	None	All
Block Groups	220,333	None	All

Source: U.S. Census Bureau. (2018). *Understanding and Using American Community Survey Data: What All Data Users Need to Know*. Retrieved on November 1, 2019 from https://www.census.gov/content/dam/Census/library/publications/2018/acs/acs_general_handbook_2018.pdf.

There are some important pros and cons to consider when using geographic estimates based on five years of data. For example, users may want to weigh how the need for more granular data compares to the potential for changes to be masked when combining multiple years of data. Pooled year estimates may be better suited to questions that address characteristics that are relatively stable—such as poverty—than issues that are likely to shift more quickly, such as computer and internet access. Estimates at lower levels of geography will also often be less precise, so we recommend that analysts apply some criterion for when to suppress estimates; for example, if the relative standard of error exceeds 30 percent or if the denominator is fewer than 50 cases.

ACCESSING AND USING ACS SUMMARY DATA

Users can download ACS tabular data directly from the U.S. Census Bureau using their new tool at ***data.census.gov***.

Users can select tables by topics, change geographies, and download data in PDF or CSV file formats. The most recent tabulations available are for 2018.

Researchers at SHADAC are also available to provide tailored, one-on-one technical assistance to state analysts working with the summary data. We can help identify tables and advise on strategies to pull down tabular data and manipulate it in statistical programs such as STATA.

Some online tools provide interactive access to the five-year ACS estimates related to SDOH and health equity. These types of tools can be particularly helpful when doing exploratory research about where to target a particular intervention or to provide preliminary framing for more in-depth analysis. The Vulnerable Populations Footprint, made available by the Center for Applied Research and Data Systems, includes a comprehensive set of indicators from the five-year ACS summary tables. Users can generate interactive maps of single metrics or use the tool to set thresholds for multiple metrics (e.g., percent living in poverty and percent with a high school education or less) to see relevant "hot spots" in a state or region. A list of the indicators available on the site, along with information about the most granular geographic data available (e.g., county, census tract) is available here.

In some cases, users may prefer to access the summary data tables directly from the Census. This may be helpful if analysts want to pull down data from multiple tables, do additional analysis (such as aggregating across categories or performing tests), or include data as inputs to statistical modeling (see sidebar for information about accessing data directly from data.census.gov). A list of tables with information about the relevant universes and availability of one- and five-year estimates is also included as a separate tab in the Excel toolkit here.

ACS Data in Action: State Examples

Some states are already using ACS data to inform population-level approaches to addressing SDOH and health equity. For example, both New Hampshire[5] and Vermont[6] are using the Social Vulnerability Index (SVI) to identify areas in need of additional assistance in the event of a disease outbreak or other emergency. The SVI measures poverty, unemployment, income, education, and uninsurance at the census tract level.[7]

Massachusetts also leverages ACS data to calculate a "Neighborhood Stress Score," which is used in its model to risk-adjust payments to Medicaid managed care organizations and accountable care organizations.[8] In Washington, ACS data are used in an online dashboard to compare characteristics across the geographic areas associated with each of the state's Accountable Communities for Health (ACH). The ACHs bring together health sectors across the state to engage in transformation projects to promote health equity.[9]

Table 5 below crosswalks specific measures used in each of these initiatives. There is quite a bit of overlap in the ACS measures in use across these examples, and consistency in how certain concepts—such as educational attainment and unemployment—are classified. However, there is more variation in the type and granularity of data used for other factors, such as poverty, relevant housing characteristics, and classification of race/ethnicity. As these examples illustrate, the ACS provides states with considerable flexibility to tailor analyses to meet specific policy and operational goals.

Table 5. State Examples: Use of SDOH and Health Equity Measures from the ACS

Measure	*Social Vulnerability Index* (VT & NH)	*MA Risk Adjustment Neighborhood Stress Score*	*WA Accountable Communities for Health*
Race/ethnicity	Percent minority (all except white non-Hispanic)		Used to stratify results. Shows seven single race categories, Hispanic, other race, and multiple race.
Poverty	Below poverty	Below poverty Below 200% poverty	Below 125% poverty
Per capita median income	X		
Unemployed (age 16+)	X	X	X
Uninsured			X
Receiving public assistance		X	
Civilian with a disability	X		
No high school diploma	X		X
Single-parent households	X	X	
Speaks English "less than well" (age 5+)	X		X
No vehicle available in the household	X	X	
Crowding (>1 person per room)	X		
Living in multiunit structures	X		
Living in institutionalized group quarters	X		
Living in mobile homes	X		

Source: SHADAC review and compilation of measure documentation from sources cited above.

Conclusion

The American Community Survey (ACS) contains content relevant to a range of social determinants of health, and the large sample size, particularly when pooling years, can be leveraged to produce estimates for key subpopulations and geographic areas. When used as part of a broader data strategy, data from the ACS can be a powerful additional tool for Medicaid programs seeking to measure social determinants of health in ways that can guide efforts to address health equity. SHADAC researchers are available to provide tailored, one-on-one technical assistance to states seeking to leverage ACS data for these purposes.

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ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

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The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at ***www.shvs.org***.

STATE HEALTH ACCESS DATA ASSISTANCE CENTER

This brief was prepared by Lacey Hartman, Elizabeth Lukanen, and Colin Planalp. SHADAC produces rigorous, policy-driven analyses focused on translating complex research findings into actionable information. SHADAC's multidisciplinary team is comprised of nationally recognized experts in collecting and applying data to inform or evaluate health policy decisions and have expertise in both federal and state data sources. SHADAC is based at the University of Minnesota. For more information visit: ***www.shadac.org***.

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By Leora I. Horwitz, Carol Chang, Harmony N. Arcilla, and James R. Knickman

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Quantifying Health Systems' Investment In Social Determinants Of Health, By Sector, 2017–19

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ABSTRACT The past decade has seen a growing recognition of the importance of social determinants of health for health outcomes. However, the degree to which US health systems are directly investing in community programs to address social determinants of health as opposed to screening and referral is uncertain. We searched for all public announcements of new programs involving direct financial investments in social determinants of health by US health systems from January 1, 2017, to November 30, 2019. We identified seventy-eight unique programs involving fifty-seven health systems that collectively included 917 hospitals. The programs involved at least $2.5 billion of health system funds, of which $1.6 billion in fifty-two programs was specifically committed to housing-focused interventions. Additional focus areas were employment (twenty-eight programs, $1.1 billion), education (fourteen programs, $476.4 million), food security (twenty-five programs, $294.2 million), social and community context (thirteen programs, $253.1 million), and transportation (six programs, $32 million). Health systems are making sizable investments in social determinants of health.

The World Health Organization defines *social determinants of health* as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[1] Social determinants account for substantially more of the variation in health outcomes than medical care does.[2,3] Interest in addressing social determinants of health has increased markedly in recent years, as exemplified by new attention from policy makers and researchers.[4] The Department of Health and Human Services (HHS) included "creat[ing] social and physical environments that promote good health for all" as one of only four overarching goals in Healthy People 2020, a set of objectives identified once a decade to improve the health of all Americans.[5] In 2010 the Affordable Care Act (ACA) mandated that tax-exempt hospitals conduct community needs assessments every three years and participate in community-level planning to improve community health. In 2014 the National Library of Medicine added *Social Determinants of Health* as a Medical Subject Headings term to enable searches on this topic, in recognition of the burgeoning literature in the field.

In 2018 Alex Azar, the HHS secretary, stated that HHS is "deeply interested" in addressing social determinants of health.[6] The Centers for Medicare and Medicaid Services recently issued new Medicaid waivers to cover social determinants of health needs.[7] The Center for Medicare and Medicaid Innovation is funding a number of programs targeted at social determinants, such as the 2018 Accountable Health Communities Model; the Integrated Care for Kids Model, which focuses on linking behavioral and physical health care; and the Maternal Opioid Misuse model, which encourages state Medicaid agen-

cies to help pregnant women with opioid use disorder obtain services such as supportive housing. Health systems are beginning to appoint directors of social determinants, health equity, and population health[8] and are increasingly adopting patient-level screening for social determinants.[9–11] Evidence is accumulating that investments in this area can have positive effects on morbidity and mortality.[12]

Nonetheless, hospitals have historically invested little in addressing social determinants.[13] One potential investment avenue is community benefit spending. However, only about 5 percent of this money is spent on community-based activities, most of which are focused on health but not necessarily on social determinants.[13,14] Moreover, the proportion of hospitals' community benefit spending allotted to community-based activities had not increased as of 2014 despite the new requirements of the ACA.[15] Therefore, in the wake of increasing interest and new policy requirements, we investigated how many health systems are making major new investments that directly address social determinants, and how these investments are being allocated across social sectors.

Study Data And Methods

There is no single, universally accepted definition of *social determinants of health*. We followed the definitions laid out in Healthy People 2020, which defines five areas: economic stability (employment, poverty, housing instability, food insecurity), education (early childhood education and development, high school graduation, enrollment in higher education, language, literacy), social and community context (civic participation, discrimination, incarceration, social cohesion), health and health care (access to health care, access to primary care, health literacy), and neighborhood and built environment (access to foods that support healthy eating patterns, crime and violence, environmental conditions, quality of housing).[16]

We found early on that health systems engaging in community-based work invariably described their programs as addressing social determinants of health. Accordingly, instead of attempting to search for every type of social determinant that could be targeted by health systems for intervention, we searched more broadly for interventions described as being targeted at social determinants or community health. To identify announcements by hospitals or health systems of investments in community health or social determinants of health, we searched LexisNexis and Google for news articles and press releases that included the terms *health system* or *hospital* and *investment* and *social determinant of health* or *community health* in the two-year period January 1, 2017–November 30, 2019, with the US as the location. We read each identified article and followed up with searches using Google if needed to identify additional information about each investment. Where available, we reviewed relevant health system or hospital and collaborating agency web pages and posted documents. We considered any type of funding commitment to be an investment in social determinants—from direct grants by health systems to community agencies without expectation of direct return or repayment to investments that were expected to generate a return. However, we had insufficient data on the degree to which a return was expected to be able to separate out the two types of community investments.

We excluded programs in which health systems were using only funds granted by other organizations; programs that provided direct medical care, subsidized unfunded care, or funded medical education; those focused only on the health care social determinant domain, except the ones that focused on providing transportation to improve health care access; those focused only on creating or implementing social determinants screening or referral tools; hospital renovation programs; programs that increased the minimum wage; and those that involved community investments only by financing agencies or insurance payers.

We categorized each initiative by target area, adapted from the Healthy People 2020 domains. Because of the large number of programs that focused on the economic stability domain, we divided it into its component parts. We also combined housing instability (in the economic stability domain) and quality of housing (in the neighborhood and built environment domain) into a single housing category, since in practice these foci were often present in the same housing-focused programs. As noted above, we excluded programs that were solely in the health domain. We therefore included six categories: employment (local hiring and purchasing, workforce development, investments in local businesses, economic opportunity programs), food security (meal programs for patients, food banks, produce stands, grocery stores, food delivery, farms, nutrition programs), housing (housing quality and stability), education (early childhood education, language and literacy, high school graduation, higher education), social and community context (community well-being or cohesion, civic participation, incarceration), and transportation (transportation for medical care, improved community transportation infrastructure).

We also recorded information on scale (total dollars committed overall and per year), health system characteristics (location; ownership; acute care beds; participation of any member hospital as of the fourth quarter of 2016 in the voluntary Medicare Bundled Payments for Care Improvement [BPCI] Initiative or the mandatory Comprehensive Care for Joint Replacement (CJR) model; and participation as of 2016 in any commercial, Medicare, or Medicaid accountable care organization [ACO] contract), and funding partners. To identify health system characteristics, we linked each health system or hospital to the 2016 Compendium of U.S. Health Systems of the Agency for Healthcare Research and Quality (AHRQ). The compendium includes information on all 626 US health systems (defined by AHRQ as at least one hospital and at least one group of physicians jointly providing comprehensive care and connected through common ownership or joint management).[17] These health systems include 3,513 of the 4,749 nonfederal acute care hospitals in the US. We were able to match every participating hospital to an associated AHRQ health system.

ANALYSIS We calculated descriptive statistics on the characteristics of our selected health systems and on the scope, scale, and focus of funded programs. We then analyzed whether the characteristics of health systems investing in social determinants (teaching status, BPCI Initiative participation, ACO participation, and bed size) were different from those of systems not investing. We used chi-square tests for categorial variables and t-tests for continuous variables.

All statistical analyses were conducted with SAS, version 9.4, with a two-tailed significance threshold of $p = 0.05$.

LIMITATIONS Our results quantified the scope and scale of investments in upstream social determinants by health systems at a substantially more granular level than has previously been available. However, there were some limitations. First, health systems may have made investments without publicly announcing them, though we suspect that any such investments would likely have been small since investment leads to public relations benefits.

Second, we could have missed some announcements if they were not captured by our search strategy, although we confirmed the accuracy of that strategy by doing other, more specific searches—such as for the terms *housing* and *hospital* and *program*. Some investments may have been made in kind and would therefore not be quantifiable. We could not always disentangle how much was committed by health systems in particular, as many programs were collaborative investments by a variety of community groups. Where we could not be sure, we omitted the investment from our calculations of total investment. Not all announcements listed the monetary commitment specifically. Accordingly, our estimates likely represent a lower bound of the total dollars committed to investments in social determinants of health.

Third, there may also be areas in which our results overstated investments. In most cases, we identified commitments but not actual expenditures. It is possible that not all health system commitments will result in actual investments. Moreover, commitments were often projected to extend over several years. Therefore, we could not reliably estimate yearly commitments. And it is possible that health systems freed up money for publicly announced investments by shifting funds that had previously been used for similar or other work focused on social determinants or by soliciting funds from donors—which would make the net impact smaller than we supposed.

Finally, it was sometimes difficult to tell how many hospitals within each health system were participating in the work. Thus, our results could not be shown at the level of individual hospitals.

Study Results

We identified 57 (9.1 percent) of the 626 health systems as having made specific commitments to 78 distinct programs (see online appendix exhibit A1 for details of each).[18] These programs involved 917 hospitals.

CHARACTERISTICS OF INVESTING SYSTEMS Forty-one of these fifty-seven health systems were secular nonprofit organizations, fourteen were nonprofit sectarian health systems (largely Catholic), and two were public health systems. None were for profit. Compared with noninvesting systems, systems making investments were significantly larger (mean beds: 2,626 versus 799) and had more member hospitals (mean hospitals: 14.28 versus 4.75) (exhibit 1). Investing systems were also significantly more likely to include at least one major teaching hospital (86 percent versus 32 percent), participate in an ACO (86 percent versus 52 percent), and participate in the BPCI Initiative or the CJR model (65 percent versus 44 percent).

CHARACTERISTICS OF FUNDED PROGRAMS Programs were taking place in thirty states, with the largest numbers in California (fifteen), Ohio (nine), Maryland (eight), Illinois (eight), and Massachusetts (six) (exhibit 2). Twenty-nine programs did not disclose the total dollars committed to them. Among the remaining forty-nine programs, the total funds committed specifically from health systems or hospitals were approximately $2.5 billion, with a median investment

EXHIBIT 1

Characteristics of health systems that did and did not announce investments in social determinants of health, January 1, 2017–November 30, 2019

	Systems that announced investments (n = 57)		Systems that did not announce investments (n = 568)	
System characteristics	**No.**	**%**	**No.**	**%**
Average no. of beds****	2,626	—[a]	799	—[a]
Average no. of acute hospitals***	14.3	—[a]	4.8	—[a]
Teaching status****				
Nonteaching	1	2	174	31
Minor teaching	27	47	258	45
Major teaching	29	51	133	23
Includes any major teaching hospital****	49	86	184	32
Pediatric care status**				
No pediatric hospital	47	83	525	92
Pediatric hospital but not majority pediatric	6	11	15	3
Predominantly dedicated to pediatric care	4	7	27	5
Participates in BPCI Initiative or CJR model**	37	65	249	44
Participates in an ACO****	49	86	298	52

SOURCE Authors' analysis of data from the Agency for Healthcare Research and Quality Compendium of U.S. Health Systems, 2016. **NOTES** BPCI is Bundled Payments for Care Improvement. CJR is Comprehensive Care for Joint Replacement. ACO is accountable care organization. [a]Not applicable. **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

per program of $2 million and a mean of $31.5 million. Most programs did not specify a commitment duration: The thirty-one that did averaged 5.4 years. Two programs involved health system commitments of annual expenditures for the foreseeable future.

Among the investments that denoted a particular social determinant, the dominant choice was housing, to which at least $1.6 billion was specifically committed via fifty-two programs (exhibit 2). The additional focus areas in order of frequency were employment (twenty-eight programs), food security (twenty-five), education (fourteen), social and community context (thirteen), and transportation (six).

Housing-related programs included strategies such as the direct building of affordable housing, often with a fraction set aside for homeless patients or those with high use of health care; funding for health system employees to purchase local homes to revitalize neighborhoods; and eviction prevention and housing stabilization programs. Nearly all of these programs, which are complex and costly, were conducted in partnership with state or local agencies, community development financial institutions, or local community groups. By contrast, simpler interventions such as investments in access to transportation were often conducted by health systems alone or in partnership with a single commercial entity, such as Uber or Lyft rideshare companies. Of note, these investments were typically pilot programs that were initially offered to few patients. For example, the Henry Ford Health System in Detroit launched a partnership with Lyft (which provides the rides) and a start-up named SPLT (which organizes scheduling) to offer rides to twenty-five patients who had a history of missing dialysis center appointments.[19]

The second most common category of investment was in employment-related programs. Some of these were in the form of direct hiring or purchasing from the community as part of anchor institution commitments. Other types of employment-related investments included developing relationships with local schools in the form of training programs, mentorship arrangements, or apprenticeships; providing job coaching assistance; and providing seed funding for locally owned small businesses and entrepreneurs or creating small-business accelerators.

Spending types included outright grants to community agencies working on social determinants of health, the reallocation of existing spending to additionally serve social determinants goals (such as local hiring and contracting programs), and investments that were expected to generate some return (such as the building of affordable housing units).

The three largest commitments were made by Kaiser Permanente ($760 million through eight distinct programs); the Johns Hopkins Health System ($162 million through four programs); and MetroHealth in Cleveland ($160 million through two programs). Exhibit 3 presents examples of investments in each sphere.

EXHIBIT 2

Characteristics of social determinants programs funded by health systems, January 1, 2017–November 30, 2019

Characteristics	No. of programs	Funds committed by hospitals or health systems (millions)
All programs	78	$2,485.2
In Medicaid expansion state[a]		
Yes	62	1,984.2
No	10	79.5
Both (programs in multiple states)	6	421.4
Focus area		
Housing	52	1,616.6
Employment	28	1,056.5
Food security	25	294.2
Education	14	476.4
Social and community context	13	253.1
Transportation	6	32.0
Region and state		
Midwest	23	358.3
IL	7	10.1
IN	1	100.0
MI	4	—[b]
MN	1	9.0
OH	9	239.2
Northeast	18	185.0
MA	6	24.5
ME	1	—[b]
NJ	5	3.0
NY	2	157.4
PA	4	500.2
South	12	232.0
MD	5	164.5
NC	2	12.0
SC	1	—[b]
TX	2	—[b]
VA	2	55.5
West	17	768.4
CA	11	746.7
CO	2	10.0
NM	1	0.7
OR	2	19.0
UT	1	12.0
Multiple states[c]	7	441.4

SOURCE Authors' analysis of information from public announcements and news articles. **NOTE** The total number of programs is larger than the total number of health systems because some health systems engage in multiple programs. [a]Under the Affordable Care Act. [b]Not available. [c]Includes programs in AK, CA (4), CO (2), DC, FL, GA, HI, IL, KY, MD (3), MT, NM, NY, OR (2), SC, TX, VA (3), WA, and WI.

Discussion

We found that in the past two years, health systems in the US have publicly committed approximately $2.5 billion toward directly addressing social determinants of health such as housing, food security, and job training. This figure is dwarfed by health systems' overall community benefit spending, which is estimated to be over $60 billion per year.[13] Nonetheless, it represents a substantial investment.

Historically, hospitals have tended to provide community benefit through uncompensated or subsidized care rather than through investment in activities not directly related to health. In one analysis of the $2.6 billion spent by all fifty-three North Carolina tax-exempt hospitals on community benefit, only 0.7 percent ($18.2 million) was spent on community investments such as affordable housing, economic development, and environmental improvements.[20] Nationally, spending on all kinds of community health improvement activities (most of which are directly related to health) is 5 percent or less of total community benefit spending.[13,14] Yet spending on community activities may be effective. For instance, although a recent study found no association between overall community benefit spending and readmission rates, hospitals in the top quintile of spending that was directed toward the community had significantly lower readmission rates than those in the bottom quintile.[21]

We found significant differences in characteristics between health systems that publicly announced making investments focused on social determinants and those that did not. The clear predominance of sectarian and other nonprofit institutions in making these investments and the absence of for-profit institutions suggest that health systems may be driven to invest in social determinants more by mission and values than by the potential for direct financial returns. However, the fact that investments are disproportionately being made by systems that are in Medicaid expansion states, in the BPCI Initiative, or in an ACO suggests that business-case considerations may also be playing a role. The complexity of making tangible commitments to improving social determinants of health is reflected in the fact that investing systems tend to be substantially larger and therefore potentially have more capacity than noninvesting systems.

Our results are consistent with national survey data, such as the data from a 2017 survey by the Deloitte Center for Health Solutions. In this survey of 300 hospitals and health systems, 88 percent reported screening patients for social needs (62 percent screened them systematically), but only 30 percent reported having a formal relationship with community-based providers for their entire target population.[22] The survey did not explore the extent to which health systems directly funded community programs. Compared to smaller hospitals and those that were for profit or independent, respectively, larger hospitals and those that were public or not for profit were more likely to screen patients for social needs—which is consistent with our finding that those are the hospitals that are also most likely to engage in direct community investment.

A key feature of this study was our ability to identify the specific social determinants that

EXHIBIT 3

Examples of health systems' investments in specific social determinants

Social determinant	Program name	Health system(s)	Description
Housing	Clark-Fulton neighborhood apartments	MetroHealth, Cleveland, OH	$60 million investment to build 250 affordable housing units with expanded green space and community programs such as an economic opportunity center
Transportation	Various	Nemours Children's Health System, DE; Boston Children's Hospital, Boston, MA; Mercy Health System, PA	Partnerships with Uber for subsidized or free transportation to doctor appointments
Food security	Food Farmacy	Lyndon B. Johnson Hospital (Harris Health System), Houston, TX	Aims to provide fruit and vegetables to patients and community members with limited access to grocery stores that stock fresh produce
Employment	HopkinsLocal and BLocal	Johns Hopkins, Baltimore, MD	$54 million spent on buying locally generated products; 1,017 city residents hired; $48.5 million spent on contracts with local, women-owned, or minority-owned design and construction firms
Education	Various youth social determinants programs	Kaiser Permanente, WA and CA	$20 million in funding for youth workforce development (apprenticeships) in Seattle, WA; community schools model and African American Male Achievement Program in Oakland, CA, schools; Youth of Color Workforce Development Pipeline for students in South Los Angeles, CA
Social and community context	Ebeid Neighborhood Promise (ENP)	Promedica, Toledo, OH	$50 million investment (approximately $11 million from Promedica) with focus on health, education, jobs, family stability, and social and educational services

SOURCE Authors' analysis of information from public announcements and news articles.

each program focused on. Prior studies have been able to quantify only overall community investment. By far the most popular focus area of the programs we identified was housing, which accounted for two-thirds of total investment. Housing is one social determinant in which investing has the most immediately apparent potential return, even though it is one of the determinants in which interventions are especially complex and costly. Housing investment also has face validity, and housing is a common pain point for health care professionals, who struggle with housing-insecure patients. These findings are consistent with those in the general literature.[12] In one systematic review of thirty-nine studies up to 2014 that addressed social determinants and measured health outcomes, the largest number of the studies (twelve) focused on housing, and ten of them reported benefits to health outcomes, costs, or both.[12] Several subsequent publications have also shown benefits from housing-focused interventions.[23–25]

In general, however, the evidence for health outcome improvements from interventions focused on social determinants is thin. A different systematic review of interventions related to social determinants that included sixty-seven articles published up to 2017 found that only 30 percent (twenty articles) reported health outcomes and 27 percent (eighteen) reported health care costs.[26] Furthermore, only 22 percent (fifteen) showed any benefit to health outcomes, 10 percent (seven) showed a reduction in emergency department visits or hospitalizations, and 7 percent (five) showed any benefit to health care costs. In fact, programs focused on multiple social determinants, food security, and legal interventions all had more articles showing positive impacts on outcomes, compared to those focused on housing. However, the quality of studies in most of the articles reviewed was poor. This is very little evidence on which to base billions in investment and may partially explain why investments to date have lagged. In the Deloitte survey, 48 percent of respondents reported that evidence for improved outcomes would increase their investments in social needs activities.[22]

Overall, we found that the increasing public interest in social determinants of health has been accompanied by health system investments in social determinants of at least $2.5 billion in the past two years, largely in housing. However, these investments still represent a small fraction of overall spending by health systems, which at present are much more likely to be developing screening and referral programs than directly investing in social determinants of health. ■

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COMMENTARY Health Care Reform

On Surprise Medical Bills, Congress Should Side With Consumers, Not Special Interests

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KEY TAKEAWAYS

Patients who try to follow insurance company rules sometimes can be hit with surprise bills through no fault of their own.

The solution to this problem is obvious: truth-in-advertising.

In seeking to ban surprise bills, Congress shouldn't takes sides between insurers and providers. Nor should it seek to split the difference between them.

If you're wondering why Congress still hasn't protected consumers from surprise medical bills, ask Rep. Lloyd Doggett, D-Texas.

"It's troubling that it's taking this long," Doggett, a senior member of the powerful House Ways and Means Committee, recently told Politico.

"But this can't be something that is 100 percent for the provider or 100 percent for the insurer. There has to be some middle ground found here."

Congress's failure to protect patients against a manifestly unfair practice has nothing to do with a partisan environment consumed by efforts to remove President Donald Trump from office.

Instead, as Doggett observed, it has to do with Congress' inability to appease rival interest groups—insurance companies and medical providers—who share blame for creating the problem.

To break the logjam, Congress should pursue a third way, one that would eliminate surprise bills by giving patients honest information before they receive care.

Patients who try to follow insurance company rules sometimes can be hit with surprise bills through no fault of their own. Insurers tell their customers that if they get care from a network doctor at a network hospital, their cost-sharing will be limited. Their insurance policies prevent network doctors and hospitals from charging them more than the rate their insurer allows. If they go out of network, they're out of luck. That's why most consumers seek out a network doctor to provide services at a network hospital or other facility.

What neither insurers nor hospitals tell patients is that they might also receive services from another doctor at that "network" hospital—a radiologist or anesthesiologist, for example—who is not part of their insurance company's network.

In other words, even if someone goes to the emergency room at a hospital in their insurance network, if the doctor on duty that night happens to be out-of-network, the patient could suddenly be faced with a bill that is thousands of dollars—and not covered by their insurance.

Weeks or months later, they will get a bill for the difference between what the non-network doctor charges and what their insurance company pays, a practice known as "balance billing."

Network doctors cannot balance bill patients. Non-network doctors can. And do. Balance bills can run into the tens of thousands, and even hundreds of thousands, of dollars.

The solution to this problem is obvious: truth-in-advertising. Congress should impose penalties on insurers that represent medical facilities—and medical facilities that represent themselves—as being in-network if doctors balance bill patients for services they provide at that facility.

Patients treated at network hospitals never should be balance billed, whether for scheduled or emergency care.

In other words, a hospital that advertises itself as being in network for insurer A, cannot allow a doctor who provides services there to balance bill a patient covered by insurer A. Ditto for insurer A. It cannot advertise a hospital as being in network if the hospital allows insurer A's customers to be balanced billed. Neither hospitals nor insurers should be permitted to give patients false and misleading information..

Unfortunately, this is not the approach Congress is considering.

Instead, it is pursuing a flawed and unsustainable search for an elusive "middle ground" between two powerful interest groups that offer competing and faulty solutions to the surprise billing problem.

Insurers and providers agree patients should not be balance-billed. But each interest group wants the federal government to impose a regime that best serves its financial interests.

Insurance companies want the government to force non-network doctors to accept network rates. Doctors want the government to appoint arbiters to decide how much insurers should pay non-network doctors.

Both approaches involve government rate-setting, a wrong-headed idea that would invite further government intervention in the private practice of medicine.

Insurers want the government to require doctors with whom the insurer does not have a contract to accept the rates that it pays doctors with whom it does have a contract. Government should not impose contract rates on non-contracting parties.

Doctors want to outsource rate-setting to government-certified arbiters. Arbitration—including baseball arbitration, to which this approach is falsely compared—is a process in which contracting parties agree to submit disputes to an arbiter and to bind themselves to the arbiter's ruling. The arbitration proposal on surprise billing is entirely different, because there is no contract between the doctor and the insurer.

Instead, government would bind non-contracting parties to a process to which neither has agreed, essentially franchising the rate-setting process to arbiters, who would set medical prices on an ad hoc basis.

Doctors support government-forced arbitration because they believe they will be paid more money. Insurers want government to compel non-network doctors to accept network rates because they believe they will pay doctors less.

Congress remains caught in the interest group crossfire, even as both sides continue to benefit from surprise bills at the expense of patients.

Instead of choosing between these bad ideas or, worse, finding some way to combine them, Congress should require hospitals and insurance companies to deal honestly with consumers. A hospital that grants privileges to doctors who balance bill patients cannot represent itself as a network hospital. Nor can an insurance company tell its customers that such a hospital is in-network.

That leaves the special case of emergency care at non-network hospitals—another circumstance in which patients can get hit with surprise bills. A patient with severe chest pains or one riding in the back of an ambulance can't shop for a network hospital. Congress can protect such patients by banning non-network hospitals from balance billing for emergency care. Federal regulations currently stipulate that insurers must pay such hospitals the greatest of the Medicare rate, the network rate or the out-of-network rate.

These changes, combined with greater price transparency, will both eliminate surprise bills and empower consumers to make better decisions about their medical care.

In seeking to ban surprise bills, Congress shouldn’t takes sides between insurers and providers. Nor should it seek to split the difference between them.

Congress should take the side of consumers.

This piece originally appeared in The Daily Signal

RAND EUROPE

RESEARCH BRIEF

How can policy and practice support an

Examining the potential of innovation to respond to healthcare challenges

In light of the challenges facing the NHS, RAND Europe and the University of Manchester were asked to conduct a study on the potential of innovation to help deliver an efficient and effective healthcare service. This independent research was funded by the National Institute for Health Research (NIHR) Policy Research Programme, in close collaboration with the Department of Health and Social Care, NHS England and the Office for Life Sciences.[1] The study examined four interrelated research questions:

1. How do organisations working in and closely with the NHS perceive and understand innovation, and how does this influence their actions?
2. Who drives and contributes to innovation and how might successful innovation have greater scale, scope and impact?
3. What practical changes to policy, culture and behaviour can support system-wide improvements in the healthcare innovation landscape?
4. How can we measure the contributions of innovation to the social and economic performance of the healthcare sector?

To help explore these issues and to enable a consideration of the structural, behavioural and cultural determinants of innovating health systems, this study adopted a systems approach to understanding healthcare innovation, and built

Methods

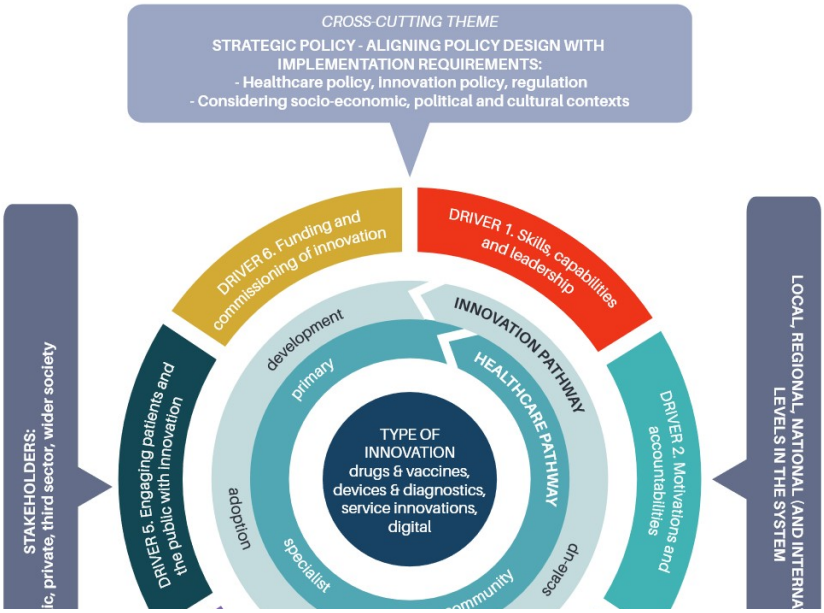
Over the course of the research (2015 – early 2019),[4] we conducted:

- In-depth key informant interviews with 197 individuals across the health innovation system.
- 13 workshops with 172 participants overall.
- A survey of 256 stakeholders across different stakeholder groups in the health system.
- 14 case vignettes of selected health innovations, including an additional 45 interviews with individuals involved with the development and/or adoption of the innovations (see page 11).
- A review of scholarly literature and policy-related documents.
- An analysis of indicators that could be used for evaluating the performance of an innovating healthcare system.
- An analysis of population-level factors associated with the uptake of innovative medicines.
- Continual engagement with policymakers and

The current health innovation landscape

The study's findings regarding the current health innovation landscape and its associated recommendations are organised around six drivers of innovation and two cross-cutting themes (see Figure 1).

Figure 1: A systems perspective on the innovating health system



Skills, capabilities and leadership

The current landscape

Diverse social and technical skills and leadership capabilities are needed to help create an environment in which innovation can be effectively managed and implemented. Essential social skills include leadership capabilities to manage risk and encourage an acceptance of innovation as part of the organisational culture in the health service; networking, brokerage and relational skills to create connected communities and to foster cooperation in innovation-related activities; and skills related to establishing a compelling business case for innovation.

Essential technical skills include the ability to assess and articulate problems and interpret innovation-related evidence; skills to implement innovations and innovation policies in organisations; economic analysis and evaluation skills that measure the performance of products, technologies and services in the real world over time and at the level of the health system (rather than in organisational silos); and intellectual property literacy.

Recommendations

providers should work together to establish programmes for the private sector on effective engagement with the NHS and on developing compelling business cases.

Innovation programmes

Historically, the health innovation system in England has emphasised the supply side of the innovation process (for example through the Clinical Entrepreneurs Training Programme; training and mentorship provided through enterprise and Innovation Hubs; Small Business Research Initiative (SBRI) health economics skills support; and others) somewhat more than the skills required for adoption, spread and scale-up on the demand side. Recent programmes such as the NHS Innovation Accelerator and the refreshed Academic Health Science Networks (AHSNs) are seeking to support a more balanced approach to building skills and capabilities for innovation and to help create a connected healthcare innovation pathway – from idea generation and development through to the adoption and spread of health innovations.

Individuals engage with the development and uptake of innovations for diverse reasons. These include personal beliefs about the value of innovation for improving healthcare quality and safety; leadership support for innovation (for example releasing time and funding for healthcare staff to incubate ideas and pursue innovation-related activities in collaboration with other stakeholders); organisational cultures that value innovation; and potential reputational, financial and career-related benefits for those involved. Many of these incentives and motivations seek to align individual interests with organisational objectives.

Recommendations

- Executive leadership, middle management and clinical leaders in healthcare provider organisations need to assume more responsibility for raising awareness and disseminating information about innovation, and to release time for staff to engage with innovation.
- Stronger monitoring of accountabilities is justified and can help tackle unwarranted variation (for example by requiring more compelling evidence and information on why proven innovations are not taken up in some contexts). Accountability for innovation should be embedded into national regulatory and improvement schemes. This does not mean mandating innovation (and, indeed, innovation

to inform their decisions. Current sources of information and evidence about specific health innovations, and about opportunities to engage with innovation initiatives, are multiple and diverse, but also fragmented. The communication and targeting of such information could be improved.

Decision makers in the NHS need information and evidence on: (i) the impact of innovation; (ii) the business case for investing in innovation; (iii) how to implement and support innovation; (iv) the potential associated decommissioning and de-implementation needs that accompany the introduction of innovations; (v) training needs; and (vi) innovation funding opportunities.

Private sector and clinical entrepreneurs need information on: (i) health system demand for specific types of innovation; (ii) funding schemes; (iii) points of contact in the NHS to engage with around innovation development, testing, evaluation, commercial negotiations and uptake; and (iv) which local, regional and national institutions they can contact for advice and help with making introductions to other healthcare system actors who can aid with the development or uptake of their products, technologies and service innovations.

Patients and the public need to be given opportunities to help identify innovation needs and be alerted to information sources on innovations they could access and benefit from.

Types of evidence and information sources

Examples of key sources include institutional websites (such as NICE guidelines and NHS England portals such as NHS Choices), AHSNs, Knowledge Transfer Networks, Innovation Hubs, quality improvement networks, conferences, trade shows, journals, and direct communication with peer and personal networks. Although improvements have been made in enhancing the information and evidence infrastructure on innovation and improvement-related data in recent years (for example through the Innovation Scorecard, Getting It Right First Time, NHS RightCare and NHS Choices), significant gaps in awareness of and access to user-friendly sources of information persist.

- Create a framework for evaluating innovations to inform adoption decisions, and establish clearly defined principles for good evaluation practice and clear evidence standards.
- Invest in consensus processes among regional and national stakeholders to identify priority innovation needs for the NHS so that innovators can respond to more stable and clear demand, at a time of finite resources.

multiple groups. However, there is scope for strengthening their capacity to better align activity at regional and national levels to support impact.

Strengthening the alignment between existing initiatives could also help prevent 'initiativitis' – in other words introducing initiatives that duplicate effort and risk wasting resources by 'reinventing the wheel' rather than developing a consistent rhythm of learning and improvement that builds on existing capacity. Although the health innovation system in England offers a range of formal and informal networks and networking opportunities, there was a perception among stakeholders that many organisations still operate in relative siloes.

Recommendations

- Improve the design of the innovating health system to align and better coordinate existing innovation-relevant initiatives, organisations and relationships. To achieve this, policymakers could work with wider stakeholders to:
  - Ensure that organisations and initiatives understand their roles and remits and the scale and timing of funding commitments they have access to.
  - Ensure that wider actors in the health system are more aware of the skills, capabilities and services on offer, as related to the remits of specific organisations.
  - Evaluate initiatives against progress and

Engaging patients and the public with innovation

The current landscape

The current landscape for patient and public involvement has evolved and recognises the value of the personal experience and knowledge of those using healthcare services. However, a coordinated strategy for patient and public involvement and engagement (PPIE) with innovation in the health system in England is yet to be developed.

PPIE happens through a broad range of activities, including identifying innovation needs; providing input into the design and testing of innovations; establishing educational activities and materials for patients about new products, technologies and services; supporting implementation of innovations in hospitals; participating in evaluations; and recruiting PPIE contributors. However, engaging patients and the public can be challenging, sometimes resulting in token involvement and variable practices. For PPIE to have value, it has to be meaningful in relation to the quality, relevance, efficiency and impact of the innovation effort.

Recommendations

- The innovating health system needs to create opportunities for PPIE across the entire to engage with innovation, and on available innovations and their impact).
- Ensure signposting and communication efforts make use of information sources that patients and the public consult (such as social media platforms, peer support groups and websites, charities, and NHS websites such as NHS Choices).

Principles for patient and public involvement and engagement (PPIE)

- A set of clearly defined principles and values should be co-developed with patients and the public to underpin a national strategy for PPIE with innovation, including:
- Ensuring that PPIE is meaningful and not a tick-box exercise.
- Embedding PPIE opportunities across the innovation

Funding and commissioning of innovation

The current landscape

A variety of funding schemes support innovation in the health system, but there is a need to improve the coordination, sustainability and stability of funding flows. A key risk in the current environment is that each funding mechanism addresses a specific need, but does not affect the wider innovation system (or potentially weakens that system by confusing decision makers and distracting from strategic goals).

Through their efforts to map the health innovation landscape, the Department of Health and Social Care, Office for Life Sciences and NHS England have identified a range of funding schemes supporting health and care innovation across six organisations. This could be a useful resource for helping those seeking to identify funding opportunities and could also inform efforts to establish a better coordinated and sustainable funding landscape. Further actions are needed to build on this development.

Recommendations

- Enhance collaborative working between government departments, public bodies and

Types of funding schemes

Historically, a greater number and variety of schemes have focused on innovation development funding than on funding for innovation adoption. Examples include Innovate UK and SBRI Healthcare funding; NIHR Invention for Innovation; NHS England funding, including for the Clinical Entrepreneurs Programme; various accelerator, catalyst and catapult funds; philanthropic funding; Health Foundation support; medical charity funds; private sector investments; and funding via various European programmes. More balanced funding is needed across the innovation process. Initiatives such as the Innovation and Technology Tariff (ITT), the Innovation and Technology Payment (ITP) and the NHS Innovation Accelerator programme are starting to address this issue.

- Enable an innovation portfolio strategy that balances short- and long-term considerations about upfront investments, short-term returns and longer-term cost and quality gains through a de-politicised structure (with cross-party and cross-departmental committees). Portfolio management techniques can support

performance or guaranteed market access and price-volume agreements, conditional reimbursement, and deferred payments).

Strategic policy: aligning policy design with implementation requirements and success criteria

The current landscape

Policies that appear sound and rooted in evidence may have limited uptake because they do not integrate implementation requirements into policy design or make their criteria for success explicit.

Recommendations

- When designing new policy interventions, assess how they relate to the existing policy infrastructure to avoid unnecessary duplication.
- Ensure that innovation, improvement and research policy bodies collaborate more closely to decide on the needs for and design of new policy initiatives.
- Identify areas where joint funding of innovation efforts can prevent piecemeal investments and support scale.
- Specify what financial and human resources will

Measuring success

The current landscape

Evaluating the innovation process and its outputs and impacts is essential for understanding the effect of innovation on the health service, patients and the economy, as well as for assessing where future policy efforts might need to focus their attention. Learning from sound measurement is also important for guiding efforts to improve how innovation is done in the health system. Commonly used indicators (such as research and development expenditure, patents, publications, Gross Domestic Product and new product sales) fail to capture the complexity and diversity of innovation processes, or to account for the diversity of factors that influence healthcare innovation pathways and their outcomes. Better metrics are needed to understand innovation impact.

Recommendations

- We propose four types of indicators to consider when measuring innovation performance: (i) indicators of the progression of an innovation across different stages of health innovation pathways; (ii) indicators of the adoption and diffusion of innovations through the healthcare

Conclusions

The innovation system supporting the NHS has been strengthened in recent years but more needs to be done to maximise the potential benefits. These actions should be based on four core principles.

First, **innovation strategies and policy should be rooted in a whole care-pathway approach**, rather than focused exclusively on solutions for only one part of the pathway (such as primary, acute or community care). This means identifying needs across care pathways and supporting the development and use of combinations of solutions (be they high- or low-tech products, technologies or service models) that can yield the required improvement in terms of quality and cost.

Second, **success requires balancing shorter-term, 'quick-win' actions with longer-term transformational interventions**.

Third, it is critical to **assess how new policies and interventions relate to the existing policy infrastructure** in order to avoid wasteful duplication, enable coordination and capitalise on existing capacity in the system.

Finally, transformative change in healthcare needs to target the structures and funding that support innovation as well as culture and behaviour. The **need for cultural and behavioural change is critical if innovating is to happen at scale and sustainably**. This means health innovation policy must simultaneously address the diverse and interdependent drivers of an innovating health system. Our study found that the effect of population-level factors (such as the prevalence of health conditions, or the age of the population) and features of clinical commissioning groups (such as CCG quality, net expenditure, financial performance, number of employees and CCG assurance ratings) on the uptake of innovation varies across different medicines. Our research indicates that it is system-level factors and types of drivers that seem to weigh particularly heavily on the likelihood for engaging with innovation and with uptake.

Policymaking has a crucial role to play in realising a vision for a health system where innovating contributes to the quality and efficiency of delivering care and to improved patient outcomes. But policymakers can neither make innovations nor spread them, nor is compliance with mandates guaranteed. A balanced and 'hybrid' model of governance and leadership for innovating in the health system – which supports both top-down and bottom-up actions – is already emerging and the possibility of a truly innovative health and care system is achievable. It is hoped that the research evidence and recommendations set out in this report can help deliver this.

Case vignettes of 14 innovations complemented the other research methods used in this study

HIGH-SENSITIVITY TROPONIN ASSAYS

Troponin is a diagnostic marker used to detect heart disorders. High-sensitivity troponin assays can detect smaller amounts of troponin in the blood than traditional procedures, and can therefore be used to identify heart disorders earlier than previously possible.

REMOTE CARDIAC MONITORING DEVICES

These are systems in patients' homes that monitor the performance of their cardiac devices, such as implantable cardioverter defibrillators, to make sure that they are working properly. The remote monitoring devices can also capture other information on the patient's health that may be relevant (such as changes to the heart rate or blood pressure). The devices send data to clinicians via the Internet, allowing them to monitor their patients from a distance, and to reduce the number of face-to-face consultations.

PROSTATIC URETHRAL LIFT (UroLift®)

Prostatic urethral lift is a minimally invasive surgical technique to treat benign prostatic hyperplasia (enlarged prostate). The technique involves introducing a device through the obstructed urethra to lift and hold the enlarged prostate tissue in order to clear the opening of the urethra, allowing urine to flow normally again and relieving patients' symptoms.

DRUG-ELUTING STENTS

Drug-eluting stents were developed to treat the effects of the arteries narrowing in the heart, which can occur after a balloon angioplasty to treat coronary heart disease. They work by opening the narrowed blood vessels to increase blood flow to the heart and also by releasing an anti-inflammatory agent.

KOOTH

MOODGYM

MoodGYM is a form of computerised CBT programme aimed at young people suffering mild to moderate anxiety or depression. The interactive online programme provides a range of CBT techniques to improve mental health.

NHS BLOOD DONOR CHAIR

A new and innovative NHS blood donor chair was developed in response to issues faced when using the previous version of the donor chair, including poor patient experience and process disruption due to fainting. The new chair reduces the risk of fainting, improves patient comfort and is also easier to transport and clean than the predecessor model.

CONTINUING HEALTHCARE CHECKLIST AND THE DECISION SUPPORT TOOLKIT (CHC2DST)

CHC2DST is software that enables electronic assessment of eligibility for NHS funding for continuing care for patients with complex and long-term health conditions. Assessments

SECURACATH

SecurAcath is a single-use device to secure and stabilise central venous catheters. In comparison to previous products, SecurAcath decreases accidental dislodgements during dressing changes in comparison to previous products, reduces the risk of skin injuries and is time-saving.

HEARTFLOW FFRCT ANALYSIS

HeartFlow FFRCT Analysis is a non-invasive coronary artery disease detection tool using regular computer scans to develop a 3D model of coronary arteries and determine the impact of artery blockages on blood flow. It helps assess the impact of blockages and prevents having invasive – and potentially unnecessary – tests.

ONE-STEP NUCLEIC ACID AMPLIFICATION (OSNA)

OSNA is a test to analyse whether breast cancer cells have spread to the sentinel lymph nodes (the lymph nodes a cancerous tumour is most likely to spread to first). The test is carried out during the removal of the tumour and takes up to

COMMENTARY Health Care Reform

Sacrificing Public and Private Health Insurance for "Medicare for All"

Jan 22nd, 2020 3 min read

Commentary By
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KEY TAKEAWAYS

Some House Democrats are co-sponsoring legislation to outlaw virtually all Americans' public and private health insurance and replace it with a new government plan.

Americans must fully grasp the necessary trade-offs—the sacrifices—they would have to make if Congress were to create and run such a massive program.

Congress can—and should—take a different approach

A majority of House Democrats are co-sponsoring legislation (H.R.1384) to outlaw virtually all Americans' public and private health insurance and replace their coverage with a new government plan. In the Senate, Sen. Bernie Sanders's "Medicare for All" bill (S. 1129) would accomplish the same objective.

Americans must fully grasp the necessary trade-offs—the sacrifices—they would have to make if Congress were to create and run such a massive program.

Medicare for All poses a very big question: Is the promise of universal health insurance under a new government health program worth the deliberate destruction of all other public, private and employer-based coverage?

In today's churning insurance markets, about 30 million American residents are uninsured. Examining the data, American Enterprise Institute analysts note that about 15 million Americans are already eligible for coverage under Medicaid, the Children's Health Insurance Program and the Affordable Care Act of 2010 (ACA, or Obamacare). Mysteriously, they do not enroll.

Almost 4 million are eligible for employer-sponsored insurance, but do not enroll. Several million (at least 4 million) are here illegally and thus ineligible for taxpayer-financed coverage. Another 2 million have annual incomes that exceed 400 percent of the federal poverty level ($103,000 for a family of four) and are ineligible for ACA insurance subsidies.

Finally, there are about 2.5 million uninsured who are poor Americans who live in states that didn't expand Medicaid. This is a problem that can be solved through targeted measures—without destroying all existing health coverage.

Then there's the cost. In the initial 10 years of implementing a Medicare for All program, the aggregate price tag could range between $54.6 trillion and $60.7 trillion, according to Charles Blahous, a former Medicare Trustee. Comprehensive econometric analyses, ranging from the Urban Institute to the Rand Corporation, also show that such a program would substantially increase total costs over current law.

Most Americans would also pay more for their health care than they do today. According to a recent Heritage Foundation analysis, financing such a program would require broad-based taxation equal to 21.2 percent of all wage and salary income, and reduce the disposable income of nearly two-thirds of American households (65.5 percent), making them financially worse off than they are today.

Another big trade-off would be a decline in the timely access to quality care. For example, the Sanders Medicare for All plan would cut medical provider rates by an estimated 40 percent below projected private reimbursement. Such a sharp reduction would inevitably mean increased waiting times, longer delays and denials of care.

Medicare today sets prices for more than 8,000 physicians' services and hundreds of hospital procedures in more than 3,000 U.S. counties. Government price fixing often results in medical goods or services being reimbursed at levels that are often too high or too low. In short, either beneficiaries or taxpayers are routinely shortchanged.

Congressional champions of Medicare for All legislation often insist that a new universal Medicare-like entitlement, compared to multi-payer private insurance, would centralize all provider payment and secure significant administrative cost savings.

Comparisons between Medicare and private insurance are often apples to oranges comparisons. For example, private firms tend to concentrate more heavily (and successfully) on such items as utilization review, quality measurement and fraud detection.Medicare does not concentrate as effectively in these areas, and though it records lower administrative costs, it also loses tens of billions of dollars annually (roughly 10 percent) in waste, fraud, abuse or "improper" payments.

These are real costs, but they are rarely counted as part of Medicare's administrative costs. The Government Accountability Office (GAO) has recorded more than $50 billion annually in waste, fraud or abuse. If today's Medicare is the model, taxpayers can expect those large annual losses to increase to scale with a universal program.

Public policy is not simply a matter of setting goals; it is also a process of making trade-offs, and Medicare for All has some very serious ones: The destruction of existing health insurance coverage, regardless of personal preferences; the abolition of alternatives to government care; higher personal and public health care costs; longer wait times and delays and denials of care; and, of course, a more thorough politicization of health care decision-making, courtesy of Congress and whatever presidential administration controls the levers of bureaucratic power.

Congress can—and should—take a different approach. It should enact policies that will give individuals and families much greater control over their health care dollars and decisions, and compel health insurers and medical professionals to compete and deliver high quality care at competitive prices.

This piece originally appeared in The Washington Times

Explaining Health Care Reform: Questions About Health Insurance Subsidies

Published: Jan 16, 2020

Health insurance can be expensive, and is therefore often out of reach for lower and moderate income families, particularly if they are not offered health benefits at work. To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, the Affordable Care Act (ACA) includes provisions to lower premiums and out-of-pocket costs for people with low and modest incomes.

This brief provides an overview of the financial assistance provided under the ACA for people purchasing coverage on their own through health insurance Marketplaces (also called exchanges).

Health Insurance Marketplace Subsidies

The ACA offers subsidies to reduce monthly premiums and out-of-pocket costs in an effort to expand access to affordable health insurance for moderate and low-income people – particularly those without access to affordable coverage through their employer, Medicaid, or Medicare. There are two types of subsidies available to marketplace enrollees. The first type of assistance, called the premium tax credit, works to reduce enrollees' monthly payments for insurance coverage. The second type of financial assistance, the cost-sharing subsidy, is designed to minimize enrollees' out-of-pocket costs when they go to the doctor or have a hospital stay. In order to receive either type of financial assistance, qualifying individuals and families must enroll in a plan offered through a health insurance Marketplace (https://www.healthcare.gov/health-plan-information/).

PREMIUM TAX CREDIT

The premium tax credit reduces marketplace enrollees' monthly payments for insurance plans purchased through the Marketplace. Health insurance plans offered through the Marketplace are standardized into four "metal" levels of coverage: bronze, silver, gold, and platinum. Bronze plans tend to have the lowest premiums but leave the enrollee subject to higher out-of-pocket costs when they receive health care services, while platinum plans tend to have the highest premiums but have very low out-of-pocket costs. The premium tax credit can be applied to any of these metal levels, but cannot be applied toward the purchase of catastrophic coverage. Catastrophic health plans (https://www.healthcare.gov/choose-a-plan/plans-categories/#catastrophic) typically have a lower monthly premium than other Qualified Health Plans in the Marketplace, but generally require beneficiaries to pay all of their medical costs until the deductible is met. To qualify for a catastrophic plan, an individual must either be under 30 years of age or eligible for a "hardship exemption."

Who is eligible for the premium tax credit?

In order to receive the premium tax credit for coverage starting in 2020, a marketplace enrollee must meet the following criteria:

- Have a household income from one to four times the Federal Poverty Level (FPL), which for the 2020 benefit year will be determined based on 2019 poverty guidelines (In 2020, the subsidy range in the continental U.S. is from $12,490 for an individual and $25,750 for a family of four at 100% FPL, to $49,960 for an individual and $103,000 for a family of four at 400% FPL.)
- Not have access to affordable coverage through an employer (including a family member's employer)
- Not eligible for coverage through Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other forms of public assistance
- Have U.S. citizenship or proof of legal residency (Lawfully present immigrants whose household income is below 100% FPL and are not otherwise eligible for Medicaid are eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.)
- If married, must file taxes jointly in order to qualify

For the purposes of the premium tax credit, household income is defined as the Modified Adjusted Gross Income (MAGI) of the taxpayer, spouse, and dependents. The MAGI calculation (http://laborcenter.berkeley.edu/modified-adjusted-gross-income-under-the-affordable-care-act/) includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security.

Table 1: Premium Subsidy Ranges, by Income in 2019 and 2020

Income % Poverty	Income Range in Dollars for the 2019 benefit year		Income Range in Dollars for the 2020 benefit year	
	Single Individual	Family of Four	Single Individual	Family of Four
Under 100%	Less than $12,140	Less than $25,100	Less than $12,490	Less than $25,750
100% – 133%	$12,140 – $16,146	$25,100 – $33,383	$12,490 – $16,612	$25,750 – $34,248
133% – 150%	$16,146 – $18,210	$33,383 – $37,650	$16,612 – $18,735	$34,248 – $38,625
150% – 200%	$18,210 – $24,280	$37,650 – $50,200	$18,735 – $24,980	$38,625 – $51,500
200% – 250%	$24,280 – $30,350	$50,200 – $62,750	$24,980 – $31,225	$51,500 – $64,375
250% – 300%	$30,350 – $36,420	$62,750 – $75,300	$31,225 – $37,470	$64,375 – $77,250
300% – 400%	$36,420 – $48,560	$75,300 – $100,400	$37,470 – $49,960	$77,250 – $103,000
Over 400%	More than $48,560	More than $100,400	More than $49,960	More than $103,000

NOTES: Alaska and Hawaii have different poverty guidelines. Note that tax credits for the 2020 benefit year are calculated using 2019 federal poverty guidelines, while tax credits for the 2019 benefit year are calculated using 2018 federal poverty guidelines.
SOURCE: KFF

Employer coverage is considered affordable if the employee's contribution is less than 9.78 percent (https://www.irs.gov/pub/irs-drop/rp-19-29.pdf) of his or her household income (for the employee's coverage only, not including the cost of adding family members). The employer's coverage must also meet the "minimum value" standard, meaning that the plan has an actuarial value of at least 60 percent (equivalent to a bronze plan). In situations in which the employer's plan fails to meet one or both of these requirements, the employee and their family may be eligible for subsidized coverage through the Marketplace if they meet the other criteria listed above.

In states that decide to expand Medicaid (http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/), tax credit eligibility effectively ranges from 138% to 400% of the poverty level (because almost all people with incomes below 138% of poverty are eligible for Medicaid and therefore are not eligible for subsidized Marketplace coverage). In states that do not decide to expand Medicaid (http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/), tax credit eligibility ranges from 100% to 400% of poverty. Residents of these states who have incomes below 100% of poverty and who do not qualify for Medicaid under their state's eligibility criteria (https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/) are not eligible for the premium tax credit. The Kaiser Family Foundation estimates that 2.3 million Americans

(https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/) living in states that did not decide to expand Medicaid fall into this coverage gap.

Table 2: Premium Cap, by Income in 2019 and 2020

Income % Poverty	Premium Cap Max % of income for 2nd lowest silver plan	
	2019	2020
Under 100%	No Cap	No Cap
100% – 133%	2.08%	2.06%
133% – 150%	3.11% – 4.15%	3.09% – 4.12%
150% – 200%	4.15% – 6.54%	4.12% – 6.49%
200% – 250%	6.54% – 8.36%	6.49% – 8.29%
250% – 300%	8.36% – 9.86%	8.29% – 9.78%
300% – 400%	9.86%	9.78%
Over 400%	No Cap	No Cap

NOTES: Alaska and Hawaii have different poverty guidelines. Note that tax credits for the 2020 benefit year are calculated using 2019 federal poverty guidelines, while tax credits for the 2019 benefit year are calculated using 2018 federal poverty guidelines.
SOURCE: KFF

The ACA includes stipulations to offer tax credits and Medicaid coverage to eligible lawfully present immigrants. Like U.S. citizens, lawfully present immigrants are eligible for subsidized coverage in the marketplaces if they meet their state's income eligibility rules. Lawfully present immigrants who meet the income eligibility rules for Medicaid in their state may be eligible for Medicaid, but, with the exception of pregnant women in certain states, are generally subject to a five-year waiting period before they can apply. Immigrants who would otherwise be eligible for Medicaid but have not yet completed their five-year waiting period may instead qualify for tax credits through the Marketplace. If an individual in this circumstance has an income below 100 percent of poverty, for the purposes of tax credit eligibility, his or her income will be treated as though it is equal to poverty (meaning that the enrollee would pay no more than 2.06% of income for a benchmark silver plan in 2020). Immigrants who are not lawfully present are ineligible to enroll in health insurance through the marketplace, receive tax credits through the marketplaces, or enroll in non-emergency Medicaid and CHIP.

What amount of premium tax credit is available to people?

The premium tax credit works by setting a cap on the amount an individual or family must spend on their monthly payments for health insurance if they enroll in a "benchmark" plan. The cap depends on the family's income, with lower-income families having a lower cap and higher income families having a higher cap (Table 2).

The "benchmark" for determining the amount of the subsidy is the second-lowest cost silver plan available to the individual or family through their state's Marketplace. If the cost of the enrollee's benchmark silver plan exceeds their premium cap, then the federal government will pay any amount over the cap. The amount of the tax credit, therefore, is equal to the difference between the individual or family's premium cap and the cost of the benchmark silver plan.

As noted above, the premium tax credit can then be applied toward any other plan sold through the Marketplace (with the exception of catastrophic coverage). The amount of the tax credit remains the same, so a person who chooses to purchase a plan that is more expensive than the benchmark plan will have to pay the difference in cost. Conversely, a person who chooses a less expensive plan, such as a bronze plan, may end up paying as little as zero dollars per month for the premium. An example shows how the premium tax credits would work for an individual during the 2020 benefit year.

Premium tax credits at 250% FPL in 2020

- Pat is 30 years old and estimates her 2020 income will be 250% of poverty (about $31,225 per year)
- Suppose the second-lowest cost silver plan available to Pat in the Marketplace is $500 per month
- Under the ACA, with an income of $31,225 per year, Pat would have a cap of 8.29% of income for the second-lowest cost silver plan
- This means that Pat would have to pay no more than $216 per month (8.29% of $31,225, divided by 12 months) to enroll in the second-lowest cost silver plan
- The tax credit available to Pat would therefore be $284 per month ($500 premium minus $216 cap)
- Pat can then apply this $284 per month discount toward the purchase of any bronze, silver, gold, or platinum Marketplace plan available

The premium tax credit cannot be applied to the portion of a person's premium that is for non-essential health benefits. For example, a plan may offer a dental or vision benefit that is not considered to be "essential" by the state or federal definition. In that case, the person would have to pay for a small portion of the premium without financial assistance. Similarly, if the person smokes cigarettes and is charged a higher premium for smoking, the premium tax credit is not applied to the portion of the premium that is the tobacco surcharge.

How will premium tax credit be provided?

To receive the premium tax credit, an individual or family must purchase insurance coverage through the Marketplace. When they apply for Marketplace coverage, enrollees will receive a subsidy determination, letting them know whether they are eligible for a premium tax credit and the amount they may receive. The person or family then has the option to receive the tax credit in advance, claim it later when they file their tax return, or some combination of the two options.

The advanced payment option allows consumers to receive their tax credit at the time of purchase and choose how much advance credit payments to apply toward their premiums each month. If the enrollee chooses the advanced payment option, then the IRS will pay insurers directly such that the cost of the premium is reduced upfront. With this option, the enrollee would need to reconcile their premium tax credit at tax time the following year. (For people receiving an advanced payment of the premium tax credit in 2020, the reconciliation would occur when they file their 2020 tax return in 2021). If the individual or family had a significant change in their income from the time they first applied for Marketplace coverage, they may be asked to repay some or all of the tax credit; or conversely, they may be owed an additional amount when they do their taxes. The table below indicates the maximum repayment limits for an individual and family, which varies depending on income level.

Table 3: Repayment Amounts under Current Law by Income Level for 2020

Income (% Federal Poverty Level)	Maximum repayment amount for a single individual	Maximum repayment amount for couples and families
Less than 200% FPL	$300	$600
200% – less than 300% FPL	$775	$1,550
300% – less than 400% FPL	$1,300	$2,600
400% FPL or greater	Full Amount	Full Amount

SOURCE: Internal Revenue Service

Alternatively, an individual or family can opt to pay their entire premium costs each month and wait to receive their tax credit until they file their annual income tax return the following year. The premium tax credit is available to qualifying enrollees regardless of whether they have federal income tax liability, although an individual is required to file a tax return for a given benefit year in order to receive financial assistance.

Cost-Sharing Subsidies

In addition to the premium tax credit, the second form of financial assistance available to Marketplace enrollees is a cost-sharing subsidy. Cost-sharing subsidies work by reducing a person or family's out-of-pocket cost when they use health care services, such as deductibles, copayments, and coinsurance.

Unlike the premium tax credit (which can be applied toward any metal level of coverage), cost-sharing subsidies can only be applied toward a silver plan. In essence, the cost-sharing subsidy increases the actuarial value (protectiveness) of a silver plan, in some cases making it similar to a gold or platinum plan.

Are cost-sharing subsidies still available for 2020?

Yes. Cost-sharing subsidies are still available for eligible Marketplace enrollees. Although the federal government will no longer be reimbursing insurers for these subsidies, insurers are required by law to provide reduced cost sharing for lower-income enrollees.

Who is eligible for the cost-sharing subsidy?

People who are eligible to receive a premium tax credit and have household incomes from 100% to 250% of poverty are eligible for cost-sharing subsidies. (The cost-sharing subsidies are available only to the lowest-income Marketplace enrollees who meet all of the other criteria for receiving the premium tax credit). Again, the eligible individual or family must purchase a silver level plan in order to receive the cost-sharing subsidy.

What amount of cost-sharing subsidies are available to people?

The ACA sets maximum out-of-pocket (OOP) spending limits, but otherwise does not specify the combination of deductibles, copayments, and coinsurance that plans must use to meet the actuarial value requirements. For example, one insurer may choose to have a relatively high deductible but low copayments for office visits and other services, while another may choose a lower deductible but higher copayments or coinsurance for each service.

Without the cost-sharing subsidy, the out-of-pocket maximum may be no more than $8,150 for an individual and $16,300 for two or more people in 2020. (This is the highest a plan may set the OOP max, but plans frequently come with a lower OOP max). With the cost-sharing reduction, the out-of-pocket maximum can be no higher than $2,700 to $6,500 for an individual, or $5,400 to $13,000 for a family in 2020, depending on income. The table below presents the reduced out-of-pocket maximums and increased actuarial values after cost-sharing subsidies are applied, within each income range.

Table 4: Maximum Annual Limitation on Cost-Sharing

Income (% Federal Poverty Level)	Actuarial Value of a silver plan	OOP Max for Individual/Family	
		2019	2020
Under 100%	70%	$7,900 / $15,800	$8,150 / $16,300
100% –150%	94%	$2,600 / $5,200	$2,700 / $5,400
150% – 200%	87%	$2,600 / $5,200	$2,700 / $5,400
200% – 250%	73%	$6,300 / $12,600	$6,500 / $13,000
Over 250%	70%	$7,900 / $15,800	$8,150 / $16,300

SOURCE: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020," *Federal Register* 83 FR 16930.

Typically, silver plans have an actuarial value of 70%, meaning that on average the plan pays 70% of the cost of covered benefits for a standard population of enrollees, with the remaining 30% of total costs being covered by the enrollees in the form of deductibles, copayments, and coinsurance. By lowering an individual or family's out-of-pocket costs, the cost-sharing subsidies increase the actuarial value of the silver plan (to 73, 87, or 94 percent depending on the enrollee's income).

How will cost-sharing subsidies be provided?

When enrolling in a silver plan, an eligible enrollee is placed into a plan that has the cost-sharing subsidy automatically applied. This means that the silver plan they choose will already have a lowered out-of-pocket maximum than the same plan would in the absence of a cost-sharing subsidy. Unlike the premium tax credit, there is no option for cost-sharing subsidies to be paid to the enrollee.

Conclusion

In combination, the premium tax credit and cost-sharing reductions require health plans offering coverage to lower-income people in the exchange to increase the actuarial value of the coverage of the plans that they receive, and to do so in a way that caps enrollee out-of-pocket liability within the specified levels.

Subsidies to make insurance more affordable and increase insurance coverage are a key element of the Affordable Care Act. Premium and cost-sharing subsidies of varying levels are available to individuals and families with low to moderate incomes, making coverage and care more affordable. These subsidies – which represent a substantial share of the federal cost of the ACA – provide assistance for low to moderate income families, enabling them to purchase coverage and gain better access to care.

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DATA BRIEF
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How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care

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The insurance coverage expansion ushered in by the Affordable Care Act (ACA) has significantly increased Americans' ability to get the health care they need since the law's main provisions went into effect in 2014. Research also indicates that the ACA narrowed racial and ethnic disparities in insurance coverage[1] — a key objective of the law, and one that enjoys substantial public support.[2]

In this brief, we examine how much the ACA also has reduced disparities in access to health care among black, Hispanic, and white adults. Using data from the federal American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) for the years 2013 to 2018, we review:

- differences in the share of black, Hispanic, and white adults who are uninsured (ages 19 to 64)
- differences in the share who went without care because of cost in the past 12 months (ages 18 to 64)
- differences in the share with a usual source of care (ages 18 to 64).

We examine the degree to which racial and ethnic differences have narrowed since the ACA went into effect, what differences exist between states that have expanded Medicaid and those that have not, and which policy options might further reduce disparities.

We hope these findings will help guide policymakers as they consider options for moving the nation closer to a more equitable, higher-performing health care system.

KEY HIGHLIGHTS

- The ACA's coverage expansions have led to historic reductions in racial disparities in access to health care since 2013, but progress has stalled and, in some cases, eroded since 2016.
- The gap between black and white adult uninsured rates dropped by 4.1 percentage points, while the difference between Hispanic and white uninsured rates fell 9.4 points.

The Commonwealth Fund

- Disparities narrowed in both states that expanded Medicaid eligibility and in those that did not. In expansion states, all three groups had better overall access to care than they did in nonexpansion states, and there were generally smaller differences between whites and the two minority groups.
- Five years after the ACA's implementation, black adults living in states that expanded Medicaid report coverage rates and access to care measures as good as or better than what white adults in nonexpansion states report.
- While black working-age adults have benefited significantly from Medicaid expansion, they disproportionately (46%) reside in the 15 states that haven't yet expanded their programs.

HOW WE CONDUCTED THIS STUDY

Indicators and Data Sources

- *Percent of uninsured adults ages 19–64:* U.S. Census Bureau, American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.
- *Percent of adults ages 18–64 who went without care because of cost during past year and Percent of adults ages 18–64 who had a usual source of care:* Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.
- *Demographics, adults ages 19–64:* American Community Survey Public Use Microdata Sample (ACS PUMS), 2018.

The ACS PUMS and BRFSS are large federal surveys used to track demographic and health characteristics of the U.S. population. The ACS samples approximately 3.5 million individuals each year, with annual response rates over 90 percent.[3] The Census Bureau makes approximately two-thirds of ACS response records available to researchers in the Public Use Microdata Sample. The Centers for Disease Control and Prevention conduct the BRFSS each year in partnership with implementing agencies in each state. The 2018 BRFSS had a response rate just under 50 percent, with approximately 437,500 completed responses; similar response rates were seen in previous years.[4]

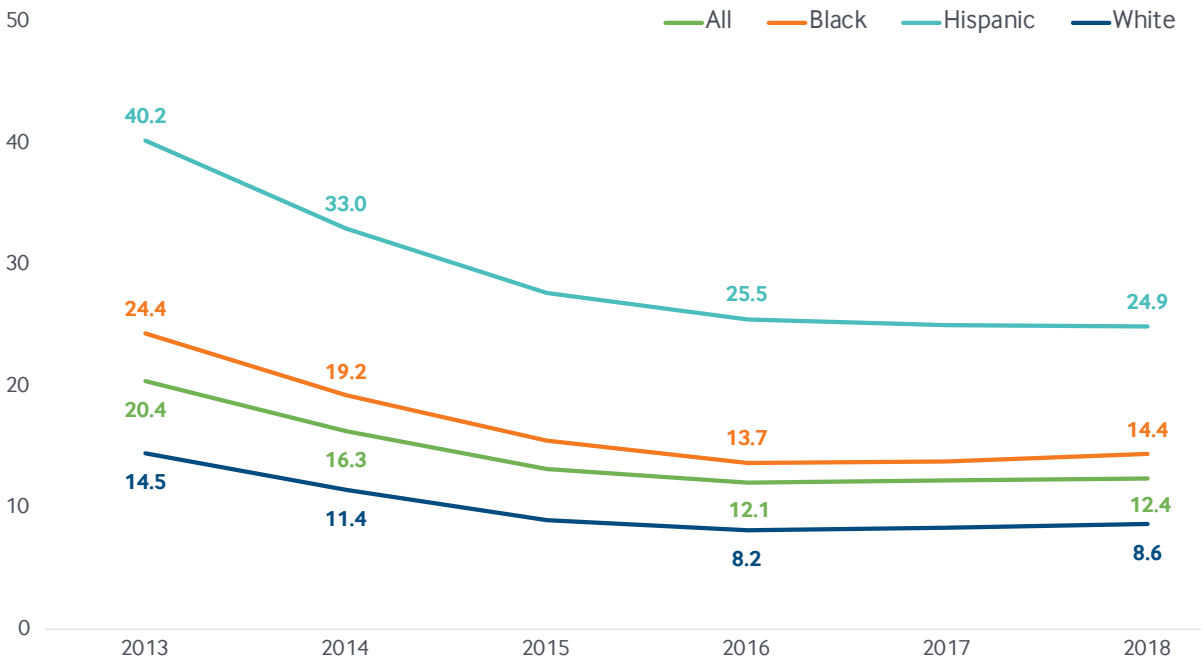
Analytical Approach

We stratified survey respondents by their self-reported race or ethnicity: white (non-Hispanic), black (non-Hispanic), or Hispanic (any race). We calculated national annual averages from 2013 to 2018 for each of the indicators listed above, stratified by race/ethnicity. We also calculated the average annual rate for white, black, and Hispanic individuals from 2013 to 2018 across two categories of states: the Medicaid expansion group included the 31 states that, along with the District of Columbia, had expanded their Medicaid programs under the ACA as of January 1, 2018; the nonexpansion group comprised the 19 states that had not expanded Medicaid as of that time (Maine and Virginia are considered nonexpansion states in this analysis because they both implemented their Medicaid expansions in 2019). Reported values for expansion/nonexpansion categories are averages across survey respondents, not averages of state rates.

In addition, for certain subpopulations in Louisiana and Georgia we calculated average annual state-specific uninsured rates from 2013 to 2018. Subpopulation rates based on small samples were suppressed. Estimates derived from ACS PUMS were suppressed if unweighted cell counts were less than 50; estimates derived from BRFSS were suppressed if the measures' unweighted cell count was less than 50 or the relative standard error (standard error divided by the estimate) was under 30 percent.

Adult uninsured rates have decreased for all groups since 2013, and disparities have narrowed significantly among whites, blacks, and Hispanics.

Percentage of uninsured adults ages 19 to 64, by race and ethnicity



Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

FINDINGS

Black, Hispanic, and white adults have all made historic insurance coverage gains under the ACA (Table 2).[5] According to the U.S. Census Bureau's American Community Survey, the U.S. working-age adult uninsured rate fell from 20.4 percent in 2013, just before the law's main provisions took effect, to 12.4 percent in 2018.[6] This improvement occurred between 2013 and 2016; since then, the rate has risen slightly.

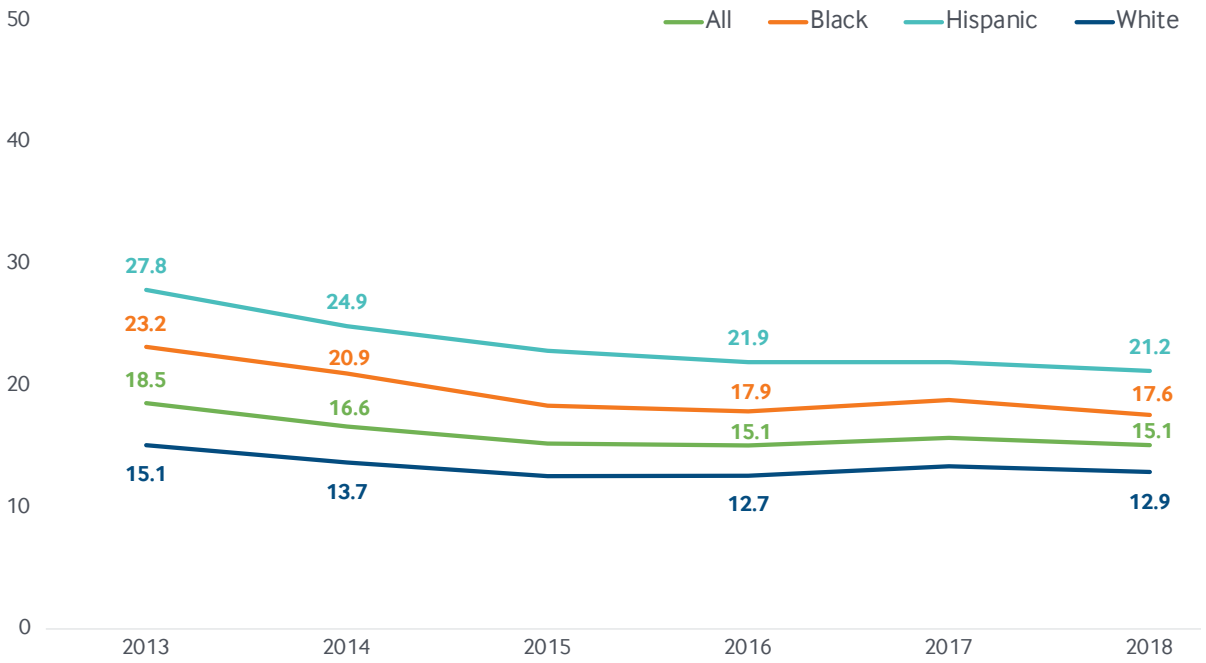
Blacks and Hispanics had the highest uninsured rates prior to the law's passage and have made the largest gains. The uninsured rate for black adults dropped from 24.4 percent in 2013 to 14.4 percent in 2018, while the rate for Hispanic adults decreased from 40.2 percent to 24.9 percent.

This progress reduced the difference between the two groups and white adults (Table 3). The black–white disparity in coverage dropped from 9.9 percentage points in 2013 to 5.8 points in 2018. The gap between uninsured Hispanics and whites, meanwhile, declined from 25.7 points to 16.3 points.

But the insurance gains made by blacks and Hispanics have stalled, and even eroded, since 2016 — much as they have for the overall population. Black adults have seen their uninsured rate tick up by 0.7 percentage points since 2016, while white adults have seen a half-percentage-point increase. This has largely halted the improvement in coverage disparities. Hispanic adults continue to report significantly higher uninsured rates than either white or black adults.

All groups are experiencing fewer financial barriers to accessing care, with black and Hispanic adults showing the largest reduction.

Percentage of adults ages 18 to 64 who avoided care because of cost in the past 12 months, by race and ethnicity



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

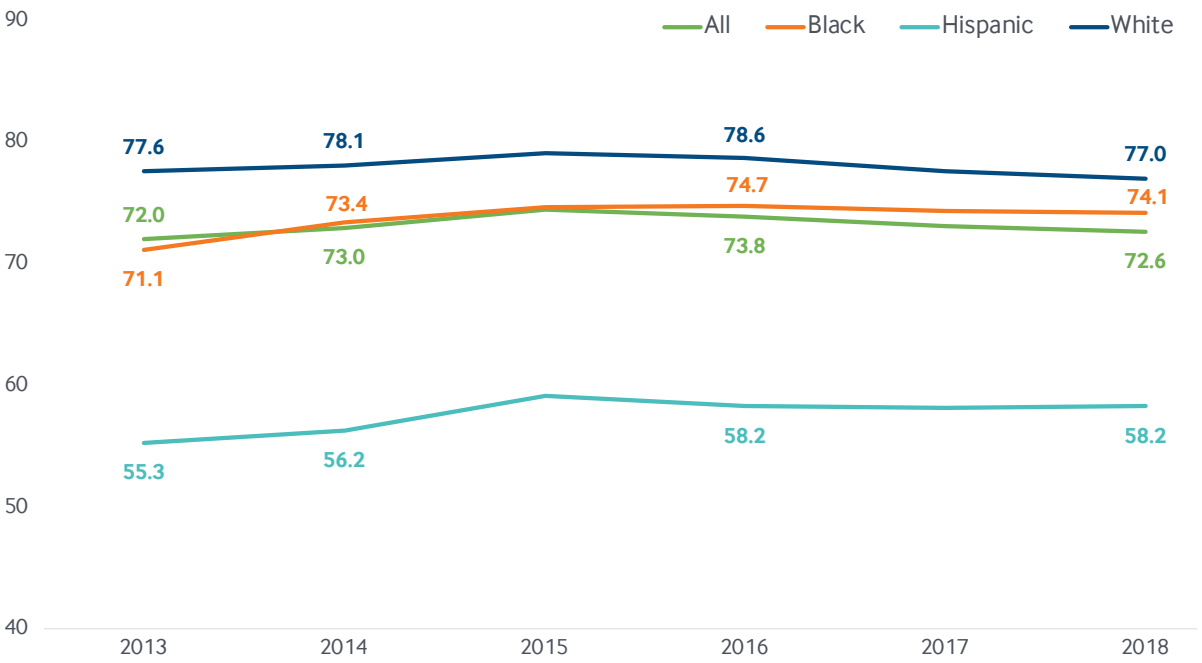
The coverage gains under the ACA made it easier for people to get health care.[7] Adults with low income have benefited the most from the law's insurance subsidies, out-of-pocket cost protections, and expansion in Medicaid eligibility.[8]

Black and Hispanic adults are almost twice as likely as white adults to have low income (less than 200% of the federal poverty level, or FPL) (Table 1) and, prior to 2013, they reported significantly higher rates of cost-related problems getting care. After the ACA's major coverage expansions in 2014, they experienced the largest overall improvements in access (Table 4). Twenty-three percent of black adults reported avoiding care because of cost in 2013, compared to 17.6 percent in 2018. Cost-related access problems among Hispanic adults fell from 27.8 percent to 21.2 percent, while those reported by whites dropped from 15.1 percent to 12.9 percent.

As a result, differences narrowed between white adults and black and Hispanic adults in cost-related access problems. The black–white disparity shrank from 8.1 percentage points in 2013 to 4.7 points in 2018, while the Hispanic–white difference fell from 12.7 points to 8.3 points (Table 3). Again, most of that improvement occurred between 2013 and 2016.

Adults with a usual source of care have modestly increased for black and Hispanic groups since 2013.

Percentage of adults ages 18 to 64 who reported a usual source of care, by race and ethnicity



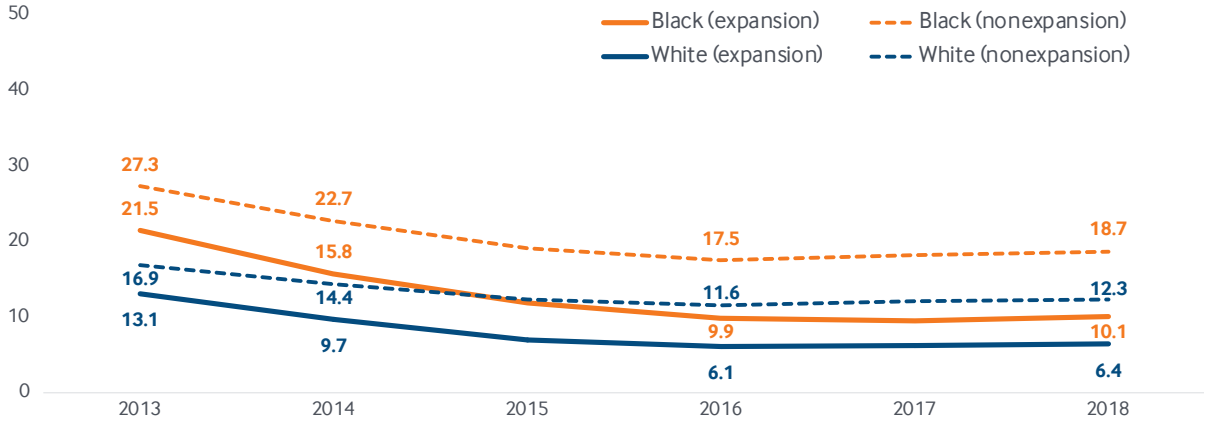
Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

Having a usual source of care — defined as a personal doctor or other health care provider like a health clinic where someone would usually go if they were sick — is generally seen as a strong indicator of health care access.[9] The share of black and Hispanic adults with a usual source of care climbed by about three percentage points between 2013 and 2018 (Table 4). This modestly reduced disparities with white adults, who continue to be the most likely to have a usual source of care among the three groups (Table 3).

The black–white disparity for reporting a usual source of care decreased from 6.5 percentage points in 2013 to 2.8 points in 2018, and the difference between Hispanics and whites dropped from 22.4 points to 18.7 points. The improvement on this measure stalled for blacks and Hispanics after 2015.

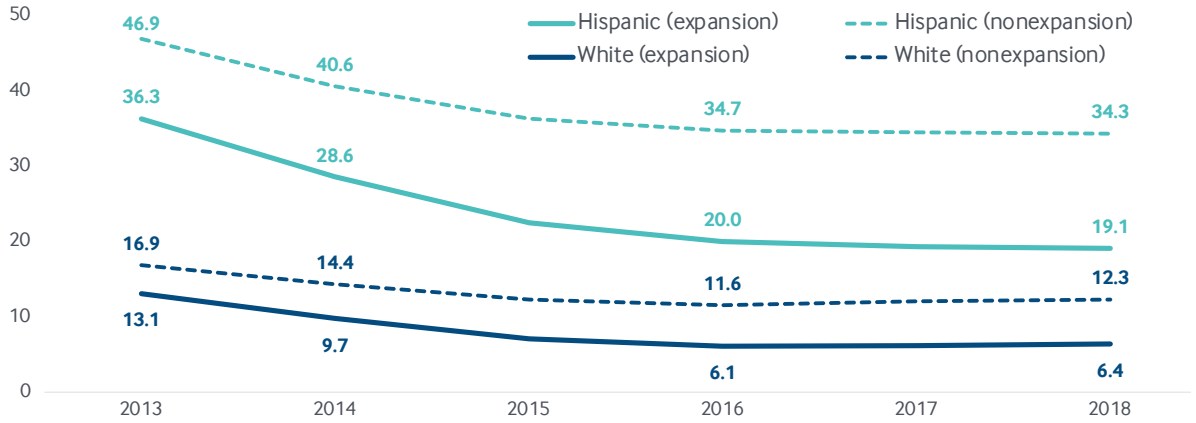
Black adults living in expansion states are now less likely to be uninsured than white adults in nonexpansion states.

Percentage of uninsured adults ages 19 to 64, race and ethnicity by Medicaid expansion status



Although Hispanic adults in both groups of states reported lower uninsured rates and reduced disparities, the gains were larger in Medicaid expansion states.

Percentage of uninsured adults ages 19 to 64, race and ethnicity by Medicaid expansion status



Note: Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

The ACA offered states the opportunity to expand eligibility for Medicaid, with the federal government picking up most of the additional cost. We examined all three of our health insurance and access measures for individuals across two categories of states — those that had expanded their Medicaid program under the ACA as of January 1, 2018, and those that had not. The 31 states that, along with the District of Columbia, had expanded their programs typically started from a stronger baseline and had smaller initial racial and ethnic disparities. This was likely because of state-specific factors, such as more generous pre-ACA Medicaid eligibility standards.[10]

Uninsured rates for blacks, Hispanics, and whites declined in both expansion and nonexpansion states between 2013 and 2018. In addition, disparities in coverage between whites and blacks and Hispanics also narrowed over that time period in both sets of states. But progress has stalled and even slightly eroded (Table 2, Table 3).

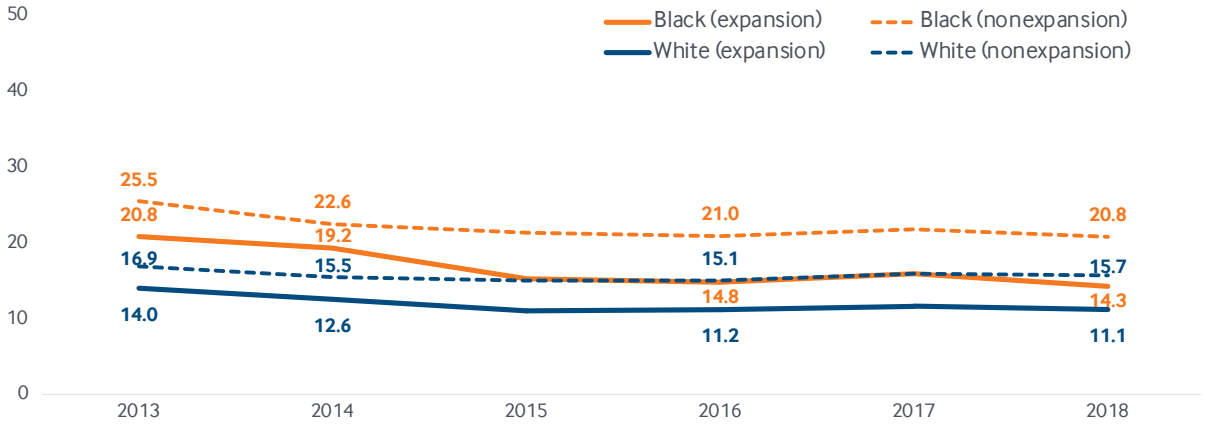
People living in Medicaid expansion states benefited the most in terms of coverage gains. All three groups reported lower uninsured rates in expansion states compared to nonexpansion states, and larger coverage improvements between 2013 and 2018.

Coverage disparities in expansion states narrowed the most over the period, even though the disparities were smaller to begin with. The black–white coverage gap in those states dropped from 8.4 percentage points to 3.7 points, while the difference between Hispanic and white uninsured rates fell from 23.2 points to 12.7 points.

Because of this progress, blacks in expansion states are now more likely to be insured than whites in nonexpansion states.

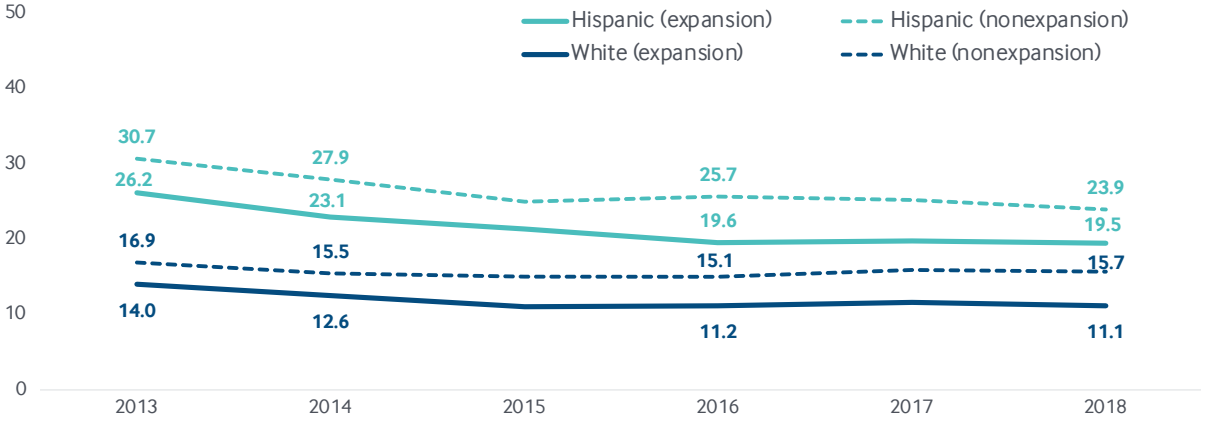
Black–white differences in cost-related access problems have narrowed in both expansion and nonexpansion states.

Percentage of adults ages 18 to 64 who avoided care because of cost in the past 12 months, race and ethnicity by Medicaid expansion status



The Hispanic–white disparity for avoiding care because of cost has dropped significantly in both expansion and nonexpansion states.

Percentage of adults ages 18 to 64 who avoided care because of cost in the past 12 months, race and ethnicity by Medicaid expansion status



Note: Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

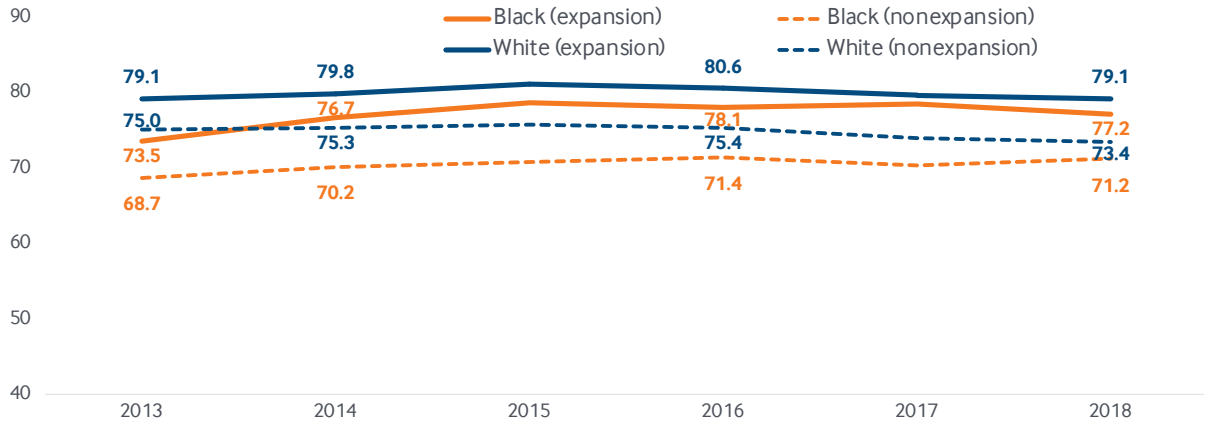
Since 2013, Hispanics, blacks, and whites in both expansion and nonexpansion states have become increasingly less likely to report that they went without health care because of cost in the past 12 months (Table 4). Disparities also have narrowed, resulting in more equitable access to care (Table 3).

Black adults in Medicaid expansion states experienced a larger reduction in cost-related access problems (6.6 percentage points) than those in nonexpansion states (4.7 points). Blacks in expansion states now report cost-related access problems at about the same rates as whites in nonexpansion states (Table 4).[11]

The gap between Hispanic and white adults reporting cost-related access problems narrowed in both expansion states (from 12.1 percentage points to 8.3 points) and nonexpansion states (from 13.8 points to 8.3 points). The larger decline in disparities in nonexpansion states was mainly because of a smaller improvement for whites in those states.

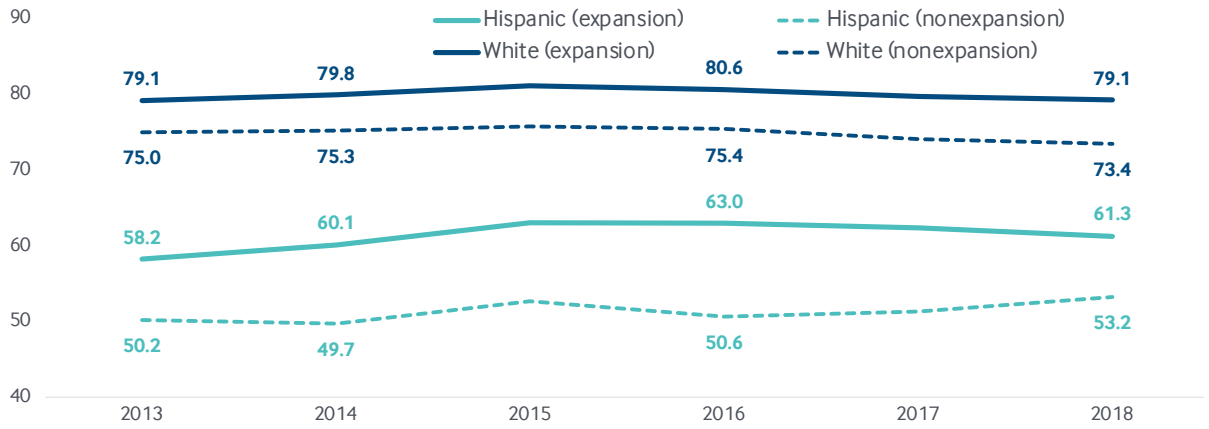
Black adults in expansion states are now almost as likely as white adults in those same states to have a usual source of care.

Percentage of adults ages 18 to 64 who reported a usual source of care, race and ethnicity by Medicaid expansion status



Hispanics in both expansion and nonexpansion states reported modestly higher rates for a usual source of care, while white adults largely maintained their higher rates.

Percentage of adults ages 18 to 64 who reported a usual source of care, race and ethnicity by Medicaid expansion status



Note: Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

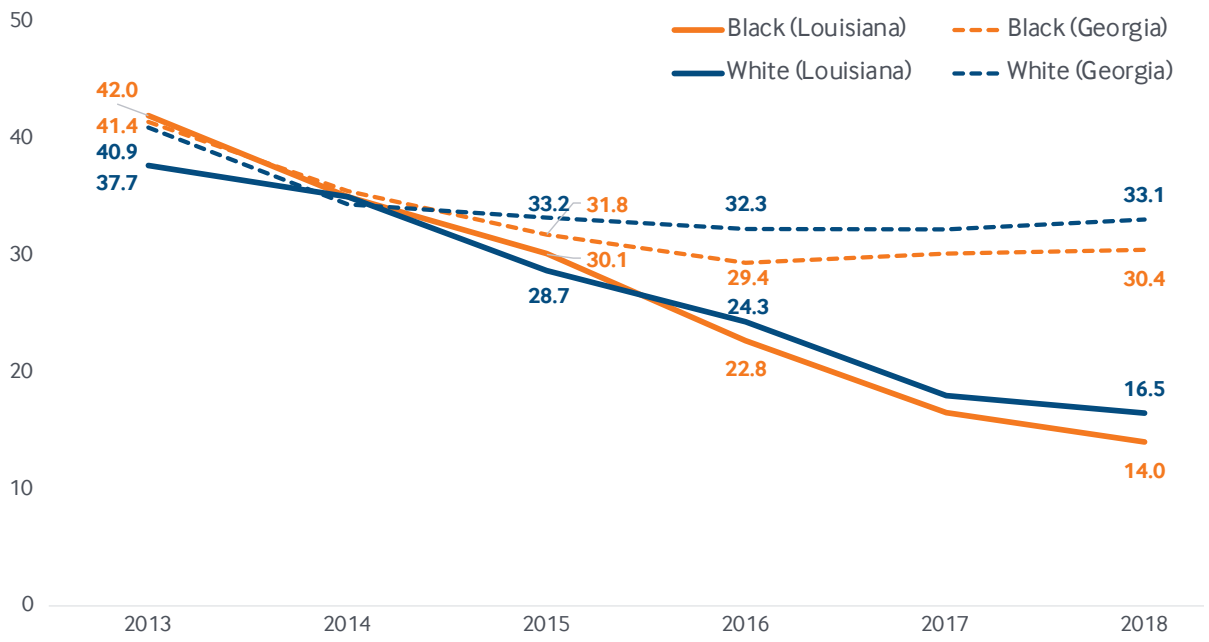
Regardless of whether they lived in a Medicaid expansion state or not, white adults did not report improvement in having a usual source of care between 2013 and 2018. Whites began the period at a comparatively higher baseline than blacks and Hispanics.

In contrast, blacks and Hispanics reported modest improvement in having a usual source of care, in both expansion and nonexpansion states (Table 4).[12] Black adults in expansion states improved the most, with 73.5 percent reporting a usual care provider in 2013 versus 77.2 percent in 2018. They are now more likely than white adults in nonexpansion states to have a usual source of care, and almost as likely as white adults in expansion states.

The gap between blacks and whites in having a usual source of care decreased in Medicaid expansion states (to 1.9 percentage points) and nonexpansion states (to 2.3 points). The difference between Hispanics and whites in expansion states dropped to 17.8 points, while in nonexpansion states it decreased to 20.2 points. Disparities actually decreased more in nonexpansion states, mainly because white adults in those states became slightly less likely to have a usual source of care during the 2013–2018 period (Table 3).

After expanding Medicaid, Louisiana's black–white insurance coverage disparity dropped rapidly in comparison to Georgia — driven largely by lower-income adults.

Percentage of uninsured adults ages 19 to 64, Louisiana and Georgia, 0–199% FPL, by race and ethnicity



Note: FPL = federal poverty level.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

Expanded Medicaid eligibility has been an important tool for improving racial equity in coverage and access to care. This is because blacks and Hispanics are disproportionately lower income.[13] But an estimated 46 percent of black working-age adults live in the 15 states that have not expanded Medicaid — a much larger share of people than the national average — along with 36 percent of Hispanics.[14] The majority of Medicaid nonexpansion states are in the South.

To illustrate the potential effects of further Medicaid expansion, we analyzed two Southern states with large black adult populations. Louisiana chose to expand Medicaid in 2016, while Georgia has yet to do so. As the exhibit shows, white and black adults with incomes under 200 percent of the federal poverty level (which is $24,980 for an individual and $51,500 for a family of four in 2020) experienced coverage gains from 2013 to 2015 in both states. But after Louisiana expanded Medicaid in July 2016, uninsured rates for both groups dropped an additional 12.2 points to 16.0 points. Georgia's uninsured rates, meanwhile, did not improve after 2016 (Table 5).

Because an estimated 54 percent of black working-age adults in Louisiana have low incomes (Table 1), Medicaid expansion helped drive the state's overall black adult uninsured rate down to 11.3 percent in 2018 (Table 5). This was lower than the rate for black adults (19.2%) and white adults (14.9%) in Georgia.

CONCLUSION

The ACA's coverage expansions have led to nationwide improvements in coverage and access to care. As our analysis and other recent studies show, the law also has led to historic reductions in racial disparities in coverage and access since 2014. This is true across most states, and especially those that have expanded Medicaid.

Still, nearly 10 years after the law's passage, notable gaps between people of color and whites remain across all regions and income levels.

Progress has also stalled for all three groups since 2016, and insurance coverage has slightly eroded for both black and white adults. That can be linked in part to congressional inaction: there has been no federal legislation since 2010 to enhance or reinforce the ACA. At the same time, recent legislation and executive actions have negatively affected Americans' coverage and access to care, including: the repeal of the individual mandate penalty for not having health insurance; substantial reductions in funding for outreach and enrollment assistance for people who may be eligible for marketplace or Medicaid coverage; and the loosening of restrictions on health plans that don't comply with the ACA's rules.

Hispanic adults also experience much larger disparities, in part because undocumented immigrants can't qualify for marketplace coverage, receive subsidies, or enroll in Medicaid.[15] These disparities could be exacerbated by the Trump administration's new "public charge" rule.[16]

Nevertheless, state and federal policymakers can take actions in the near term to further reduce the racial differences in health care access that persist:

- **Expand Medicaid without restriction in the remaining 15 states.** Medicaid expansion is a proven tool for reducing racial disparities, one that our data show benefits blacks and Hispanics the most. Yet expanded Medicaid eligibility is not available to nearly half of black adults and more than a third of Hispanics, causing an inordinately negative impact on these communities of color. If more states don't choose to expand Medicaid, further reductions in racial disparities may be difficult to attain.

  Our findings on the positive effects of expanding Medicaid also offer a window into the potential impact that current congressional reform bills and proposals could have on disparities. That includes not only "Medicare for all" approaches, but also reforms that seek to eliminate the Medicaid expansion gap and realize the ACA's original intent.[17] Alternatively, Republican proposals to end Medicaid expansion altogether would likely reverse the ACA's historic improvements in racial disparities in health care access.[18]

- **Make marketplace subsidies available to people with incomes under 100 percent of the poverty level or otherwise fill the Medicaid coverage gap.** With significantly lower incomes, black and Hispanic adults in nonexpansion states are at high risk of falling into a coverage gap in which their income is too high for existing Medicaid but not high enough to qualify for marketplace premium subsidies (100%–400% of poverty).[19]

- **Remove the income cap on marketplace subsidy eligibility.** Premium contributions for marketplace plans are capped at a certain percentage of income for people between 100 percent and 400 percent of poverty, with a maximum of 9.78 percent of income. Removing the upper income limit would provide relief to people who are currently spending more than this maximum share of their earnings on health insurance.[20]

- **Enact targeted, state-specific Medicaid expansions beyond the ACA.** For example, California recently expanded its Medicaid program to cover undocumented young adults.[21]

- **Allow undocumented immigrants to shop for coverage in the marketplaces.** This group is currently ineligible for coverage through the ACA insurance exchanges.

All the policies presented here can help make the U.S. health care system more equitable. But they will need to be accompanied by efforts to address drivers of racial inequities in health that extend beyond access to health insurance. Those include inequities in educational opportunity and income[22] and the fact that people of color are often perceived and treated differently by health care providers.[23] A recent survey of Americans' values with regard to health care shows that a majority do not believe that everyone in the U.S. receives equal treatment within the health system.[24] And an overwhelming majority believe that everyone should.

Table 1. U.S. Demographic Estimates, 2018 (base: adults ages 19–64)

	United States		Expansion states		Nonexpansion states		Louisiana		Georgia	
	Total (millions)	%	Total (millions)	%	Total (millions)	%	Total (thousands)	%	Total (thousands)	%
Total	193	100.0%	119	100.0%	74	100.0%	2,695	100.0%	6,245	100.0%
Race/Ethnicity										
White	116	60.1%	72	60.6%	44	59.1%	1,599	59.3%	3,257	52.2%
Black	24	12.5%	12	10.1%	12	16.3%	854	31.7%	1,993	31.9%
Hispanic	35	18.1%	22	18.2%	13	18.0%	134	5.0%	573	9.2%
Income										
0–199% FPL	53	27.5%	31	26.2%	22	29.6%	981	36.6%	1,823	29.5%
200%–399% FPL	56	29.2%	33	27.9%	23	31.2%	737	27.5%	1,855	30.0%
400%+ FPL	83	43.3%	54	45.9%	29	39.2%	959	35.8%	2,498	40.4%
Race/Ethnicity, by income										
White										
0–199% FPL	25	21.7%	15	20.8%	10	23.3%	423	26.6%	743	23.0%
200%–399% FPL	32	27.5%	19	26.2%	13	29.7%	445	28.0%	903	28.0%
400%+ FPL	58	50.8%	38	53.1%	20	47.0%	721	45.4%	1,581	49.0%
Black										
0–199% FPL	9	39.5%	5	38.7%	5	40.3%	454	53.6%	716	36.4%
200%–399% FPL	8	31.6%	4	29.7%	4	33.5%	223	26.4%	644	32.8%
400%+ FPL	7	28.9%	4	31.6%	3	26.1%	170	20.1%	607	30.9%
Hispanic										
0–199% FPL	14	38.9%	8	37.8%	5	40.6%	61	46.3%	249	43.8%
200%–399% FPL	12	34.7%	7	34.5%	5	35.0%	38	28.4%	194	34.2%
400%+ FPL	9	26.4%	6	27.7%	3	24.4%	33	25.2%	125	22.1%

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

FPL = federal poverty level.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2018.

Table 2. Uninsured Rates by Demographics, 2013–2018 (base: adults ages 19–64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)
Total	20.4	12.1	12.2	12.4	–8.0	18.4	9.2	9.1	9.2	–9.1	23.9	16.8	17.3	17.6	–6.3
Race/Ethnicity															
White	14.5	8.2	8.4	8.6	–5.9	13.1	6.1	6.2	6.4	–6.7	16.9	11.6	12.1	12.3	–4.5
Black	24.4	13.7	13.9	14.4	–9.9	21.5	9.9	9.5	10.1	–11.4	27.3	17.5	18.3	18.7	–8.6
Hispanic	40.2	25.5	25.1	24.9	–15.3	36.3	20.0	19.3	19.1	–17.2	46.9	34.7	34.5	34.3	–12.6
Income															
0–199% FPL	37.9	23.1	23.1	23.2	–14.7	34.6	17.1	16.6	16.6	–18.0	42.8	31.8	32.2	32.4	–10.4
200%–399% FPL	20.0	12.9	13.4	13.9	–6.1	18.9	10.8	10.9	11.3	–7.7	21.7	15.9	16.9	17.7	–4.0
400%+ FPL	6.7	4.1	4.5	4.8	–1.9	6.3	3.4	3.6	3.9	–2.4	7.7	5.4	6.1	6.6	–1.1
Race/Ethnicity, by income															
0–199% FPL															
White	31.2	17.5	17.8	18.0	–13.2	28.7	12.4	12.3	12.5	–16.1	35.0	25.1	25.8	25.9	–9.0
Black	34.4	20.3	20.5	20.8	–13.6	30.1	13.7	13.1	13.6	–16.5	38.5	26.7	27.5	27.7	–10.8
Hispanic	54.0	36.7	36.1	36.0	–18.0	48.5	28.1	27.3	26.9	–21.6	63.0	50.2	49.6	49.6	–13.4
200%–399% FPL															
White	15.3	9.6	10.2	10.6	–4.7	14.5	8.0	8.3	8.5	–6.0	16.5	12.0	12.9	13.5	–3.0
Black	20.5	11.9	12.3	13.3	–7.2	19.3	10.0	9.6	10.3	–9.0	21.6	13.7	14.7	15.9	–5.7
Hispanic	35.5	23.2	23.1	23.7	–11.8	32.7	19.1	18.6	19.1	–13.6	40.4	30.0	30.5	31.0	–9.3
400%+ FPL															
White	5.2	3.1	3.4	3.7	–1.5	4.8	2.6	2.8	3.0	–1.9	6.0	4.2	4.6	5.0	–1.0
Black	10.2	5.6	6.1	7.1	–3.2	9.8	4.7	4.9	5.6	–4.2	10.8	6.8	7.6	8.9	–2.0
Hispanic	15.0	9.5	10.4	10.7	–4.3	13.9	8.0	8.4	8.7	–5.1	17.0	12.1	14.1	14.1	–2.9

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Net change is percentage-point change between 2013 and 2018.

FPL = federal poverty level.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

Table 3. Trends in Black–White and Hispanic–White Disparities in Insurance Coverage and Access, 2013–2018

	Black–White disparity (percentage points)			Hispanic–White disparity (percentage points)		
	2013	2018	Net change (% points)	2013	2018	Net change (% points)
Uninsured rates (base: adults ages 19–64)*						
U.S. average	9.9	5.8	–4.1	25.7	16.3	–9.4
Expansion states	8.4	3.7	–4.7	23.2	12.7	–10.5
Nonexpansion states	10.4	6.4	–4.0	30.0	22.0	–8.0
Care avoided because of cost (base: adults ages 18–64)**						
U.S. average	8.1	4.7	–3.4	12.7	8.3	–4.4
Expansion states	6.8	3.1	–3.7	12.1	8.3	–3.8
Nonexpansion states	8.6	5.2	–3.5	13.8	8.3	–5.5
Usual source of care (base: adults ages 18–64)**						
U.S. average	6.5	2.8	–3.7	22.4	18.7	–3.6
Expansion states	5.6	1.9	–3.7	20.9	17.8	–3.1
Nonexpansion states	6.3	2.3	–4.1	24.8	20.2	–4.6

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

DATA

* American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

** Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

Table 4. Rates for Access Indicators by Race/Ethnicity, 2013–2018 (base: adults ages 18–64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)
Care Avoided Because of Cost in Previous 12 Months															
Total	18.5	15.1	15.7	15.1	–3.4	17.0	13.3	13.7	13.2	–3.9	21.0	18.1	18.9	18.2	–2.8
Race/Ethnicity															
White	15.1	12.7	13.3	12.9	–2.2	14.0	11.2	11.6	11.1	–2.9	16.9	15.1	16.0	15.7	–1.3
Black	23.2	17.9	18.8	17.6	–5.6	20.8	14.8	15.9	14.3	–6.6	25.5	21.0	21.7	20.8	–4.7
Hispanic	27.8	21.9	21.9	21.2	–6.7	26.2	19.6	19.7	19.5	–6.7	30.7	25.7	25.3	23.9	–6.7
Usual Source of Care															
Total	72.0	73.8	73.1	72.6	0.6	73.9	76.4	75.7	75.0	1.0	68.9	69.6	68.9	68.8	0.0
Race/Ethnicity															
White	77.6	78.6	77.5	77.0	–0.6	79.1	80.6	79.6	79.1	0.0	75.0	75.4	74.1	73.4	–1.6
Black	71.1	74.7	74.4	74.1	3.0	73.5	78.1	78.6	77.2	3.7	68.7	71.4	70.3	71.2	2.5
Hispanic	55.3	58.2	58.1	58.2	3.0	58.2	63.0	62.4	61.3	3.1	50.2	50.6	51.3	53.2	3.0

NOTES

Expansion states are those that expanded Medicaid by January 1, 2018. As of that date, there were 19 states that had not yet expanded Medicaid. Maine and Virginia implemented Medicaid expansion in 2019 and are considered nonexpansion for this analysis.

Net change is percentage-point change between 2013 and 2018.

DATA

Behavioral Risk Factor Surveillance System (BRFSS), 2013–2018.

Table 5. Louisiana/Georgia Uninsured Rates by Demographics, 2013–2018 (base: adults ages 19–64)

	Louisiana					Georgia				
	2013	2016	2017	2018	Net change (% points)	2013	2016	2017	2018	Net change (% points)
Total	24.7	15.4	12.5	11.8	–12.9	26.0	18.1	18.7	19.1	–6.9
Race/Ethnicity										
White	18.9	11.8	9.7	9.5	–9.4	19.1	13.9	14.1	14.9	–4.2
Black	31.3	17.3	13.0	11.3	–19.9	28.4	18.0	19.0	19.2	–9.2
Hispanic	52.7	43.8	38.0	39.6	–13.2	60.1	46.8	45.3	45.5	–14.6
Income										
0–199% FPL	41.8	25.9	19.7	17.8	–24.0	46.3	35.0	35.5	35.9	–10.4
200%–399% FPL	21.3	14.4	11.9	11.6	–9.7	21.9	16.4	17.6	18.8	–3.1
400%+ FPL	9.7	5.5	5.5	5.9	–3.8	8.1	5.6	6.5	7.3	–0.8
Race/Ethnicity, by income										
0–199% FPL										
White	37.7	24.3	18.0	16.5	–21.2	40.9	32.3	32.2	33.1	–7.9
Black	42.0	22.8	16.6	14.0	–27.9	41.4	29.4	30.1	30.4	–11.0
Hispanic	70.7	58.5	51.8	54.0	–16.7	75.5	62.6	62.7	63.4	–12.1
200%–399% FPL										
White	19.0	12.0	10.6	10.9	–8.1	17.9	13.7	14.9	16.4	–1.5
Black	22.5	14.3	10.3	8.7	–13.8	21.0	14.1	14.9	16.4	–4.6
Hispanic	45.3	38.4	33.6	34.8	–10.5	50.0	40.4	38.9	40.7	–9.3
400%+ FPL										
White	7.4	4.5	4.2	4.6	–2.7	5.9	4.5	5.1	5.7	–0.3
Black	14.6	6.4	7.5	8.0	–6.6	12.4	6.5	7.9	9.3	–3.0
Hispanic	31.4	20.0	20.3	20.4	–11.0	21.3	16.2	17.1	18.6	–2.6

NOTES

Net change is percentage-point change between 2013 and 2018.

FPL = federal poverty level.

DATA

American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2018.

NOTES

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The Commonwealth Fund

Affordable, quality health care. For everyone.

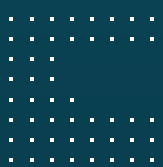
About the Commonwealth Fund
The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

U.S. Health Reform—Monitoring and Impact

Marketplace Premiums and Insurer Participation: 2017 – 2020

January 2020

By John Holahan, Erik Wengle, and Caroline Elmendorf



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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

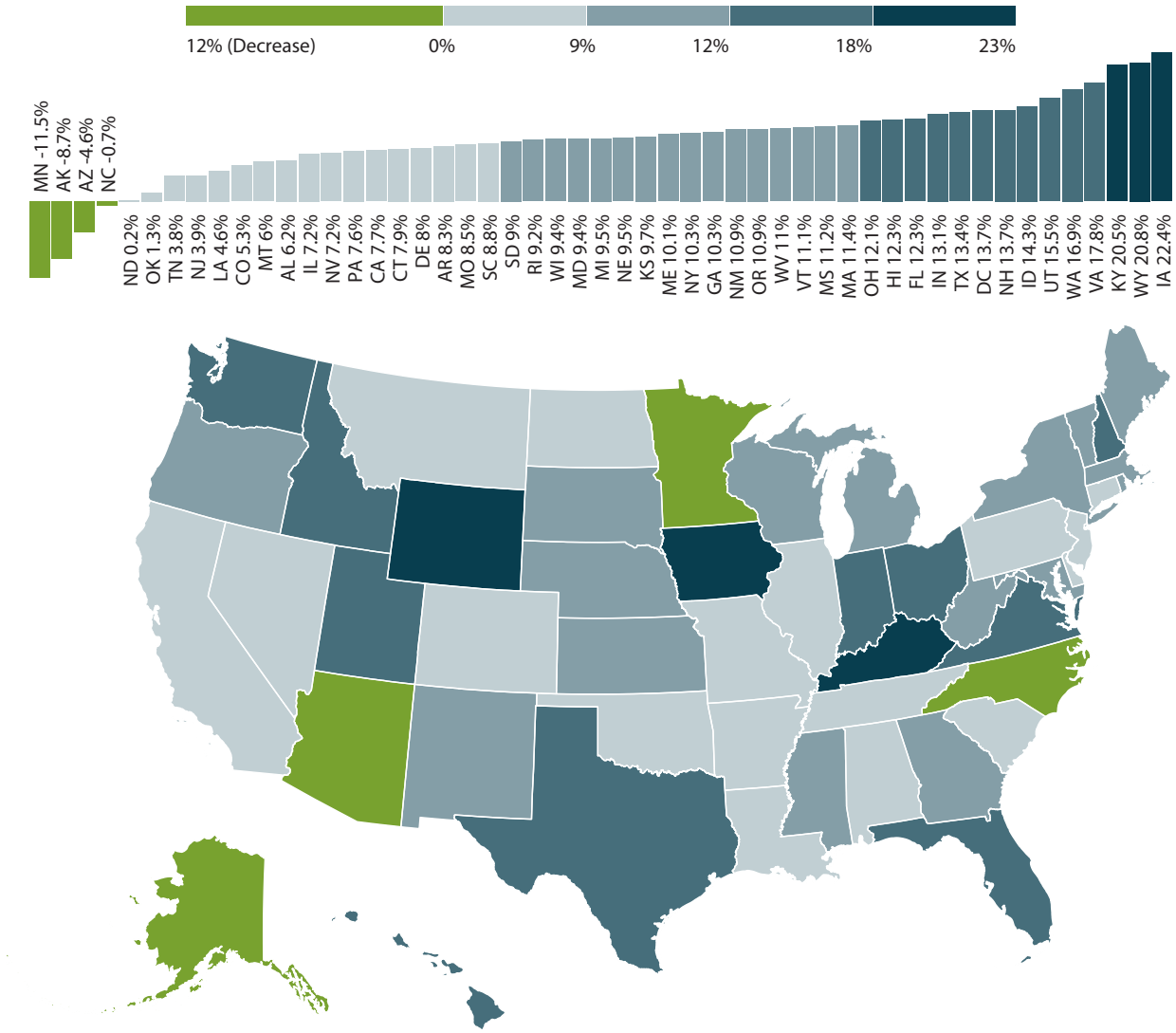
EXECUTIVE SUMMARY

In 2018 and 2019, the Affordable Care Act's (ACA) marketplaces experienced considerable turmoil that resulted in huge swings in premiums. The first major change resulted from the administration's decision (announced October 2017) to stop directly reimbursing insurers for cost-sharing reductions. Because the ACA requires marketplace insurers to reduce out-of-pocket costs for people with incomes below 250 percent of the federal poverty level, insurers increased premiums (typically silver marketplace premiums[1]) to cover these costs beginning in the 2018 plan year. In addition, beginning in early 2017, there was widespread fear that the administration would not enforce the individual mandate, thus threatening the risk pool and forcing insurers to increase premiums to cover the additional risk. This turmoil led to concerns about the marketplaces' stability and long-term viability. Congress endeavored to pass various pieces of legislation that would repeal the ACA and replace it with alternatives that would reduce and alter insurance market regulation. Though none of these bills were passed, they created immense uncertainty for insurers while they determined and filed premiums for the 2018 plan year.

For these reasons, the lowest silver marketplace premium offered in each rating region increased sharply in 2018, by 29.7 percent on average.[2] Twenty-eight states had average lowest silver premium increases that exceeded 29 percent. By the end of 2017, Congress passed, and the president signed into law, tax legislation that eliminated the individual mandate penalties beginning in 2019.[3] However, when insurers set their nongroup market premiums for the 2019 plan year, it became clear that many of them had overreacted to the tumult and uncertainty surrounding the 2018 plan year. Consequently, increases for the lowest silver premiums in 2019 averaged -0.4 percent nationwide, and in many states premiums decreased. This year, as a sign of continuing stability, premiums have fallen across all states by an average of 3.5 percent, with 31 states having lower premiums today than in 2019.

In this paper, we show the changes in average lowest silver premiums from 2017 to 2020 by state and in the lowest silver premiums offered by each insurer in selected markets (Figure ES.1). As in previous years, premium changes across states varied considerably in all plan years. The markets we examine also saw considerable insurer entries and exits. In 2018, many more insurers exited than entered the marketplaces, but this reversed in 2019. Even with increased insurer participation, by 2019, most markets had fewer marketplace insurers than they had a few years prior; in 2017, the national average number of insurers per region was 3.7, compared with 3.3 in 2019. During this period, the large national commercial insurers (e.g., Humana, Cigna, and Anthem) continued to leave the markets they had been in since the early years of the ACA. UnitedHealthcare and Aetna had left most markets before our study period. Medicaid managed care organizations (that had offered coverage through Medicaid programs before 2014 but had not sold insurance on the private markets until then) frequently offered the lowest-premium plans, and they have begun entering markets with a sole dominant insurer, often a Blue Cross Blue Shield affiliate. The trend of increased participation has continued in 2020, with insurers, particularly Bright Health and Oscar, entering new markets; the average number of insurers participating per rating region is now 3.9. The 2019 and 2020 increase in insurer participation suggests many insurers now believe these markets are stable, functional, and potentially profitable.

Figure ES.1. Average Annual Change in Lowest-Cost Silver Plan Premium, 2017–20

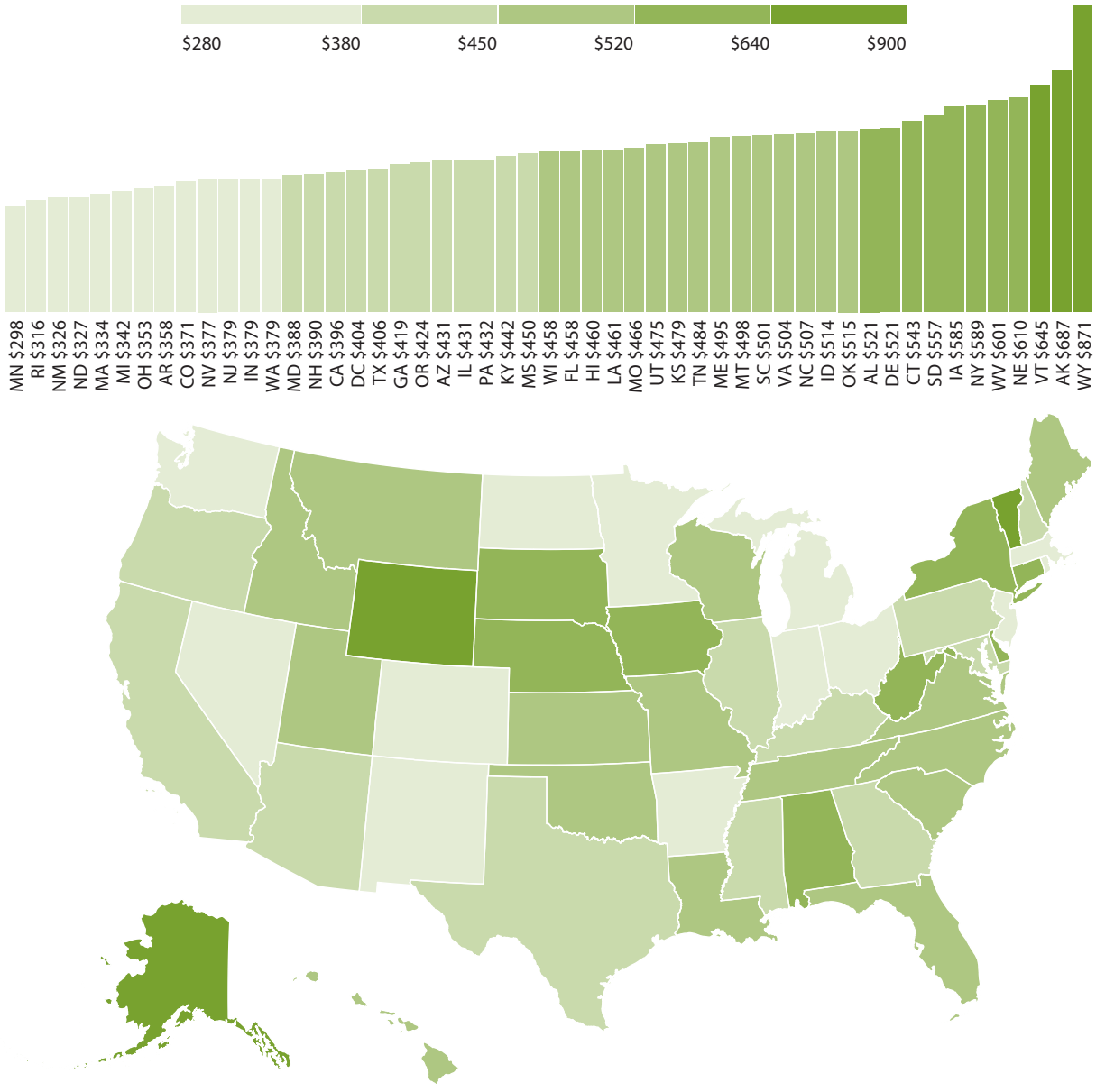


Source: Healthcare.gov and relevant state-based marketplace websites.

Note: Changes are calculated based on premiums for 40-year-old non-smokers.

Premium levels still vary considerably across states. The national average lowest silver marketplace premium for single coverage is currently $426 per month (Figure ES.2). Still, six states (Alaska, Iowa, Nebraska, South Dakota, West Virginia, and Wyoming) had average lowest silver premiums exceeding $550 per month, and eight states (Arkansas, Massachusetts, Michigan, Minnesota, New Mexico, North Dakota, Ohio, and Rhode Island) had average lowest-cost premiums below $360 per month. In states with higher silver premiums, one insurer typically dominates the marketplace, preventing competition; New York and Vermont had average lowest silver premiums exceeding $550, but this was because of community rating, meaning its premiums for a 40-year-old are not comparable with those of other states.[4] States with lower silver premiums generally have robust competition among several insurers, including a competing Medicaid insurer.

Figure ES.2. State Average Lowest-Cost Silver Plan Premium, 2020



Source: Healthcare.gov and relevant state-based marketplace websites.

Note: Premiums displayed are for 40-year-old non-smokers.

INTRODUCTION

Following uncertainty and regulatory changes in 2017, Affordable Care Act (ACA) marketplace premiums jumped in 2018, accompanied by a net exit of insurers. Some observers expressed concern that 2018 premium increases would begin a slow decline of the marketplace because large premium increases would lower enrollment and increase the potential for adverse selection, leading to further premium increases and insurer exits. In this paper, we analyze the changes and the lowest silver marketplace premiums for a 40-year-old non-smoker in 2017, 2018, and the two subsequent years, 2019 and 2020. We find that in most rating regions, premiums increased considerably between 2017 and 2018 and stabilized in 2019 and 2020. We also examine insurer entrances and exits in 39 selected markets and find increased insurer participation in 2019 and 2020, which suggests that many insurers now believe these markets are stable, functional, and potentially profitable. Finally, we show how premiums across markets are associated with insurer competition.

BACKGROUND: CHANGES IN THE POLICY ENVIRONMENT FROM 2017 TO 2020

Substantial policy uncertainty, and ultimately changes in policy, characterized the 2017 marketplace plan year. Just after the November 2016 election, Congress began discussing strategies to repeal the ACA through the budget reconciliation process after President Trump's January 2017 inauguration.[5] That discussion led to a prolonged legislative effort to repeal the ACA and replace it with other reforms that would reduce insurance market regulations and fundamentally alter the federal approach to subsidizing private health insurance in the nongroup markets.[6,7,8,9] The legislative activity around these varied efforts continued into early fall 2017, creating challenges for insurers that were required to file premiums for the 2018 plan year without knowing how those markets might function. In addition, media reports relayed consumer confusion as to whether the ACA had already been repealed, calling enrollment levels for the next year into question.[10] The consumer confusion increased insurers' difficulty setting premiums, because low enrollment rates could translate into adverse selection (i.e., enrollment being skewed toward people with high medical need), which would lead to higher average claims costs and higher premiums. Insurer participation fell from an average of 3.7 per region in 2017 to an average of 3.0 in 2018.

Though efforts to repeal and replace the ACA ultimately failed, in October 2017, just before the start of the marketplace's annual open enrollment period, the U.S. Department of Health and Human Services announced that it would stop directly reimbursing insurers for the cost-sharing reductions that marketplace insurers must provide to eligible enrollees with incomes below 250 percent of the federal poverty level.[11] Given the uncertainty about whether the administration would take such action, some states instructed their insurers to file 2018 plan year premiums in two ways: assuming cost-sharing reductions would be reimbursed and assuming they would not be. In other states, insurers could make last-minute changes to the premium levels they had already submitted to accommodate the change.

To pay for the claims associated with these cost-sharing reductions, insurers increased premiums. How insurers responded varied by state, because the federal government permitted state governments to instruct insurers how to recoup their costs, and states made different choices, sometimes offering no guidance to insurers at all.[1] State instructions ranged from the most narrow— loading these costs exclusively in silver marketplace premiums—to the most broad—spreading the costs across all plans sold both on and off the marketplace in all metal tiers. Corlette, Lucia, and Kona (2017) finds that for the 2018 plan year, 26 states had insurers allocate the cost-sharing reduction costs to silver marketplace premiums alone, 8 states had the costs allocated to silver plans on and off the marketplaces, 3 states had insurers spread the costs across all metal tiers in the marketplace, 3 had insurers spread the costs across all metal tiers on and off the marketplace, and in 3 states approaches varied across insurers.[1] Information on the remaining states was not available.

Premiums increased in 2018 for other reasons, beyond accounting for elimination of federal reimbursement for cost-sharing reductions. Throughout 2017, the administration indicated it might not enforce the individual mandate penalties,[12] and the Tax Cuts and Jobs Act of 2017, passed in December 2017, explicitly set the penalties to zero beginning in plan year 2019.[4] The threat of nonenforcement played the largest role in premium increases for the 2018 plan year because premiums were filed before the Tax Cuts and Jobs Act passed. The virtual elimination of federal advertising funds, the large reduction in federal enrollment assistance

funds, the shortened open enrollment period in federally facilitated and some state-based marketplaces, and reduced hours of access to the Healthcare.gov enrollment platform further increased uncertainty in these markets. Insurers feared that these changes would reduce enrollment, leave a less healthy risk pool, and increase enrollees' average claims. These potential changes gave insurers strong reasons for requesting large premium increases across all plans, both on and off the marketplace. Therefore, such incentives affected premiums both on and off the marketplaces, because insurers must pool risk across all their individual market products.

Finally, the 2018 premium increases reflect insurers' calculations of the adequacy of their 2017 premiums, their expectations about market competition in 2018, and assumptions about changes in underlying costs of care. First, mispriced 2017 premiums likely affected insurers' 2018 premium decisions. Second, lower premiums are associated with greater market competition, which implies that higher premiums may result from reduced competition when insurers exit the markets.[11] The ACA's medical-loss-ratio rules limit the share of premiums attributable to administrative costs, meaning insurers who set higher-than-necessary premiums must provide rebates to comply with these rules, which most insurers wish to avoid.[13] If an insurer faces little or reduced competition (e.g., because of persistently low insurer competition or other insurers having exited the market), premium increases will tend to be higher, because the insurers have little incentive to keep administrative costs below the maximum or negotiate lower provider payment rates. Third, premiums are adjusted based on medical inflation or expected changes in health care use.

Likewise, changes to premiums in 2019 reflect insurers' perceptions of the adequacy of 2018 premiums, as well as perceptions about future competition and the costs of care. If insurers' 2018 premiums were more than adequate, or if the premiums placed the insurer at a competitive disadvantage, then premium increases for 2019 were likely modest. Similar considerations apply for 2020; if 2019 premiums were more than adequate, premium increases for 2019 were low, if not negative, despite increases in medical inflation. If insurers perceive marketplaces to be stabilizing, they are more likely to enter new markets and remain in those they are in. Overall, insurer participation in the marketplaces reversed its 2018 decline, increasing to an average of 3.3 per region in 2019. It climbed further to an average of 3.9 per region in 2020.

DATA/METHODS

In this paper, we analyze marketplace silver premium data and insurer marketplace participation data from 2017 through 2020. We present this data in two forms; first, in Table 1, we present state averages of the lowest silver premium available in every rating region in the country for each of our study years. These averages are weighted using the rating region population taken from the U.S. Census Bureau's county population estimates and aggregated to the rating region level. Figures 1 and 2, U.S. rating region maps, also show the changes in the lowest silver premium during our study period. We also analyze insurer participation in 39 rating regions in 18 states, selecting a mix of federally facilitated and state-based marketplaces in varying locations to get a representative sample. We present each participating insurer's lowest silver offering across the four study years. When possible, we select both rural and urban regions within a state to examine how participation and pricing vary within states. The premium and insurer participation data were taken from Healthcare.gov landscape files and relevant state-based marketplace websites.

Table 1. State Average Lowest Silver Premium for a 40-Year-Old Non-smoker and Percent Change, 2017–20

	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
US average	**$342**	**$443**	**$442**	**$426**	**29.7%**	**-0.4%**	**-3.5%**	**7.6%**
Alabama	$435	$515	$504	$521	18.5%	-2.2%	3.3%	6.2%
Alaska	$901	$698	$704	$687	-22.5%	0.8%	-2.4%	-8.7%
Arizona	$497	$487	$448	$431	-2.0%	-8.0%	-3.8%	-4.6%
Arkansas	$281	$341	$362	$358	21.2%	6.1%	-1.1%	8.3%
California	$317	$394	$413	$396	24.1%	5.0%	-4.2%	7.7%
Colorado	$317	$420	$487	$371	32.4%	16.0%	-23.9%	5.3%
Connecticut	$433	$539	$444	$543	24.7%	-17.6%	22.2%	7.9%
DC	$275	$317	$380	$404	15.0%	19.9%	6.4%	13.7%
Delaware	$414	$573	$660	$521	38.3%	15.2%	-21.0%	8.0%
Florida	$323	$458	$467	$458	41.8%	2.1%	-2.1%	12.3%
Georgia	$312	$482	$434	$419	54.7%	-10.0%	-3.5%	10.3%
Hawaii	$325	$437	$480	$460	34.4%	9.8%	-4.1%	12.3%
Idaho	$344	$328	$474	$514	-4.8%	44.7%	8.3%	14.3%
Illinois	$350	$468	$446	$431	33.6%	-4.7%	-3.4%	7.2%
Indiana	$261	$332	$333	$379	26.9%	0.3%	13.8%	13.1%
Iowa	$320	$681	$606	$585	113.0%	-10.9%	-3.5%	22.4%
Kansas	$362	$481	$516	$479	32.8%	7.2%	-7.2%	9.7%
Kentucky	$253	$378	$413	$442	49.5%	9.3%	7.1%	20.5%
Louisiana	$403	$455	$419	$461	12.9%	-7.8%	9.9%	4.6%
Maine	$371	$551	$512	$495	48.6%	-7.1%	-3.4%	10.1%
Maryland	$296	$436	$404	$388	47.3%	-7.4%	-3.9%	9.4%
Massachusetts	$241	$306	$321	$334	26.8%	5.0%	3.9%	11.4%
Michigan	$260	$347	$358	$342	33.2%	3.3%	-4.6%	9.5%
Minnesota	$429	$363	$313	$298	-15.5%	-13.6%	-5.0%	-11.5%
Mississippi	$327	$478	$457	$450	46.5%	-4.5%	-1.6%	11.2%
Missouri	$365	$487	$475	$466	33.5%	-2.5%	-1.9%	8.5%
Montana	$418	$494	$522	$498	18.2%	5.6%	-4.7%	6.0%
Nebraska	$464	$689	$706	$610	48.6%	2.4%	-13.6%	9.5%
Nevada	$306	$445	$398	$377	45.6%	-10.5%	-5.4%	7.2%
New Hampshire	$266	$457	$373	$390	71.9%	-18.4%	4.8%	13.7%
New Jersey	$338	$399	$342	$379	18.1%	-14.3%	10.8%	3.9%
New Mexico	$239	$414	$348	$326	73.4%	-16.1%	-6.3%	10.9%
New York	$439	$486	$559	$589	10.9%	15.0%	5.2%	10.3%
North Carolina	$517	$601	$563	$507	16.3%	-6.3%	-10.1%	-0.7%

	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
North Dakota	$325	$293	$376	$327	-9.8%	28.1%	-12.9%	0.2%
Ohio	$251	$347	$359	$353	38.2%	3.3%	-1.4%	12.1%
Oklahoma	$495	$520	$514	$515	5.1%	-1.3%	0.3%	1.3%
Oregon	$311	$388	$424	$424	24.8%	9.1%	0.1%	10.9%
Pennsylvania	$347	$453	$446	$432	30.6%	-1.7%	-3.0%	7.6%
Rhode Island	$243	$287	$315	$316	18.4%	9.7%	0.3%	9.2%
South Carolina	$389	$524	$554	$501	34.4%	5.8%	-9.6%	8.8%
South Dakota	$430	$467	$511	$557	8.6%	9.4%	9.0%	9.0%
Tennessee	$433	$597	$507	$484	37.9%	-15.1%	-4.4%	3.8%
Texas	$279	$394	$403	$406	41.3%	2.5%	0.6%	13.4%
Utah	$308	$528	$508	$475	71.3%	-3.8%	-6.6%	15.5%
Vermont	$470	$474	$493	$645	0.8%	4.1%	30.7%	11.1%
Virginia	$309	$506	$526	$504	64.0%	3.9%	-4.2%	17.8%
Washington	$238	$326	$368	$379	37.0%	13.2%	3.0%	16.9%
West Virginia	$440	$514	$562	$601	16.9%	9.3%	6.9%	11.0%
Wisconsin	$350	$502	$483	$458	43.5%	-3.7%	-5.2%	9.4%
Wyoming	$494	$860	$854	$871	74.0%	-0.7%	2.0%	20.8%

CHANGES IN THE LOWEST SILVER PREMIUMS

Tables 1 and 2 provide an overview of changes in the lowest silver premiums in 2018, 2019, and 2020. Table 1 shows that the national average increase in lowest silver premiums in 2018 was 29.7 percent, followed by an average 0.4 percent decrease in 2019 and another 3.5 percent reduction in 2020. However, these national averages mask considerable variation across states. Average premium increases exceeded 29.7 percent in 28 states in 2018. Most of the large increases in the average lowest silver premiums in 2018 were in smaller states that lacked competitive markets, including Iowa (113.0 percent), Maine (48.6 percent), Mississippi (46.5 percent), Nebraska (48.6 percent), New Mexico (73.4 percent), Utah (71.3 percent), and Wyoming (74.0 percent). However, average lowest silver premium increases were substantial even in some states with several insurers, like Georgia (54.7 percent), Ohio (38.2 percent), and Virginia (64.0 percent). Average lowest silver premiums in these nine states increased or decreased by 15.0 percent or less: Arizona (2.0 percent decrease), Idaho (4.8 percent decrease), Louisiana (12.9 percent increase), New York (10.9 percent increase), North Dakota (9.8 percent decrease), Oklahoma (5.1 percent increase), South Dakota (8.6 percent increase), Vermont (0.8 percent increase), and Washington, D.C. (15.0 percent increase). The largest average decrease in the lowest silver plan was 22.5 percent in Alaska, which enacted a reinsurance program in the nongroup market in 2017 but has seen continued decreases in premiums since.

Contrary to 2018 trends and beliefs that the 2018 premium increases would unravel the nongroup market, large premium increases were rare in 2019, and premiums decreased in 23 states. Average lowest silver premiums increased by 15.0 percent or more in only six states: Colorado (16.0 percent), Delaware (15.2 percent), Idaho (44.7 percent), New York (15.0 percent), and Washington, D.C. (19.9 percent). The typically much lower premium increases and frequent decreases in 2019 appear to reflect corrections for some insurers' overreactions to the policy changes and uncertainty when 2018 premiums were set. Consequently, 2017 through 2019 saw considerable disequilibrium in marketplace premiums; 2018 premiums reflected policy changes and fears over the future of the risk pool, and 2019 premiums reflected corrections to 2018 premiums based on recent experience.

Many observers were surprised that enrollment did not drop as much as feared in the wake of the 2018 premium increases and other changes.[14] Most marketplace enrollees are shielded from the full weight of premium increases because their premium costs are limited to a percentage of family income. This suggests that the marketplace may be stable given the structure of the subsidies.

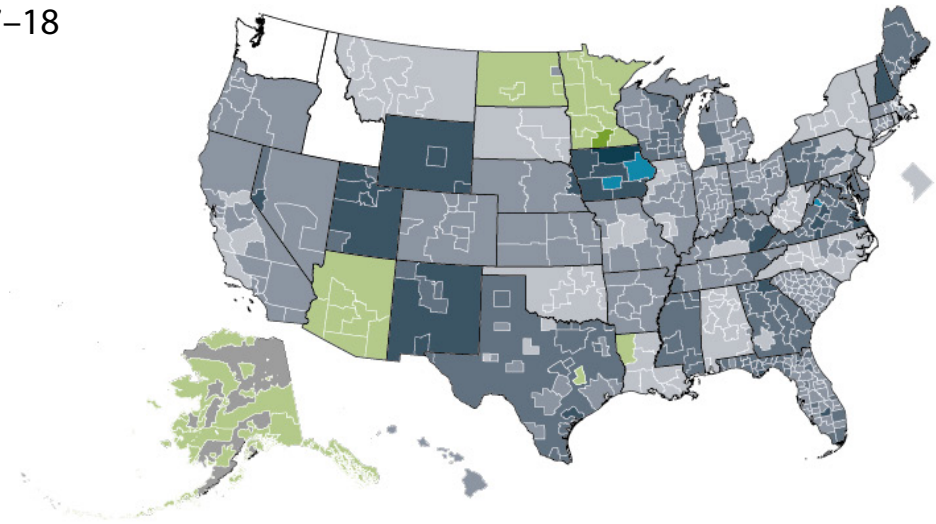
Insurers' awareness of and confidence in the stability of the market seems to have continued this year. In 2020, lowest silver premiums fell by an average of 3.5 percent across the United States, with lowest silver premiums decreasing in 32 states. Additionally, by 2020, 12 states (Alaska, Colorado, Delaware, Maine, Maryland, Minnesota, Montana, New Jersey, North Dakota, Oregon, Rhode Island, and Wisconsin) enacted reinsurance programs, contributing to reductions in the lowest silver premiums.[15]

Table 1 also shows the continued variation in the *levels* of premiums as of this year. The national average lowest silver premium for a 40-year-old non-smoker is currently $426 per month. States with the highest average silver premiums (above $550) tend to be smaller and/or have less competitive insurance markets and include Alaska ($687), Iowa ($585), Nebraska ($610), South Dakota ($557), West Virginia ($601), and Wyoming ($871). Other states had substantially lower premiums (below $360), including Arkansas ($358), Massachusetts ($334), Michigan ($342), Minnesota ($298), New Mexico ($326), North Dakota ($327), Ohio ($353), and Rhode Island ($316). Most of the lower-cost states had at least one participating Medicaid insurer, a large number of competing insurers, or both. As we have shown elsewhere, lowest silver premiums in a rating region are associated with a large number of participating insurers, a participating Medicaid insurer, and urban areas.[14] Medicaid insurers tend to have narrower networks and contract with providers willing to accept lower payment rates.

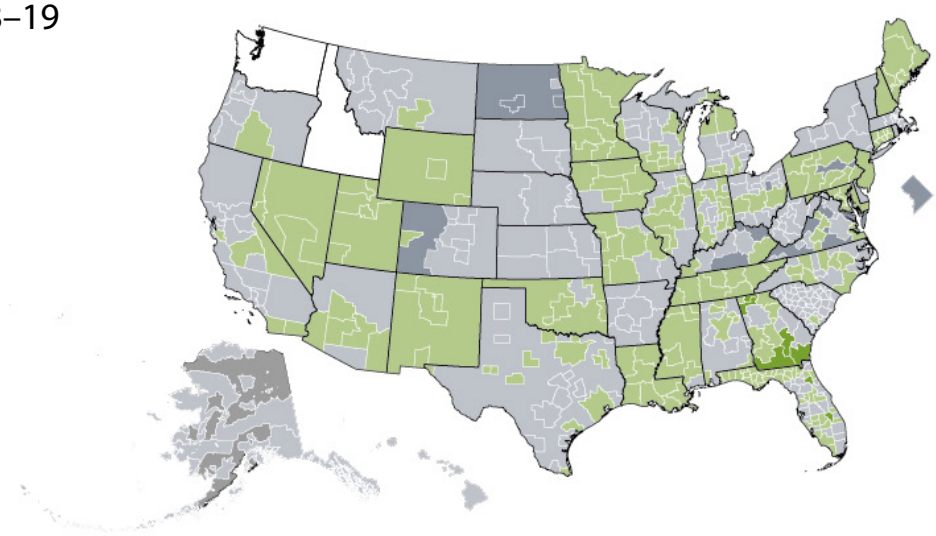
Figure 1 displays three maps of annual changes in the lowest silver plan available across the United States at the rating region level. It shows that most of the increases in the lowest silver premiums occurred for the 2018 plan year, mostly because of the various administrative changes discussed above. Figure 2 is a map of the average annual percent change in the lowest-cost silver plans available from 2017 to 2020 and shows large increases in almost every state, despite reduced premiums in 2019 and 2020.

Figure 1. Annual Percent Change in Lowest-Cost Silver Plan at Rating Region Level, 2017–20

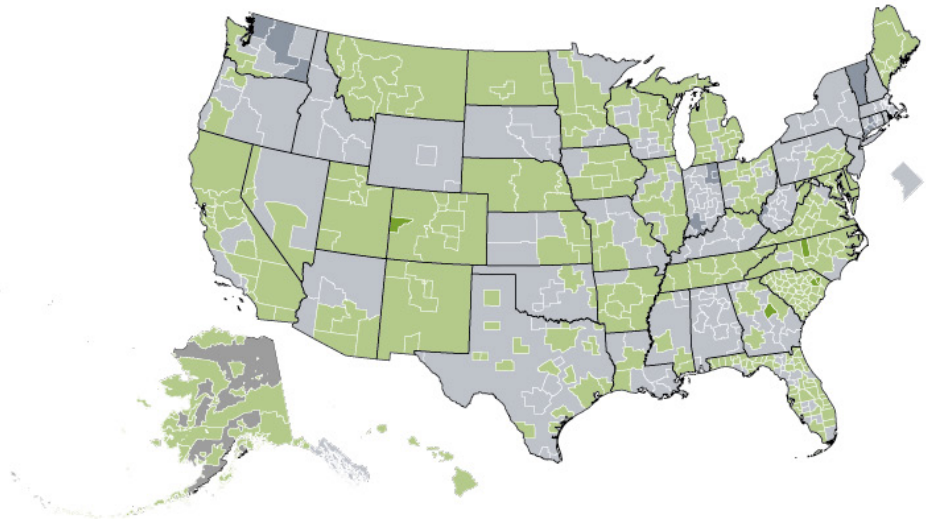
2017–18

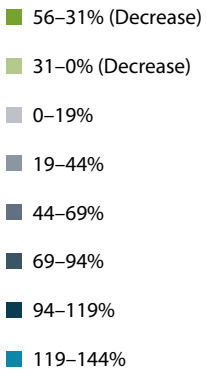


2018–19



2019–20

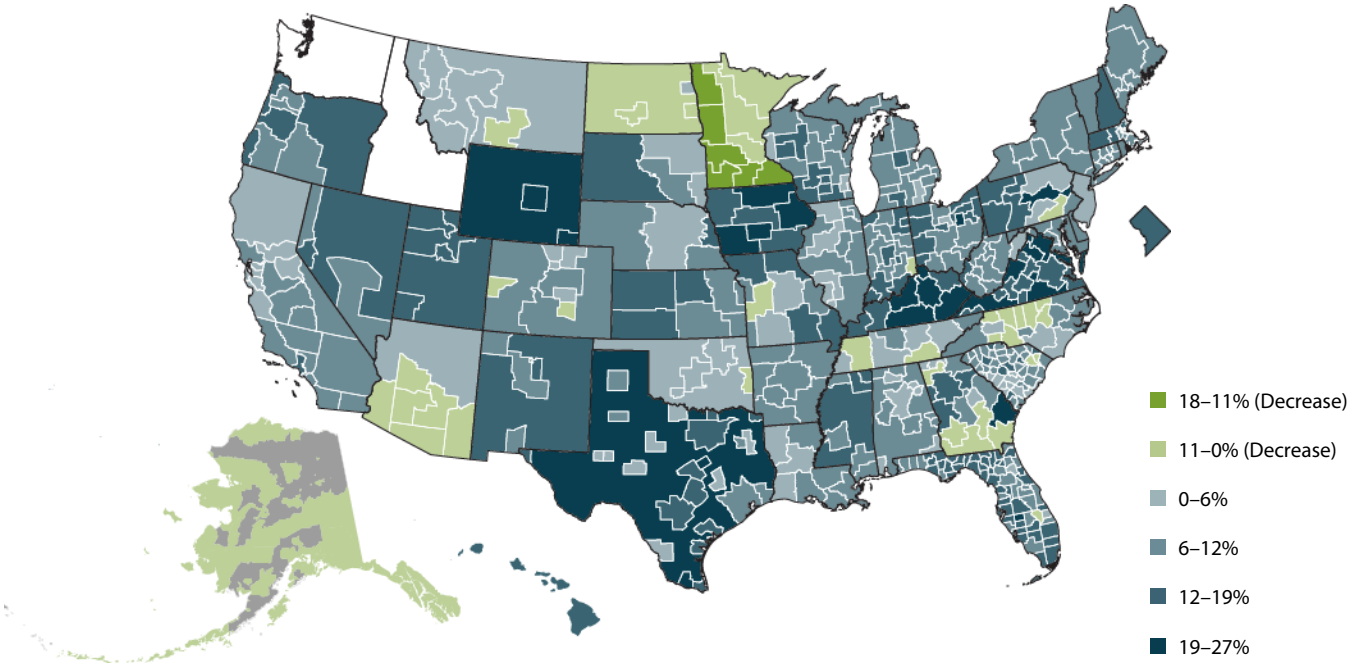




Source: Healthcare.gov and relevant state-based marketplace websites.

Note: For 2017 through 2019, Idaho and Washington are excluded because they redrew their rating regions.

Figure 2. Average Percent Change in Lowest-Cost Silver Plan at Rating Region Level, 2017–20



Source: Healthcare.gov and relevant state-based marketplace websites.

Note: Idaho and Washington are excluded because they redrew their rating regions in 2019.

SELECT SUBSTATE FINDINGS

Table 2 presents information on premiums in specific substate rating areas (geographic regions within which a plan's premiums cannot vary) for selected states. In general, we selected a major urban area and, when possible, another region with mostly rural counties. Table 2 shows the lowest silver premium available for a 40-year-old single adult across all participating insurers in each rating region and the percent change in the lowest premium available in 2018, 2019, and 2020. Currently, premiums tend to be higher in rural areas than in urban areas in Arizona, California, North Carolina, Ohio, and Oregon. In Arizona, the lowest silver premium in the selected rural area is $656 per month, compared with $394 in Phoenix. In Ohio, the lowest silver premium in the selected rural area is $386, compared with $366 in Columbus and $322 in Cleveland. In Oregon, the lowest premium in the rural region is $438, compared with $397 in Portland. However, there are exceptions; rural premiums are somewhat lower than urban premiums in Alabama, Georgia, and Indiana.

Table 2. State Average Lowest Silver Premium and Percent Change from 2017 to 2020, by Select Rating Regions in Study States

State	Rating Area	State Average Lowest Silver Premium				Percent Change			
		2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017-20
Alabama	State Average	$435	$515	$504	$521	18.5%	-2.2%	3.3%	6.2%
	Birmingham	$457	$544	$512	$525	18.9%	-5.8%	2.6%	4.7%
	Rural	$416	$493	$494	$507	18.5%	0.2%	2.7%	6.8%
Arizona	State Average	$497	$487	$448	$431	-2.0%	-8.0%	-3.8%	-4.6%
	Phoenix	$475	$471	$415	$394	-0.9%	-11.8%	-5.0%	-6.0%
	Rural	$638	$618	$648	$656	-3.1%	4.9%	1.1%	0.9%

State	Rating Area	State Average Lowest Silver Premium				Percent Change			
		2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017-20
Arkansas	State Average	$281	$341	$362	$358	21.2%	6.1%	-1.1%	8.3%
	Little Rock	$292	$353	$363	$358	21.0%	2.7%	-1.4%	7.0%
	Rural	$295	$356	$378	$358	21.0%	6.0%	-5.3%	6.7%
California	State Average	$317	$394	$413	$396	24.1%	5.0%	-4.2%	7.7%
	Northern Counties	$402	$478	$494	$468	19.1%	3.4%	-5.4%	5.2%
	Sacramento	$402	$446	$474	$468	11.0%	6.3%	-1.3%	5.2%
	East Los Angeles	$251	$316	$337	$327	26.2%	6.5%	-3.0%	9.3%
	San Diego	$297	$392	$391	$359	32.1%	-0.1%	-8.2%	6.6%
Florida	State Average	$323	$458	$467	$458	41.8%	2.1%	-2.1%	12.3%
	Tampa	$305	$428	$467	$432	40.3%	9.2%	-7.5%	12.4%
	Miami	$296	$435	$440	$445	46.7%	1.2%	1.1%	14.5%
Georgia	State Average	$312	$482	$434	$419	54.7%	-10.0%	-3.5%	10.3%
	Atlanta	$264	$417	$438	$419	57.8%	5.1%	-4.5%	16.6%
	Augusta	$322	$464	$490	$401	44.3%	5.5%	-18.2%	7.6%
	Rural	$430	$629	$324	$367	46.1%	-48.5%	13.3%	-5.2%
Indiana	State Average	$261	$332	$333	$379	26.9%	0.3%	13.8%	13.1%
	Indianapolis	$284	$364	$372	$421	28.2%	2.0%	13.3%	14.0%
	Rural	$201	$268	$257	$330	33.1%	-4.0%	28.4%	17.9%
Maryland	State Average	$296	$436	$404	$388	47.3%	-7.4%	-3.9%	9.4%
	Baltimore	$309	$436	$404	$388	41.1%	-7.4%	-3.9%	7.9%
	Washington, D.C., Suburbs	$309	$436	$404	$388	41.1%	-7.4%	-3.9%	7.9%
Minnesota	State Average	$429	$363	$313	$298	-15.5%	-13.6%	-5.0%	-11.5%
	Minneapolis	$363	$315	$282	$261	-13.2%	-10.4%	-7.6%	-10.4%
New York	State Average	$439	$486	$559	$589	10.9%	15.0%	5.2%	10.3%
	New York City	$454	$504	$581	$619	11.2%	15.3%	6.5%	11.0%
	Long Island	$446	$480	$562	$585	7.5%	17.2%	4.0%	9.4%
North Carolina	State Average	$517	$601	$563	$507	16.3%	-6.3%	-10.1%	-0.7%
	Charlotte	$565	$659	$503	$405	16.7%	-23.7%	-19.4%	-10.5%
	Raleigh	$468	$556	$487	$410	18.7%	-12.3%	-15.8%	-2.8%
	Rural	$537	$610	$664	$661	13.5%	9.0%	-0.5%	7.2%
Ohio	State Average	$251	$347	$359	$353	38.2%	3.3%	-1.4%	12.1%
	Columbus	$284	$385	$382	$366	35.4%	-0.8%	-4.1%	8.8%
	Cleveland	$224	$307	$323	$322	36.8%	5.1%	-0.1%	12.8%
	Rural	$290	$415	$469	$386	43.2%	12.8%	-17.6%	10.0%
Oregon	State Average	$311	$388	$424	$424	24.8%	9.1%	0.1%	10.9%
	Portland	$302	$375	$408	$397	24.2%	8.8%	-2.7%	9.5%
	Rural	$302	$375	$408	$438	24.2%	8.8%	7.4%	13.2%

State	Rating Area	State Average Lowest Silver Premium				Percent Change			
		2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017-20
Rhode Island	State Average	$243	$287	$315	$316	18.4%	9.7%	0.3%	9.2%
Texas	State Average	$279	$394	$403	$406	41.3%	2.5%	0.6%	13.4%
	Dallas	$277	$411	$410	$408	48.4%	-0.2%	-0.7%	13.7%
	Houston	$283	$390	$385	$381	37.9%	-1.1%	-1.1%	10.5%
Virginia	State Average	$309	$506	$526	$504	64.0%	3.9%	-4.2%	17.8%
	Richmond	$289	$439	$490	$489	51.6%	11.7%	-0.3%	19.1%
	Virginia Beach/Norfolk	$350	$641	$572	$478	83.1%	-10.7%	-16.5%	12.5%
	Washington, D.C., Suburbs	$319	$472	$566	$514	48.2%	19.9%	-9.2%	20.3%
Washington	State Average	$238	$326	$368	$379	37.0%	13.2%	3.0%	16.9%
	Seattle	$235	$328	$368	$379	39.6%	12.3%	2.9%	17.3%
West Virginia	State Average	$440	$514	$562	$601	16.9%	9.3%	6.9%	11.0%
	Charleston	$505	$555	$611	$653	9.8%	10.2%	6.8%	8.9%
	Rural	$485	$555	$614	$656	14.5%	10.7%	6.8%	10.6%

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based marketplace websites.

Note: State average is the population-weighted average of lowest silver premium offered in each rating region.

As we have done in previous studies, we also describe the competition within these substate areas, identifying the pricing dynamics over the period for each participating insurer's lowest silver premium offering, as well as insurer entries and exits. We provide additional data on selected states in at least one major metropolitan area and one rural region where applicable.

ALABAMA

Alabama has little competition in its marketplace. At $521 per month, the state's average lowest silver premium for a 40-year-old non-smoker is currently well above the national average ($426 per month). The lowest-cost silver premiums increased by 18.5 percent in 2018, fell by 2.2 percent in 2019, and increased by 3.3 percent in 2020. Table 3 provides insurer-specific data for Birmingham and a rural rating region.

Table 3. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Alabama Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Birmingham								
Blue Cross and Blue Shield of Alabama	$457	$542	$525	$539	18.5%	-3.0%	2.7%	5.7%
Bright Health	N/A	$546	$499	$525	N/A	-8.6%	5.4%	N/A
Percent Change in Lowest Option Available					**18.5%**	**-8.0%**	**5.4%**	**4.7%**
Selected Rural Region								
Blue Cross and Blue Shield of Alabama	$416	$493	$494	$507	18.5%	0.2%	2.7%	6.8%
Percent Change in Lowest Option Available					**18.5%**	**0.2%**	**2.7%**	**6.8%**
State Average (All Regions)	**$435**	**$515**	**$504**	**$521**	**18.5%**	**-2.2%**	**3.3%**	**6.2%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: N/A: Insurer was not participating in the marketplace this year

In Birmingham, the lowest silver premium between the two participating insurers increased by 18.5 percent in 2018, fell by 8.0 percent in 2019, and increased by 5.4 percent in 2020. The entry of a new insurer into a previously monopolistic market appears to have catalyzed competition there. Blue Cross and Blue Shield of Alabama has dominated the state's individual market for many years; it was the only marketplace insurer in Birmingham in 2017, and it remained the lowest-cost insurer in 2018 by a small margin ($4 per month), despite Bright Health's entry into the market with competitive premiums. However, Bright Health became the lowest-priced insurer in the rating region in 2019 when it reduced its lowest silver offering by almost 9 percent, while Blue Cross and Blue Shield only lowered its offering by 3.0 percent. Bright Health remains the lowest-cost insurer in this market despite a small premium increase (5.4 percent).

Blue Cross and Blue Shield remains the only insurer in Alabama's rural rating region, and its lowest premium there remained essentially flat following an 18.5 percent increase in 2018. Blue Cross and Blue Shield of Alabama raised its lowest-cost silver premium by only 2.7 percent this year.

ARIZONA

Arizona had few competing insurers in 2017, and its lowest silver marketplace premiums were higher than the national average (Table 4). However, its average lowest silver premiums fell in all three study years as more insurers entered the market. Consequently, Arizona's lowest silver premiums are currently just barely above the national average. Table 4 shows insurer-specific data for Phoenix and a rural rating region.

Table 4. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2016 to 2020, by Insurer in Selected Arizona Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Phoenix								
Blue Cross Blue Shield of Arizona	N/A	N/A	N/A	$423	N/A	N/A	N/A	N/A
Bright Health	N/A	N/A	$427	$394	N/A	N/A	-7.5%	N/A
Cigna	N/A	N/A	$426	$423	N/A	N/A	-0.8%	N/A
Health Net	$475	$471	$415	$411	-0.9%	-11.8%	-1.1%	-4.7%
Oscar	N/A	N/A	$479	$426	N/A	N/A	-10.9%	N/A
Percent Change in Lowest Option Available					**-0.9%**	**-11.8%**	**-5.0%**	**-6.0%**
Selected Rural Region								
Blue Cross and Blue Shield of Arizona	$638	$618	$648	$656	-3.1%	4.9%	1.1%	0.9%
Percent Change in Lowest Option Available					**-3.1%**	**4.9%**	**1.1%**	**0.9%**
State Average (All Regions)	**$497**	**$487**	**$448**	**$431**	**-2.0%**	**-8.0%**	**-3.8%**	**-4.6%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: N/A: Insurer was not participating in the marketplace this year

In 2017 and 2018, only one insurer, Health Net, a former Medicaid-only insurer, participated in the Phoenix marketplace. Health Net reduced its lowest silver premium by 0.9 percent in 2018, perhaps because it paid enrollees rebates for the 2017 plan year.[16] Oscar, Bright Health, and Cigna joined Health Net in this market beginning in the 2019 plan year. Blue Cross Blue Shield of Arizona entered the Phoenix marketplace this year. Perhaps because of the added competition, Health Net lowered its 2019 silver premium by 11.8 percent, giving it the lowest silver premium in the state in 2019. Bright Health became the lowest-cost insurer this year, despite Health Net reducing its premiums by another 1.1 percent. All five insurers' silver premiums are similar.

Blue Cross Blue Shield of Arizona has been the only insurer offering marketplace coverage in rural northern Arizona since 2017. The lowest silver premium in this region has remained relatively constant for the past three years, decreasing by 3.1 percent in 2018 and increasing by 4.9 and 1.1 percent in 2019 and 2020. However, premiums are significantly higher in this rural region than in Phoenix; the lowest silver premium for a 40-year-old in 2019 was $656 per month, compared with $394 in Phoenix.

ARKANSAS

Arkansas has few participating insurers, but two of them are Medicaid only. Average lowest silver marketplace premiums in Arkansas have been well below the national average in the last four years ($358 versus $426 in 2020). The state's average lowest silver premiums increased by 21.2 and 6.1 percent in 2018 and 2019, before falling by 1.1 percent in 2020 (Table 5). In Little Rock and the rural southwestern rating region, no insurers have entered or exited the markets since 2017 (Table 5). Three insurers participate in both rating regions: Ambetter (a subsidiary of the Centene Corporation), QualChoice Health Insurance, and USAble Mutual Insurance (Blue Cross Blue Shield of Arkansas). However, Centene purchased QualChoice Health Insurance in January 2019, reducing the number of competing insurers in the state.[17]

Table 5. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Arkansas Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Little Rock								
Ambetter	$292	$353	$363	$358	21.0%	2.7%	-1.4%	7.0%
QualChoice Health Insurance (also Ambetter)[1]	$359	$429	$423	$414	19.4%	-1.4%	-2.1%	4.9%
USAble Mutual Insurance	$330	$392	$381	$390	19.0%	-2.9%	2.3%	5.7%
Percent Change in Lowest Option Available					**21.0%**	**2.7%**	**-1.4%**	**7.0%**
Selected Rural Region								
Ambetter	$295	$356	$378	$358	21.0%	6.0%	-5.3%	6.7%
QualChoice Health Insurance (also Ambetter)[1]	$379	$476	$447	$414	25.4%	-6.1%	-7.3%	3.0%
USAble Mutual Insurance	$323	$384	$381	$390	18.7%	-0.8%	2.3%	6.4%
Percent Change in Lowest Option Available					**21.0%**	**6.0%**	**-5.3%**	**6.7%**
State Average (All Regions)	**$281**	**$341**	**$362**	**$358**	**21.2%**	**6.1%**	**-1.1%**	**8.3%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

In Little Rock, the average lowest silver premiums across all three insurers increased by 21.0 and 2.7 percent in 2018 and 2019. The lowest silver premium available fell by 1.4 percent this year. Ambetter has had the lowest silver premium in Little Rock in all four years. All three insurers increased their lowest silver premium offerings by at least 19.0 percent in 2018.

From 2017 to 2019, the lowest silver premiums across insurers in the rural rating region were similar to those in Little Rock, increasing by 21.0 percent on average in 2018 and 6.0 percent in 2019, before falling by 5.3 percent in 2020. Each insurer's premium changes varied slightly from those in Little Rock. As in Little Rock, Ambetter offered the lowest silver premium plan in the rural region. USAble Mutual Insurance was very competitive, particularly in 2019, following a small reduction in its lowest silver premium. Currently, premiums in the rural area and Little Rock for all three insurers are the same.

CALIFORNIA

California's marketplaces tend to have several participating insurers, including commercial and former Medicaid-only insurers. The average lowest silver premium in California has been consistently below the national average ($396 versus $426). Premiums increased by 24.1 and 5.0 percent in 2018 and 2019 but declined by 4.2 percent in 2020. Table 6 provides insurer-level data for four California rating regions, three in major metropolitan areas (East Los Angeles, Sacramento, and San Diego) and one in a rural area (northern counties).

In the four study years, insurer participation in each of these areas remained steady. In each area, the average increase in the lowest silver premiums in 2018 was large (ranging from 11.0 percent in Sacramento to 32.1 percent in San Diego). These were followed by moderate single-digit increases for 2019 (ranging from virtually no change in San Diego to 6.5 percent in East Los Angeles). Each region has seen single-digit reductions in the lowest silver premiums this year.

Table 6. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected California Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
East Los Angeles (Rating Region 15)								
Anthem	$287	N/A	N/A	$380	N/A	N/A	N/A	N/A
Blue Shield of California	$284	$325	$346	$352	14.6%	6.3%	1.7%	7.4%
Health Net	$269	$325	$337	$327	20.8%	3.7%	-3.0%	6.7%
Kaiser Permanente	$320	$391	$404	$390	22.1%	3.4%	-3.6%	6.8%
L.A. Care Health Plan	$258	$316	$338	$342	22.5%	6.8%	1.3%	9.9%
Molina Healthcare	$251	$406	$391	$377	62.1%	-3.7%	-3.6%	14.6%
Oscar	N/A	$408	$443	$357	N/A	8.5%	-19.4%	N/A
Percent Change in Lowest Option Available					**26.2%**	**6.5%**	**-3.0%**	**9.3%**
San Diego								
Anthem	$444	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blue Shield of California	$406	$394	$419	$427	-2.9%	6.3%	1.7%	1.7%
Health Net	$307	$392	$395	$359	27.6%	0.8%	-9.0%	5.4%
Kaiser Permanente	$354	$432	$447	$431	22.1%	3.4%	-3.6%	6.8%
Molina Healthcare	$297	$418	$391	$370	41.1%	-6.4%	-5.5%	7.6%
Sharp Health Plan	$356	$479	$457	$385	34.8%	-4.7%	-15.6%	2.7%
Percent Change in Lowest Option Available					**32.1%**	**-0.1%**	**-8.2%**	**6.6%**
Sacramento								
Blue Shield of California	$479	$446	$474	$482	-6.9%	6.3%	1.7%	0.2%
Health Net	$501	$584	$620	$648	16.5%	6.1%	4.5%	8.9%
Kaiser Permanente	$402	$478	$494	$468	19.1%	3.4%	-5.4%	5.2%
Western Health Advantage	$426	$557	$596	$573	30.7%	7.0%	-3.8%	10.4%
Percent Change in Lowest Option Available					**11.0%**	**6.3%**	**-1.3%**	**5.2%**

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Northern Counties, Rural								
Anthem	$408	$602	$623	$542	47.5%	3.6%	-13.1%	9.9%
Blue Shield of California	$450	$578	$644	$633	28.4%	11.3%	-1.7%	12.0%
Health Net	$519	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kaiser Permanente	$402	$478	$494	$468	19.1%	3.4%	-5.4%	5.2%
Percent Change in Lowest Option Available					**19.1%**	**3.4%**	**-5.4%**	**5.2%**
State Average (All Regions)	**$317**	**$394**	**$413**	**$396**	**24.1%**	**5.0%**	**-4.2%**	**7.7%**

Source: CoveredCalifornia, https://www.coveredca.com/

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

In East Los Angeles, the lowest silver premiums across the participating insurers increased by 26.2 and 6.5 percent in 2018 and 2019, before falling by 3.0 percent in 2020. Six insurers participated in the marketplace for each of the first three study years; Anthem left the market in 2018 but returned this year, and Oscar entered the market in the 2018 plan year and has remained. East Los Angeles has three Medicaid insurers offering plans in the marketplace, including L.A. Care Health Plan and Health Net, which have been among the three lowest-premium insurers for all four years. Molina Healthcare, the third Medicaid insurer, offered the plan with the lowest silver premium in 2017, but it had the largest premium increase in 2018, and its modest premium decrease in 2019 was too small for Molina to regain its previous lowest-cost position. With only small premium increases since 2017, Blue Shield of California has become more price competitive, possibly indicating success in negotiating provider rates within its network. The lowest silver premium offered by Oscar, the newest entrant, was higher than all of its competitors' premiums in both 2018 and 2019; however, it reduced its premiums by 19.4 percent this year, bringing Oscar's lowest silver premium closer to those of lower-cost plans.

The lowest silver marketplace premiums in San Diego stayed nearly constant in 2019, following a large increase in 2018, and fell by 8.2 percent this year. Two Medicaid insurers compete in the San Diego marketplace (Molina and Health Net), along with two provider-sponsored insurers (Kaiser Permanente and Sharp Health Plan) and a Blue Cross–affiliated insurer (Blue Shield of California). Anthem left the market in 2018. Our previous work has shown that competition from Medicaid insurers tends to be associated with lower premiums and smaller premium increases.[14] Health Net was the lowest cost insurer in 2018 and 2020, while Molina was the lowest cost insurer in 2019. Molina priced aggressively, lowering its lowest silver premium by 6.4 percent in 2019 and by another 5.5 percent this year; it currently offers the second-lowest silver premium, behind Health Net.

The Sacramento market insurers' lowest silver premiums increased by an average of 11.0 percent in 2018, the smallest average increase in all the California markets we studied. In 2019, the average premium increase was 6.3 percent, followed by a 1.3 percent decline this year. The same four insurers, Health Net, Kaiser Permanente, Western Health Advantage, and Blue Shield of California, have competed in the Sacramento marketplace for all four years. Competition from two provider-sponsored insurers (Kaiser Permanente and Western Health Advantage) seems to have motivated Blue Shield to price competitively, keeping the area's 2018 premium increases relatively low in a year characterized by large, double-digit increases in many other areas. In 2018, Blue Shield decreased its lowest silver premium by 6.9 percent, while its competitors in the area increased their premiums by 16.5 to 30.7 percent. (This was the year in which insurers were first instructed to load the costs associated with cost-sharing subsidies into the silver premiums.) Kaiser Permanente and Blue Shield now have the lowest premiums in this market. Surprisingly, Health Net, often one of the lower-priced insurers in other urban areas of the state, had the highest premiums in each of the four years.

In the Northern California region composed of rural counties, each insurers' lowest silver premiums increased greatly in 2018. The lowest silver premium increased by 19.1 and 3.4 percent in 2018 and 2019, before falling by 5.4 percent in 2020. In 2019, only three insurers participated in this region; Health Net, the highest-premium insurer, left after the 2017 plan year. This is the smallest number of participating insurers among the California markets we examined, but it is still more than most rural regions in our other study states. Following Health Net's exit, no Medicaid insurers participate in Northern California's marketplace. Kaiser Permanente currently offers the lowest silver premium in this market ($468).

FLORIDA

Several insurers, including two national Medicaid insurers, participate in the marketplaces we studied in Florida. The average lowest silver premium was below the national average in 2017. In 2018, premiums were about 5 percent higher than the national average, owing to a 41.8 percent state average increase in lowest silver premiums. Currently, the average of the lowest silver premiums in the state is $458, compared with $426 nationally. Following the large increase in 2018, premiums remained fairly flat in 2019 and 2020. Table 7 shows data on the Miami and Tampa rating regions.

Table 7. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Florida Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Miami								
Ambetter	$296	$435	$440	$452	46.7%	1.2%	2.7%	15.1%
Florida Blue (Blue Cross Blue Shield of Florida)	$422	$583	$543	$524	37.9%	-6.9%	-3.4%	7.5%
Health Options	$318	$442	$458	$450	39.0%	3.5%	-1.6%	12.3%
Humana	$477	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Molina Healthcare	$320	$567	$568	$551	77.5%	0.1%	-2.9%	19.9%
Oscar	N/A	N/A	N/A	$445	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**46.7%**	**1.2%**	**1.1%**	**14.5%**
Tampa								
Ambetter	$305	$428	$467	$437	40.3%	9.2%	-6.4%	12.8%
Florida Blue (Blue Cross Blue Shield of Florida)	$341	$496	$489	$475	45.5%	-1.4%	-2.7%	11.7%
Bright Health	N/A	N/A	N/A	$432	N/A	N/A	N/A	N/A
Health Options	$325	$481	$491	$446	48.1%	2.1%	-9.2%	11.1%
Humana	$428	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Molina Healthcare	$339	$567	$585	$552	67.3%	3.1%	-5.6%	17.6%
Oscar	N/A	N/A	N/A	$447	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**40.3%**	**9.2%**	**-7.5%**	**12.4%**
State Average (All Regions)	**$323**	**$458**	**$467**	**$458**	**41.8%**	**2.1%**	**-2.1%**	**12.3%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

In 2018, the lowest silver premium in Miami increased by 46.7 percent and was followed by small increases in 2019 (1.2 percent) and 2020 (1.1 percent). Miami had five participating insurers in 2017: Ambetter, Health Options, Molina, Florida Blue, and Humana. Humana exited the marketplace before the 2018 plan year and has not returned. Oscar entered the Miami market this year with the lowest silver premium. Ambetter was the lowest-priced insurer in Miami from 2017 to 2019, before being slightly undercut by Oscar this year. Unlike in many states where it participates, Molina was the highest-priced silver insurer in Miami (and Tampa) in 2019 and remains so today. The lowest silver premium in Miami stayed almost constant in 2019 and 2020 (increasing by 1.2 and 1.1 percent) suggests that insurers participating in this market overpriced their 2018 premiums at least somewhat relative to increasing medical costs.

Tampa's lowest premium increased by 40.3 and 9.2 percent in 2018 and 2019 and fell by 7.5 percent in 2020. The same insurers participated in the Tampa and Miami marketplaces in 2017. As in Miami, Humana exited the Tampa marketplace before the 2018 plan year. Before its exit, Humana was the highest-priced insurer. Oscar and Bright Health both entered the Tampa market this year. In 2019 and 2020, Florida Blue was far more competitively priced in Tampa than in Miami. Ambetter has been the lowest-premium insurer in Tampa until this year, when it was slightly underbid by Bright Health. As in Miami, Oscar entered this market very competitively, and is one of the lower cost competitors in this market.

GEORGIA

In Georgia, the Atlanta market had several insurers, and the other two regions we examined had two insurers, one of which was a Medicaid insurer. Georgia's average lowest silver premiums are slightly lower than the national average for 2020 ($419 versus $426), following a 54.7 percent increase in 2018 and 10.0 and 3.5 percent decreases in 2019 and 2020. Table 8 provides data for three rating regions in Georgia: Atlanta, Augusta, and a rural region in the southeastern portion of the state. As noted, Atlanta has the most insurer participation of our selected regions in the state; three insurers (Anthem, Ambetter, and Kaiser Permanente) offered coverage in 2019 and five offer coverage today, because Oscar and CareSource, a former Medicaid-only insurer from the Midwest, entered the marketplace this year. Humana participated in the Atlanta marketplace in 2017 but exited before 2018, like it did in the Florida markets we studied. Ambetter was the lowest-priced insurer in Atlanta for 2017 and 2018, before being displaced in 2019 by Anthem, who severely decreased its lowest silver premium for 2019. The year before that, Anthem had increased its lowest silver premium by 79.2 percent, making them the most expensive insurer by a large margin. However, as noted, Anthem greatly reduced its premiums for 2019, by 24.5 percent, bringing their least expensive option just slightly below Ambetter's lowest premium. Ambetter increased its lowest silver offering by 57.8 and 5.4 percent in 2018 and 2019. After being undercut by Anthem in 2019, Ambetter reduced its lowest silver offering by 4.8 percent, making it the lowest-priced silver insurer in Atlanta again.

Table 8. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Georgia Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Atlanta								
Ambetter	$264	$417	$440	$419	57.8%	5.4%	-4.8%	16.6%
Anthem (Blue Cross Blue Shield of Georgia)	$324	$581	$438	$440	79.2%	-24.5%	0.4%	10.7%
CareSource	N/A	N/A	N/A	$473	N/A	N/A	N/A	N/A
Humana	$538	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kaiser Permanente	$372	$421	$529	$545	13.3%	25.5%	3.1%	13.6%
Oscar	N/A	N/A	N/A	$557	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**57.8%**	**5.1%**	**-4.5%**	**16.6%**
Augusta								
Ambetter	N/A	N/A	N/A	$401	N/A	N/A	N/A	N/A
Anthem (Blue Cross Blue Shield of Georgia)	$322	$464	$490	$473	44.3%	5.5%	-3.5%	13.7%
Percent Change in Lowest Option Available					**44.3%**	**5.5%**	**-18.2%**	**7.6%**
Selected Rural Region								
Ambetter	N/A	N/A	$324	$367	N/A	N/A	13.3%	N/A
Anthem (Blue Cross Blue Shield of Georgia)	$430	$629	$666	$684	46.1%	6.0%	2.7%	16.7%
Percent Change in Lowest Option Available					**46.1%**	**-48.5%**	**13.3%**	**-5.2%**
State Average (All Regions)	**$312**	**$482**	**$434**	**$419**	**54.7%**	**-10.0%**	**-3.5%**	**10.3%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into all silver plans, both on marketplace and off.

Note: N/A: Insurer was not participating in the marketplace this year

Anthem was the only insurer offering coverage in the Augusta marketplace until this year. It increased its lowest silver premiums in the rating region dramatically from 2017 to 2019; most of the increase occurred in the 2018 plan year, when Anthem increased its lowest silver premium by 44.3 percent. In 2019, Anthem increased its lowest premium again, by 5.5 percent, but then reduced its lowest premiums by 3.5 percent this year. Ambetter entered the Augusta market this year with premiums well below Anthem's (by $72 per month for a 40-year-old), making it the lowest-cost insurer in the region, despite Anthem's 3.5 percent reduction.

Anthem was the only insurer in the southeastern rural rating region in 2017 and 2018, and the insurer raised its lowest silver premium by 46.1 percent in 2018, leaving the area's lowest-priced option well above the state average ($629 compared with $482 per month for a 40-year-old). However, Ambetter entered this market to compete with Anthem in the 2019 plan year. Entering with extremely aggressive pricing, Ambetter offered its lowest silver option for under half of Anthem's price ($324 compared with $666 for a 40-year-old). Currently, Ambetter's lowest premium is still well below Anthem's ($367 versus $684), even with a relatively large increase of 13.3 percent.

INDIANA

Several insurers participated in Indiana's market before 2017, but the state now has only two insurers, both of which are Medicaid insurers. Indiana's lowest-priced silver premiums have been consistently below the national average ($379 versus $426 in 2020), even after 28.2 and 13.8 percent statewide average increases in 2018 and 2020. Table 9 shows data specific to Indianapolis and a rural region in the southern portion of the state. As noted, insurer participation decreased in Indianapolis after 2017, when Anthem and MDwise exited. Only the two Medicaid plans, Ambetter and CareSource, remain. The region's lowest silver premium increased by 28.2 percent in 2018, 2.0 percent in 2019, and 13.3 percent in 2020. Both Ambetter and CareSource increased their premiums by about 28 percent in 2018. In 2019, Ambetter increased its lowest silver premium by another 2 percent, while CareSource increased its lowest-priced option by 7.9 percent. This allowed Ambetter to increase the small price advantage it had over CareSource in the preceding years. However, this reversed this year, because Ambetter increased its lowest silver premium by 18.6 percent and CareSource increased its lowest silver premium by 6.5 percent, making CareSource the lowest-cost insurer in the region.

Table 9. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Indiana Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Indianapolis								
Ambetter	$284	$364	$372	$441	28.2%	2.0%	18.6%	15.8%
Anthem	$414	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CareSource	$286	$366	$396	$421	28.1%	7.9%	6.5%	13.8%
MDwise	$317	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**28.2%**	**2.0%**	**13.3%**	**14.0%**
Selected Rural Region								
Ambetter	$201	$268	$257	$330	33.1%	-4.0%	28.4%	17.9%
CareSource	$258	$295	$312	$332	14.2%	5.9%	6.5%	8.8%
Percent Change in Lowest Option Available					**33.1%**	**-4.0%**	**28.4%**	**17.9%**
State Average (All Regions)	**$261**	**$332**	**$333**	**$379**	**26.9%**	**0.3%**	**13.8%**	**13.1%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into all marketplace metal tiers.

Note: N/A: Insurer was not participating in the marketplace this year

Ambetter and CareSource have been the only insurers offering coverage in the rural area in southern Indiana since 2017. The lowest silver premium increased by 33.1 percent in 2018 but fell by 4.0 percent in 2019. Ambetter has offered the lowest silver premium in the region across all four years. CareSource had a much smaller relative premium increase in 2018 (14.2 percent versus Ambetter's 33.1 percent), but it was not low enough to undercut Ambetter's pricing because of the large 2017 pricing differential. In addition, Ambetter cut its lowest silver premium by 4.0 percent in 2019, while CareSource increased its premiums by 5.9 percent, setting its pricing further beyond that of Ambetter. However, Ambetter increased its premiums by 28.4 percent this year, compared with Caresource's 6.5 percent increase. The two insurers' lowest silver premiums are now virtually identical, with only $2 per month (for a 40-year-old) separating the two.

MARYLAND

Maryland has only two marketplace insurers but adopted a reinsurance program, which significantly affected its lowest silver premiums. The state's average lowest silver premiums are below the national average ($388 versus $426 in 2020). Maryland's average lowest silver premiums increased by 47.3 percent in 2018 but fell by 7.4 and 3.9 percent in 2019 and 2020 (Table 10). Cigna left the market in 2017, and no new insurers have entered since, leaving only CareFirst and Kaiser Permanente. Maryland introduced a reinsurance program in 2018 (for the 2019 plan year), and, consequently, insurers were able to lower their silver premiums in 2019. Each insurers' lowest silver premiums are the same in both the Baltimore and Washington, D.C., suburbs. CareFirst had the largest increase in 2018 and then the largest reductions in 2019 and 2020, at 12.5 and 18.0 percent. Throughout the period, Kaiser Permanente had lower premiums than CareFirst in both markets. Because of the substantial reduction in CareFirst's lowest silver premiums in 2019 and 2020, the difference between Kaiser Permanente's and CareFirst's premiums is now relatively small ($388 versus $401) in both markets. Following the creation of the reinsurance program, Kaiser Permanente's premiums fell from $436 in 2018 to $388 today and CareFirst's fell from $559 in 2018 to $401 today. The state also has a hospital rate-setting system, in which insurers cannot benefit from negotiating better rates than a competitor. The rate-setting system may also be helping keep premiums low relative to national standards.

Table 10. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Maryland-Area Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Rating Region 1: Baltimore								
CareFirst	$355	$559	$489	$401	57.5%	-12.5%	-18.0%	4.2%
Cigna	$415	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kaiser Permanente	$309	$436	$404	$388	41.1%	-7.4%	-3.9%	7.9%
Percent Change in Lowest Option Available					**41.1%**	**-7.4%**	**-3.9%**	**7.9%**
Rating Region 3: Washington, D.C., Suburbs								
CareFirst	$355	$559	$489	$401	57.5%	-12.5%	-18.0%	4.2%
Cigna	$409	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kaiser Permanente	$309	$436	$404	$388	41.1%	-7.4%	-3.9%	7.9%
Percent Change in Lowest Option Available					**41.1%**	**-7.4%**	**-3.9%**	**7.9%**
State Average (All Regions)	**$296**	**$436**	**$404**	**$388**	**47.3%**	**-7.4%**	**-3.9%**	**9.4%**

Source: Maryland Health Connection.

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

MINNESOTA

Several insurers participate in Minneapolis' marketplace, and, like Maryland, Minnesota created a statewide reinsurance program. Minnesota's lowest silver premiums fell further below the national average this year because of three consecutive years of reduced average premiums. Table 11 only includes substate data for the Minneapolis region, because we do not have data on any of the state's rural areas for prior years. As noted, Minnesota instituted a statewide reinsurance program for its nongroup market in 2017, lowering premiums significantly. Between 2017 and 2018, the lowest silver premium in Minneapolis fell by 13.2 percent. In the next two years, the lowest silver premium fell by 10.4 and 7.6 percent. Additionally, four insurers have consistently offered coverage in Minneapolis for the past four years: Blue Plus, HealthPartners, Medica, and Ucare. Ucare, a local Medicaid insurer, has consistently been among the lowest-priced insurers over these four years, and it again offers the lowest premium today. However, as of now, the competition and reinsurance program have driven all four participating insurers' lowest silver premiums fairly close together.

Table 11. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Minneapolis, Minnesota

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Minneapolis								
Blue Plus	$419	$425	$309	$294	1.7%	-27.5%	-4.7%	-11.1%
HealthPartners	$363	$327	$304	$295	-9.9%	-7.1%	-2.9%	-6.7%
Medica	$395	$352	$300	$306	-10.9%	-14.7%	2.1%	-8.1%
UCare	$366	$315	$282	$261	-13.8%	-10.4%	-7.6%	-10.6%
Percent Change in Lowest Option Available					**-13.2%**	**-10.4%**	**-7.6%**	**-10.4%**
State Average (All Regions)	**$429**	**$363**	**$313**	**$298**	**-15.5%**	**-13.6%**	**-5.0%**	**-11.5%**

Sources: 2017 data taken from the Robert Wood Johnson Foundation's HIX Compare dataset. 2018, 2019, and 2020 data were gathered from MNsure.

NEW YORK

The regions we examined in New York had several participating insurers, both Medicaid and commercial. Because of community rating, New York's premiums are not directly comparable with the U.S. average. New York's lowest-cost silver premiums saw average increases of 10.9 percent in 2018, 15.0 percent in 2019, and 5.2 percent in 2020 (Table 12). The two regions we examined were New York City and Long Island, which both saw exits from North Shore LIJ (now known as Northwell Health) and Affinity Health Plan. North Shore LIJ is a provider-sponsored insurer that had a very competitive lowest-cost silver premium in 2017. Affinity is a Medicaid insurer that had higher silver premiums than competing Medicaid insurers and left the market in 2018. In both markets, three Medicaid insurers have the lowest premiums.

Table 12. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected New York Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
New York City								
Affinity Health Plan	$483	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EmblemHealth	$518	$652	$791	$898	25.7%	21.4%	13.5%	20.1%
Empire Blue Cross Blue Shield	$575	$883	$905	$874	53.5%	2.6%	-3.5%	15.0%
Fidelis Care	$456	$510	$598	$622	11.7%	17.2%	4.0%	10.9%
Healthfirst	$454	$531	$581	$623	17.1%	9.5%	7.1%	11.2%
MetroPlus	$468	$504	$591	$619	7.7%	17.2%	4.8%	9.8%
NorthShore LIJ	$487	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Oscar	$483	$538	$590	$657	11.3%	9.7%	11.3%	10.8%
UnitedHealthcare	$714	$825	$803	$888	15.5%	-2.7%	10.5%	7.5%
Percent Change in Lowest Option Available					**11.2%**	**15.3%**	**6.5%**	**11.0%**
Long Island								
Affinity	$494	N/A	N/A	N/A	N/A	N/A	N/A	N/A
EmblemHealth	$590	$741	$900	$1,021	25.7%	21.4%	13.5%	20.1%
Empire Blue Cross Blue Shield	$510	$783	$725	$769	53.4%	-7.5%	6.1%	14.6%
Fidelis Care	$446	$480	$562	$585	7.5%	17.2%	4.0%	9.4%
Healthfirst	$454	$564	$617	$642	24.4%	9.5%	3.9%	12.3%
NorthShore LIJ	$487	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Oscar	$483	$538	$590	$646	11.3%	9.7%	9.5%	10.2%
UnitedHealthcare	$714	$825	$803	$888	15.5%	-2.7%	10.5%	7.5%
Percent Change in Lowest Option Available					**7.5%**	**17.2%**	**4.0%**	**9.4%**
State Average (All Regions)	**$439**	**$486**	**$559**	**$589**	**10.9%**	**15.0%**	**5.2%**	**10.3%**

Source: New York State of Health

Note: N/A: Insurer was not participating in the marketplace this year

In New York City, Oscar has lowest silver premiums somewhat above the Medicaid insurers' premiums ($657 per month compared with $619 for the lowest-cost Medicaid insurer offering). The two commercial insurers, EmblemHealth and Empire Blue Cross Blue Shield and one of the state's Blue Cross Blue Shield insurers, United Healthcare, have substantially higher premiums. Currently, their premiums are $898, $874, and $888, compared with Medicaid insurers' premiums that range from $619 to $623. It seems that these commercial insurance plans do not attempt to compete with the Medicaid insurers on price but rather on access to broader networks.

The Long Island marketplace is very similar to that of New York City; the lowest silver premium increased by 7.5 percent in 2018, 17.2 percent in 2019, and 4.0 percent in 2020. The lowest silver premiums were offered by the two Medicaid insurers, Fidelis Care and Healthfirst, followed closely by Oscar. Like in New York City, the three traditionally broad network plans, EmblemHealth, Empire Blue Cross Blue Shield, and United Healthcare, have far higher premiums (e.g., Emblem's lowest premium is currently $1,021).

NORTH CAROLINA

One insurer dominated the North Carolina rating regions we studied. However, two additional insurers have recently started participating in two of the urban markets we studied. Since 2017, the state's average lowest silver premiums have been much higher than the national average, though premium reductions for this year bring the state closer to the national average (Table 13). Today the average lowest silver premium is $507, versus $426 per month nationally for a 40-year-old. The North Carolina average lowest silver premium increased by 16.3 percent in 2018 but decreased by 6.3 and 10.1 percent in 2019 and 2020. Blue Cross Blue Shield of North Carolina has a major presence in the state; it was the only insurer in Charlotte until this year (when Bright Health entered the market), is one of three insurers in the Raleigh-Durham market, and is the only insurer in the rural western region we examined. In Charlotte, the lowest silver premium increased by 16.7 percent in 2018 and fell by 23.7 percent in 2019. Because Bright Health entered the market with a very competitive price, the lowest silver premium declined by 19.4 percent this year.

Table 13. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected North Carolina Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Charlotte								
Blue Cross Blue Shield of North Carolina	$565	$659	$503	$428	16.7%	-23.7%	-15.0%	-8.9%
Bright Health	N/A	N/A	N/A	$405	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**16.7%**	**-23.7%**	**-19.4%**	**-10.5%**
Raleigh-Durham								
Ambetter	N/A	N/A	$470	$410	N/A	N/A	-12.6%	N/A
Blue Cross Blue Shield of North Carolina	$489	$571	$452	$437	16.7%	-20.9%	-3.2%	-3.7%
Cigna	$447	$541	$541	$522	20.8%	0.0%	-3.5%	5.3%
Percent Change in Lowest Option Available					**20.8%**	**-16.5%**	**-9.1%**	**-2.8%**
Selected Rural Region								
Blue Cross Blue Shield of North Carolina	$537	$610	$664	$661	13.5%	9.0%	-0.5%	7.2%
Percent Change in Lowest Option Available					**13.5%**	**9.0%**	**-0.5%**	**7.2%**
State Average (All Regions)	**$517**	**$601**	**$563**	**$507**	**16.3%**	**-6.3%**	**-10.1%**	**-0.7%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

In Raleigh-Durham, Blue Cross Blue Shield of North Carolina competed with Cigna in 2017 and 2018, and Ambetter entered the market in 2019. Cigna had lower silver premiums than Blue Cross Blue Shield in 2018 and 2019, but Blue Cross Blue Shield reduced its lowest silver premium by 20.9 percent in 2019, becoming the lowest-priced insurer, despite Cigna having kept its 2018 pricing for 2019. Ambetter entered the Raleigh-Durham market competitively, with premiums close to Blue Cross Blue Shield's lowest silver premium that year. Both Blue Cross Blue Shield and Cigna decreased their lowest silver premiums for 2020 but not as much as Ambetter, which became the lowest-cost insurer.

In the rural region, where Blue Cross Blue Shield monopolizes the market, lowest silver premiums increased by 13.5 and 9.0 percent in 2018 and 2019. Premiums fell by 0.5 percent this year. The 2018 and 2019 lowest silver premium increases in this area led to a lowest premium of $661 in 2020, well above the silver premiums in the urban markets and the national average.

OHIO

The rating regions we examined in Ohio have had several insurers, including three large national or multistate Medicaid insurers. Ohio's average lowest silver premiums remain well below the national average ($353 versus $426 in 2020), despite 38.2 and 3.3 percent increases in 2018 and 2019. Table 14 provides data for three Ohio rating regions: Columbus, Cleveland, and a rural rating region in the state's southeast. Historically, the metropolitan markets in Ohio have had significant insurer participation. From 2017 to 2019, Columbus and Cleveland each had between four and five competing marketplace insurers. Anthem left both metropolitan markets in 2018. Ambetter from Buckeye Health Plan entered Columbus in 2018, and Oscar entered Cleveland's marketplace in 2018 and Columbus' in 2019.

Table 14. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Ohio Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Columbus								
Ambetter from Buckeye Health Plan	N/A	$417	$401	$366	N/A	-3.7%	-8.8%	-6.3%
Anthem	$342	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CareSource	$284	$385	$474	$460	35.4%	23.3%	-3.0%	17.4%
Medical Mutual of Ohio	$326	$423	$437	$493	29.9%	3.4%	12.7%	14.8%
Molina Healthcare	$301	$461	$444	$391	53.5%	-3.7%	-12.1%	9.1%
Oscar	N/A	N/A	$382	$407	N/A	N/A	6.7%	N/A
Percent Change in Lowest Option Available					**35.4%**	**-0.8%**	**-4.1%**	**8.8%**
Cleveland								
Ambetter from Buckeye Health Plan	$224	$307	$323	$322	36.8%	5.1%	-0.1%	12.8%
Anthem	$363	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CareSource	$253	$319	$371	$360	26.2%	16.1%	-2.9%	12.5%
Medical Mutual of Ohio	$376	$364	$360	$407	-3.1%	-1.2%	13.2%	2.7%
Molina Healthcare	$252	$346	$366	$330	37.2%	5.7%	-9.8%	9.3%
Oscar	N/A	$434	$466	$453	N/A	7.4%	-2.6%	N/A
Percent Change in Lowest Option Available					**36.8%**	**5.1%**	**-0.1%**	**12.8%**
Selected Rural Region								
Anthem	$413	N/A	$555	$619	N/A	N/A	11.7%	N/A
CareSource	$347	$579	$708	$618	66.8%	22.2%	-12.7%	21.2%
Medical Mutual of Ohio	N/A	N/A	N/A	$579	N/A	N/A	N/A	N/A
Molina Healthcare	$290	$415	$469	$386	43.2%	12.8%	-17.6%	10.0%
Percent Change in Lowest Option Available					**43.2%**	**12.8%**	**-17.6%**	**10.0%**
State Average (All Regions)	**$251**	**$347**	**$359**	**$353**	**38.2%**	**3.3%**	**-1.4%**	**12.1%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

The lowest silver premium in Columbus, like much of the United States, increased significantly in the 2018 plan year, by 35.4 percent. However, the lowest silver premium decreased by 0.8 percent in 2019 and by another 4.1 percent this year. CareSource has offered marketplace coverage in all four years and offered the lowest-priced option in 2017 and 2018. However, inconsistent with the market in 2019 generally, CareSource increased its lowest-priced silver option considerably, by 23.3 percent, thus becoming the highest-priced insurer in this market. Among other insurers in the Columbus marketplace, changes to lowest silver premiums ranged from a 3.7 percent decrease to a 23.3 percent increase. In Columbus, Oscar offered the lowest premium silver option for 2019, lower than the that for the three Medicaid insurers and Medical Mutual of Ohio. Both Ambetter and Molina currently have the two lowest premiums.

The lowest silver premium in Cleveland increased by 36.8 and 5.1 percent in 2018 and 2019. The Cleveland rating region's marketplace has had three Medicaid plans throughout the study period. Ambetter has offered the lowest silver premium plan since 2018, despite the aforementioned 36.8 and 5.1 percent increases in 2018 and 2019. Molina and CareSource also increased their lowest premium offerings considerably in 2018 (by 37.2 and 26.2 percent). Their increases continued in 2019, but CareSource increased its lowest premium by 16.1 percent, making it the only insurer in that market with a double-digit percent increase that year. Unlike in Columbus, Oscar was the highest-priced insurer in Cleveland in 2018 and 2019 and remains so today. Ambetter still has the lowest silver premiums.

The lowest silver premiums in our selected rural region increased by 43.2 and 12.8 percent in 2018 and 2019, considerably larger increases than those in Cleveland and Columbus. Three insurers participated in this area in 2019, up from two in 2018. Anthem participated in 2017, left the market for the 2018 plan year, and returned for 2019. Medical Mutual of Ohio entered this year. Molina has been the lowest premium insurer in this region across the four study years; its lowest premium for a 40-year-old is currently $386 per month. Between 2017 and 2019, CareSource more than doubled its lowest-priced silver premiums. Though Anthem returned to this market in 2019, it still has relatively high premiums.

OREGON

Several insurers participated in both the rural and urban markets in the Oregon rating regions we analyzed. Oregon's lowest silver premiums are about the same as the national average ($424 versus $426 in 2020), following 24.8 and 9.1 percent increases in 2018 and 2019. Table 15 provides data on marketplace-participating insurers in Portland and a rural region in eastern Oregon. The lowest silver premium in Portland increased by 24.2 and 8.8 percent in 2018 and 2019, before falling by 2.7 percent in 2020. Insurer participation has been consistently high in Portland throughout the study period, with the same five insurers competing. Kaiser Permanente offered the lowest silver premium option in the region through 2019. Currently, four competitors have lower silver premiums than Kaiser, though the premiums are all similar. There are no Medicaid insurers in the Portland marketplace, but the high and consistent insurer participation has helped hold premium levels down. Several provider-sponsored insurers (Providence Health Plan, Kaiser) participate in Portland's marketplace, and these insurers tend to have narrow networks that give their own providers preferential pricing.

Table 15. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Oregon Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Portland								
BridgeSpan Health Company	$361	$391	$420	$421	8.2%	7.3%	0.3%	5.2%
Kaiser Permanente	$302	$375	$408	$438	24.2%	8.8%	7.4%	13.2%
Moda Health	$386	$405	$433	$414	4.9%	6.9%	-4.4%	2.4%
PacificSource Health Plans	$442	$484	$425	$436	9.5%	-12.2%	2.6%	-0.5%
Providence Health Plan	$326	$380	$414	$397	16.6%	8.9%	-4.1%	6.8%
Percent Change in Lowest Option Available					**24.2%**	**8.8%**	**-2.7%**	**9.5%**
Selected Rural Region								
Kaiser Permanente	$302	$375	$408	$438	24.2%	8.8%	7.4%	13.2%
Moda Health	$397	$436	$478	$455	9.8%	9.6%	-4.8%	4.7%
PacificSource Health Plans	$446	$488	$445	$455	9.4%	-8.8%	2.2%	0.7%
Providence Health Plan	$490	$456	$517	$496	-6.9%	13.4%	-4.1%	0.4%
Percent Change in Lowest Option Available					**24.2%**	**8.8%**	**7.4%**	**13.2%**
State Average (All Regions)	**$311**	**$388**	**$424**	**$424**	**24.8%**	**9.1%**	**0.1%**	**10.9%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into silver plans, both on and off marketplace.

Note: N/A: Insurer was not participating in the marketplace this year

Premiums increased at about the same rates in the rural Oregon region and Portland. In the rural region, the lowest silver premiums increased by 24.2 percent for the 2018 plan year, 8.8 percent for 2019, and 7.4 percent for 2020. Again, Kaiser Permanente was the lowest-priced insurer in all four years and offered the same premiums available in Portland. Though Kaiser's premiums increased faster than other insurers' premiums, Kaiser remained the lowest-priced insurer in 2020 because it priced well below the other insurers in 2017.

RHODE ISLAND

Only two insurers participated in Rhode Island's marketplace during the study period, but one was a Medicaid insurer. Rhode Island's lowest silver premiums were quite low compared with national standards, and the entire state comprises only one rating region (Table 16). The state's participating insurers were Neighborhood Health Plan and Blue Cross Blue Shield of Rhode Island. Neighborhood Health Plan is a local Medicaid insurer that has successfully kept its premium increases low, going up 18.4 percent in 2018, 9.7 percent in 2019, and 0.3 percent in 2020. The pricing gap between Blue Cross Blue Shield and Neighborhood has grown in recent years, with a large difference remaining ($316 versus $372). Blue Cross Blue Shield increased its lowest silver premium by 45.2 percent in 2018, lowering it by only 1.0 percent in 2019 and 2.4 percent in 2020. In addition to the competition between these two insurers, the state's Division of Insurance regulation reviews insurer contracts with hospitals; this process helps keep hospital costs low, which helps keep premiums lower than they otherwise would be.

Table 16. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Rhode Island

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Entire State								
Blue Cross Blue Shield of Rhode Island	$265	$385	$381	$372	45.2%	-1.0%	-2.4%	12.0%
Neighborhood Health Plan of Rhode Island	$243	$287	$315	$316	18.4%	9.7%	0.3%	9.2%
State Average Change in Lowest Option Available	**$243**	**$287**	**$315**	**$316**	**18.4%**	**9.7%**	**0.3%**	**9.2%**

Source: Healthsource RI.

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

TEXAS

Several insurers, including two national Medicaid insurers, participated in the urban Texas markets we studied. Texas' lowest silver premiums have consistently been below the national average, though the state average lowest silver premiums increased by 41.3 percent in 2018, 2.5 percent in 2019, and 0.6 percent in 2020. Table 17 provides data on two major Texas metropolitan regions, Dallas and Houston. We did not study a rural area because the state grouped nearly every rural county into a single rating region, resulting in different insurers participating in different counties with different lowest silver premiums. The lowest silver premiums in the Dallas market increased by 48.4 percent in 2018 and fell by 0.2 and 0.7 percent in 2019 and 2020. The same three insurers have participated in this market since the 2017 plan year: Molina, Ambetter, and Blue Cross and Blue Shield of Texas. Oscar entered the Dallas market this year. Ambetter and Molina have been in tight competition over this period, particularly in 2018 and 2019. Currently, all four insurers have similar premiums, and Blue Cross Blue Shield continues to be the most expensive insurer in the region despite offering an HMO product.

Table 17. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Texas Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Dallas/Fort Worth								
Ambetter	$322	$415	$410	$410	29.0%	-1.1%	-0.2%	8.4%
Blue Cross and Blue Shield of Texas	$449	$570	$555	$428	27.0%	-2.6%	-23.0%	-1.6%
Molina Healthcare	$277	$411	$431	$408	48.4%	4.7%	-5.3%	13.7%
Oscar	N/A	N/A	N/A	$411	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**48.4%**	**-0.2%**	**-0.7%**	**13.7%**
Houston								
Ambetter	NA	$390	$385	$381	NA	-1.1%	-1.1%	-1.1%
Blue Cross and Blue Shield of Texas	$431	$545	$508	$422	26.5%	-6.8%	-16.9%	-0.7%
Community Health Choice	$311	$460	$464	$464	48.0%	1.0%	0.0%	14.3%
Molina Healthcare	$283	$399	$418	$395	41.3%	4.6%	-5.4%	11.9%
Oscar	N/A	N/A	N/A	$416	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**37.9%**	**-1.1%**	**-1.1%**	**10.5%**
State Average (All Regions)	**$279**	**$394**	**$403**	**$406**	**41.3%**	**2.5%**	**0.6%**	**13.4%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: N/A: Insurer was not participating in the marketplace this year

The lowest silver premiums in Houston increased by 37.9 percent in 2018 but fell by 1.1 percent in both 2019 and 2020. Molina, Community Health Choice (a local Medicaid insurer), and Blue Cross Blue Shield of Texas offered coverage throughout the study period in Houston. They were joined by Ambetter in 2018 and Oscar this year. Molina offered the lowest silver premium option in 2017, but Ambetter became the lowest-cost silver insurer when it entered the market. Like in Dallas, Blue Cross Blue Shield was the highest-priced insurer from 2017 to 2019, despite a lower-than-average premium increase in 2018 and a 6.8 percent decrease to the lowest silver premium in 2019. With another 16.9 percent premium reduction this year, Blue Cross Blue Shield's silver premiums are no longer the highest.

VIRGINIA

Several insurers have participated in the Virginia markets we studied, and the number varies by rating region. Additionally, several insurers entered and exited the market during the study period. Virginia's average lowest silver premium was below the national average in 2017, but 64.0 and 3.9 percent increases in 2018 and 2019 have driven current premiums well above the national average ($504 versus $426). Table 18 shows data on three markets in Virginia: Richmond, Virginia Beach/Norfolk, and the Washington, D.C., suburbs. Several insurers have entered and exited the Richmond market since 2017. Aetna and United Healthcare both left before the 2018 plan year, and Optima Health, a provider-sponsored insurer, entered in 2018. Virginia Premier Health Plan, a local Medicaid insurer, entered for the 2019 plan year. Three insurers participated in all four years: Cigna, Anthem HealthKeepers, and Kaiser Permanente. In 2018, Cigna, Anthem HealthKeepers, and Kaiser Permanente increased their lowest silver premiums considerably, with a 51.6 percent increase in the lowest-cost offering. Aetna offered the lowest silver premium in 2017 but left most of the ACA marketplaces after that plan year. Following Aetna's exit, Cigna became the lowest silver premium insurer in 2018 and remained so for the 2019 plan year. Virginia Premier entered the market in 2019 and was one of the lowest-priced silver insurers then and remains so today. Optima Health entered the marketplace in 2018 with extraordinarily higher premiums than those of other participating insurers, and even an 11 percent premium decrease in their lowest silver offering in 2019 could not bring their premiums close to those of other insurers in the Richmond area. However, Optima became one of the lowest-priced insurers this year. Anthem HealthKeepers, an HMO product, is currently the lowest-cost silver plan.

Table 18. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected Virginia Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Richmond								
Aetna	$289	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anthem HealthKeepers	$303	$497	$531	$489	64.2%	6.7%	-8.0%	17.3%
Cigna	$296	$439	$490	$502	48.0%	11.7%	2.5%	19.3%
Kaiser Permanente	$329	$447	$638	$592	36.0%	42.7%	-7.3%	21.6%
Piedmont Community Health Plan	$357	$572	$674	N/A	60.0%	17.9%	N/A	N/A
Optima Health	N/A	$900	$801	$528	N/A	-11.0%	-34.1%	N/A
Oscar	N/A	N/A	N/A	$520	N/A	N/A	N/A	N/A
UnitedHealthcare	$333	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Virginia Premier Health Plan	N/A	N/A	$504	$514	N/A	N/A	2.1%	N/A
Percent Change in Lowest Option Available					**51.6%**	**11.7%**	**-0.3%**	**19.1%**
Virginia Beach/Norfolk								
Aetna	$336	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anthem HealthKeepers	$338	N/A	$542	$515	N/A	N/A	-5.0%	N/A
Optima Health	$376	$641	$602	$478	70.5%	-6.1%	-20.6%	8.3%
Percent Change in Lowest Option Available					**90.8%**	**-15.4%**	**-11.9%**	**12.5%**

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Washington D.C. Suburbs [1]								
Anthem HealthKeepers	$336	$511	$552	$514	52.3%	8.0%	-6.9%	15.3%
Cigna	$313	$458	$508	$527	46.1%	11.0%	3.8%	18.9%
Innovation Health	$296	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kaiser Permanente	$329	$447	$638	$592	36.0%	42.7%	-7.3%	21.6%
UnitedHealthcare	$319	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**51.4%**	**13.5%**	**1.2%**	**20.3%**
State Average (All Regions)	**$309**	**$506**	**$526**	**$504**	**64.0%**	**3.9%**	**-4.2%**	**17.8%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Notes: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

1. We exclude CareFirst from this analysis since it only serves a small portion of the entire region.

Note: N/A: Insurer was not participating in the marketplace this year

The lowest silver premiums in Virginia Beach/Norfolk increased by 90.8 percent in 2018 but fell by 15.4 and 11.9 percent in 2019 and 2020. Optima Health, linked to their own hospital system in Virginia Beach and Norfolk, is the only insurer participating in this market in all four years. Aetna left the marketplace after 2017, like they did in many marketplaces around the country. Similarly, Anthem HealthKeepers left the marketplace in 2018 but returned in 2019, as it did elsewhere in the state. Optima increased its lowest silver premium by 70.5 percent after 2017, making it an extremely high–priced insurer in 2018. Optima reduced its premiums by 6.1 and 20.6 percent in 2019 and 2020 to become the lowest-cost insurer this year. Anthem reentered the marketplace in 2019 with a lowest silver premium considerably below that offered by Optima Health in 2019 but not in 2020.

The lowest silver premiums in the Washington, D.C., suburbs increased by 51.4 and 13.5 percent in 2018 and 2019, and only slightly increased by 1.2 percent in 2020. Five insurers competed in this market in 2017, but this number dropped to three for 2018, 2019, and 2020. Carefirst, another licensee of the Blue Cross Blue Shield Association, offers marketplace coverage only in the area of this rating region where Anthem does not participate. (For comparison, we concentrate our analysis only on the part of the D.C. suburbs not served by CareFirst.) Innovation Health, a provider-sponsored insurer linked to the dominant hospital system in Northern Virginia, left the marketplace after the 2017 plan year despite being the lowest-priced insurer. Innovation was a collaboration between the Inova health system and Aetna. However, when Aetna left the marketplaces nationwide, this product was no longer offered in the Virginia marketplace. United Healthcare left that year as well. Cigna was the lowest-priced insurer in 2019, and it was the second-lowest-priced insurer in 2017 and 2018. Anthem's HMO product, HealthKeepers, was the second-lowest-priced insurer in this market by 2019 and is the lowest-priced insurer today. Kaiser offered the lowest silver premium in 2018, but its 42.7 percent increase for 2019 made it the highest-priced insurer in both 2019 and 2020.

WASHINGTON

Several insurers participate in Washington's marketplace, including two national Medicaid insurers. Washington's average lowest silver premiums have been consistently below the national average over this period; currently, their state average lowest silver premium for a 40-year-old is $379, compared with $426 nationally. The average premiums increased by 37.0 percent in 2018, 13.2 percent in 2019, and 3.0 percent in 2020. Table 19 provides data for the Seattle rating region. In response to insurers' requests, Washington redrew its premium rating regions beginning in the 2019 plan year, but the Seattle rating region remained the same. The state's marketplace insurers wanted to expand the number of regions to more easily comply with regulations limiting the premium difference between the cheapest and most expensive rating regions.[18] Seven insurers sold coverage in Seattle through the marketplace in 2017, including several Medicaid, Blue Cross–affiliated, and regional insurers. After 2017, however, three insurers (BridgeSpan Health Company, LifeWise, and Regence) left the marketplace. Both BridgeSpan and LifeWise returned this year. LifeWise is owned by Premera Blue Cross, and both offer two of the three most expensive lowest silver premiums in this region this year. Premera has maintained a presence in this market during all four years. Despite Bridgespan's exit and reentry, this marketplace has remained relatively competitive, with fairly low premiums among the Medicaid insurers and Kaiser Permanente. Coordinated Care, a subsidiary of the Centene Corporation, offered the lowest-premium silver option from 2017 to 2019. Molina, another national Medicaid insurer, had the second lowest silver premiums from 2017 to 2019, and offered the lowest-premium silver option in 2020. Kaiser Permanente (formerly Group Health) remains in the market as well, and its lowest silver option continues to be priced reasonably competitively with those of the Medicaid insurers.

Table 19. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Seattle, Washington

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change 2017–20
Seattle								
BridgeSpan Health Company	$315	N/A	N/A	$447	N/A	N/A	N/A	N/A
Coordinated Care	$235	$328	$368	$380	39.6%	12.3%	3.2%	17.4%
Group Health (Kaiser Permanente)	$280	$404	$439	$405	44.2%	8.7%	-7.7%	13.1%
LifeWise	$324	N/A	N/A	$419	N/A	N/A	N/A	N/A
Molina HealthCare	$257	$385	$412	$379	49.7%	6.9%	-8.1%	13.7%
Premera Blue Cross	$404	$517	$520	$515	27.9%	0.7%	-0.9%	8.5%
Regence	$326	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percent Change in Lowest Option Available					**39.6%**	**12.3%**	**2.9%**	**17.3%**
State Average (All Regions)	**$238**	**$326**	**$368**	**$379**	**37.0%**	**13.2%**	**3.0%**	**16.9%**

Source: Washington Healthplan Finder.

Note: Insurers instructed to load the cost of cost-sharing reductions into silver marketplace premiums only.

Note: Group Health is now owned by Kaiser Permanente. It is now marketed as Kaiser Permanente but was marketed as Group Health during this time period.

Note: N/A: Insurer was not participating in the marketplace this year

WEST VIRGINIA

West Virginia has had little marketplace competition, though a Medicaid insurer now participates in each of our study regions. Currently, West Virginia's average lowest silver premiums remain well above the 2020 national average ($601 versus $426 for a 40-year-old). Table 20 provides data for two rating regions: Charleston and a rural region in northeastern West Virginia. The same two insurers have participated in both regions in all four study years: CareSource, a regional Medicaid insurer, and Highmark Blue Cross Blue Shield. Highmark is a Blue Cross affiliate and has historically dominated the West Virginia nongroup insurance market. CareSource began offering nongroup marketplace coverage in the state in 2017 and has offered the lowest-priced silver plans in both regions in each of the four years. The average increase in the lowest silver premiums in these markets was well below the national average in 2018, likely because the state instructed insurers to load the cost of the cost-sharing reductions into the premiums of all metal tiers both on and off marketplace, instead of in the silver premiums alone. However, the 2019 lowest silver premium increases were well above the national average, keeping the state's silver premiums high during our study period. Still, CareSource provides a lower-priced silver option for consumers in the state, with the differential between its most affordable plan and that of Highmark being particularly significant in the Charleston area.

Table 20. Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2020, by Insurer in Selected West Virginia Markets

Insurer	Lowest Silver Premium				Percent Change			
	2017	2018	2019	2020	2017–18	2018–19	2019–20	Average Annual Change, 2017–20
Charleston								
CareSource	$505	$555	$611	$653	9.8%	10.2%	6.8%	8.9%
Highmark Blue Cross Blue Shield	$541	$653	$713	$747	20.7%	9.1%	4.8%	11.3%
Percent Change in Lowest Option Available					**9.8%**	**10.2%**	**6.8%**	**8.9%**
Selected Rural Region								
CareSource	$485	$555	$614	$656	14.5%	10.7%	6.8%	10.6%
Highmark Blue Cross Blue Shield	$493	$595	$649	$680	20.7%	9.1%	4.8%	11.3%
Percent Change in Lowest Option Available					**14.5%**	**10.7%**	**6.8%**	**10.6%**
State Average (All Regions)	**$440**	**$514**	**$562**	**$601**	**16.9%**	**9.3%**	**6.9%**	**11.0%**

Source: Healthcare.gov, https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Note: Insurers instructed to load the cost of cost-sharing reductions into all metal tiers, both on marketplace and off.

CONCLUSION

The ACA's nongroup insurance marketplaces experienced considerable turmoil between 2017 and 2019. Threats to the ACA, from the elimination of direct funding of cost-sharing reductions to not enforcing the individual mandate, along with an array of other regulatory changes caused insurers to increase premiums dramatically in 2018; the national average increase in insurers' lowest silver premium in 2018 was 29.7 percent, and twenty-eight states had average increases that exceeded that level. In 2019, national average lowest silver premiums were stable; many states' average premiums fell while most others' premiums increased only modestly. Lowest silver premiums have fallen by 3.5 percent this year, suggesting that the market is stabilizing following the shocks of 2017 and 2018. In addition, states took action to stabilize their marketplaces with reinsurance programs, which are clearly associated with lower reported premiums.[19]

The specific markets we examined experienced a considerable number of insurer entries and exits. In 2018, far more insurers left marketplaces than entered them, and insurers and policymakers shared skepticism about the stability of the marketplaces. In 2019, the reverse was true, suggesting that insurers came to see the marketplaces as more stable, even with the repeal of the individual mandate penalty starting in 2019. In several instances, insurers that exited the marketplaces after 2017 reentered for the 2019 plan year. Many more insurers, like Bright Health and Oscar, have entered than exited markets in 2020. In fact, more insurers participate per region now than in 2017 (3.9 compared with 3.8).

Continued variation in premiums across states, within states, and across metropolitan and rural areas is associated with market competition and other factors (Figure 1). Currently, the national average lowest silver premium for a 40-year-old is $426, but six states have average lowest silver premiums exceeding $550 per month. In each of these states, one insurer dominated, leaving little market competition. Additionally, all these states maintain relatively lax regulatory environments, permitting grandmothered plans; allowing the sale of full-year, short-term limited duration plans; and not regulating health care–sharing ministries. At the other end of the spectrum, eight states currently have average lowest silver premiums below $360 per month. Each of these states' marketplaces include multiple competing insurers and at least one participating Medicaid insurer.

Marketplaces continued to evolve from 2017 to 2019; much of the change appears attributable to the policy upheaval and uncertainty beginning in early 2017, with some of the change owed to other factors. Comparing Figures 1 and 2 reinforces this, as shown by the large increases in premiums in 2018, the two subsequent years of decreased national average premiums, and the overall increase in premiums from 2017 to today. The large national commercial insurers, Humana, United, Aetna, and Anthem, continued to leave marketplaces they had operated in since the early years of the ACA. Medicaid insurers now frequently offer the lowest silver premiums in the marketplaces. We also see some Medicaid insurers entering new markets previously dominated by a single insurer (e.g., Alabama, North Carolina, and West Virginia). More insurers entering markets in 2019 and 2020, following the 2018 drop-off in participation, shows that some insurers believe that the marketplaces are stabilizing, functional, and potentially profitable, even with all the administrative and legislative changes to the ACA in recent years.

The future pricing stability in the ACA marketplaces rests on several unanswered questions, however. Do consumers find marketplace provider networks adequate? If the increase in narrow-network plans leads to access concerns, higher provider payment rates (and thus higher premiums) may be required to broaden networks. How many healthier-than-average enrollees have left the ACA-compliant nongroup market to purchase short-term, limited-duration plans or other noncompliant policies? Such exits will hurt the ACA's risk pool (and push average premiums higher) in the near term. Has the effect of the elimination of the individual mandate penalties been fully felt in these markets? If some people were unaware of the elimination of the penalties as of the 2020 plan year, more people (and those who are healthier than average) may choose to drop coverage in the coming years, increasing the average health care costs of the remaining insurance pool and pushing premiums upward. Maintaining stable nongroup insurance markets may require additional regulatory or legislative action.

However, reducing premiums in markets without insurer and/or provider competition requires more significant changes than reversing or enhancing recent legislative or regulatory changes. Due to the significant barriers to entry for both insurers and providers in these markets, it is unlikely that competitive pressures will improve the situations. Reducing premiums in noncompetitive markets will likely require introducing a public option and/or capping provider payment rates at levels below those resulting from monopolistic pricing.

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PLOS MEDICINE

RESEARCH ARTICLE

Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses

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Abstract

Background

The United States is the only high-income nation without universal, government-funded or -mandated health insurance employing a unified payment system. The US multi-payer system leaves residents uninsured or underinsured, despite overall healthcare costs far above other nations. Single-payer (often referred to as Medicare for All), a proposed policy solution since 1990, is receiving renewed press attention and popular support. Our review seeks to assess the projected cost impact of a single-payer approach.

Methods and findings

We conducted our literature search between June 1 and December 31, 2018, without start date restriction for included studies. We surveyed an expert panel and searched PubMed, Google, Google Scholar, and preexisting lists for formal economic studies of the projected costs of single-payer plans for the US or for individual states. Reviewer pairs extracted data on methods and findings using a template. We quantified changes in total costs standardized to percentage of contemporaneous healthcare spending. Additionally, we quantified cost changes by subtype, such as costs due to increased healthcare utilization and savings due to simplified payment administration, lower drug costs, and other factors. We further examined how modeling assumptions affected results. Our search yielded economic analyses of the cost of 22 single-payer plans over the past 30 years. Exclusions were due to inadequate technical data or assuming a substantial ongoing role for private insurers. We found that 19 (86%) of the analyses predicted net savings (median net result was a savings of 3.46% of total costs) in the first year of program operation and 20 (91%) predicted savings over several years; anticipated growth rates would result in long-term net savings for all plans. The largest source of savings was simplified payment administration (median 8.8%), and the best predictors of net savings were the magnitude of utilization increase, and

Competing interests: I have read the journal's policy and the authors of this manuscript have the following competing interests: CC is an executive board member of Students for a National Health Program (SNaHP). SNaHP had no role in study design, data collection, analysis, decision to publish or manuscript preparation.

Abbreviations: ACO, accountable care organization; OECD, Organisation for Economic Co-operation and Development; VA, US Veterans Administration.

savings on administration and drug costs (R^2 of 0.035, 0.43, and 0.62, respectively). Only drug cost savings remained significant in multivariate analysis. Included studies were heterogeneous in methods, which precluded us from conducting a formal meta-analysis.

Conclusions

In this systematic review, we found a high degree of analytic consensus for the fiscal feasibility of a single-payer approach in the US. Actual costs will depend on plan features and implementation. Future research should refine estimates of the effects of coverage expansion on utilization, evaluate provider administrative costs in varied existing single-payer systems, analyze implementation options, and evaluate US-based single-payer programs, as available.

Author summary

Why was this study done?

- As the US healthcare debate continues, there is growing interest in "single-payer" also known as "Medicare for All." Single-payer uses a simplified public funding approach to provide everyone with high-quality health insurance.
- Public support for provision of universal health coverage through a plan like Medicare for All is as high as 70%, but falls when costs are emphasized.
- Economic models help assess the financial viability of single-payer. Yet, models vary widely in their assumptions and methods, and can be hard to compare.

What did the researchers do and find?

- We found and compared cost analyses of 22 single-payer plans for the US or individual states.
- Nineteen (86%) of the analyses estimated that health expenditures would fall in the first year, and all suggested the potential for long-term cost savings.
- The largest savings were predicted to come from simplified billing and lower drug costs.
- Studies funded by organizations across the political spectrum estimated savings for single-payer.

What do these findings mean?

- There is near-consensus in these analyses that single-payer would reduce health expenditures while providing high-quality insurance to all US residents.
- To achieve net savings, single-payer plans rely on simplified billing and negotiated drug price reductions, as well as global budgets to control spending growth over time.

- Replacing private insurers with a public system is expected to achieve lower net healthcare costs.

Introduction

Nine years after passage of the Affordable Care Act, 10.4% (27.9 million) of the nonelderly US population remains uninsured [1]. Lack of insurance is associated with worse health outcomes, including death [2], due to decreased access to healthcare and preventive services [3–5]. Underinsurance, defined as cost sharing that represents significant financial barriers to care or risk of catastrophic medical expenditures, is rising and is associated with a 25% or greater likelihood of omitted or delayed care [6,7]. Low-income adults with public insurance have improved access and quality of care compared to uninsured adults [8].

Meanwhile, healthcare costs continue to rise, approaching one-fifth of the economy. In 2018, national health expenditures reached $3.6 trillion, equivalent to 17.7% of GDP [9]. Government funding, including public programs, private insurance for government employees, and tax subsidies for private insurance, represented 64% of national health expenditures in 2013, or 11% of GDP, more than total health expenditures in almost any other nation [10]. Higher costs in the US are due primarily to higher prices and administrative inefficiency, not higher utilization [11–13].

An oft-proposed alternative to the contemporary multi-payer system is single-payer, also referred to as Medicare for All. Key elements of single-payer include unified government or quasi-government financing, universal coverage with a single comprehensive benefit package, elimination of private insurers, and universal negotiation of provider reimbursement and drug prices. Single-payer as it has been proposed in the US has no or minimal cost sharing. Polled support for single-payer is near an all-time high, as high as two-thirds of Americans [14] and 55% of physicians [15]. Two-thirds of Americans support providing universal health coverage through a national plan like Medicare for All as an extremely high priority for the incoming Congress [16]. However, support varies substantially according to how single-payer is described [17]. As of November 2019, there are 2 "Medicare for All Act of 2019" legislative proposals in the US Congress: Senate Bill 1129 and House of Representatives Bill 1384.

Economic analyses are crucial for formally estimating the net cost of single-payer proposals. These models estimate how potential added costs of single-payer, due to increased utilization of services, compare with the savings induced by simplified payment administration, lower drug prices, and other factors. Such economic projections can shape plan design, contribute to policy discourse, and affect the viability of legislation. As single-payer proposals gain legislative traction, the importance of economic models rises.

However, these analyses are complex and heterogeneous, making generalizations difficult. Findings vary across studies, from large "net savings" to "net costs," as do modeling assumptions, such as the extent of administrative savings and presence or absence of drug price negotiations. The diversity of findings contributes to political spin and fuels popular uncertainty over the anticipated costs of a single-payer healthcare system. For example, a 2018 study by Pollin et al. (Political Economy Research Institute) estimated that a national Medicare for All system would save $313 million in the first year of implementation, while a 2018 study by Blahous (Mercatus Center) found that the same system would save $93 million in the first year, and a 2016 report from Holahan et al. (Urban Institute) suggested that a modified form of this

proposal, e.g., relying on private insurers, would increase costs [18–20]. Variation in single-payer proposals and analytic approaches likely explains many of the differences in outcomes across studies, but no comparative review has been undertaken, to our knowledge.

The goal of this study is to systematically review economic analyses of the cost of single-payer proposals in the US (both national and state level), summarize results in a logical but accessible manner, examine the association of findings with plan features and with analytic methods, and, finally, examine the empirical evidence regarding key study assumptions.

Methods

Overview

We specified in advance that we would extract and quantitatively compare increased costs due to utilization rises and savings due to administrative simplification, drug savings, and other factors. We searched for studies by examining existing lists, querying experts, and searching online. Ethics approval was not deemed to be necessary since all data were publicly available. All data are available in the original studies, which are listed in S1 Appendix. We included studies that examined insurance plans with essential single-payer features and that provided adequate technical detail on inputs and results. For these studies, we extracted information about plan features, analytic assumptions, and findings (costs due to higher utilization, savings of all types, and net costs; see Table A in S1 Appendix for definitions of terms). We expressed all estimates as a percentage of contemporaneous healthcare spending, to facilitate comparison across settings and time periods. We summarized study methods and findings graphically and analyzed associations between studies and spending estimates.

Search

We adopted a broad search strategy, reflecting our initial assessment (subsequently confirmed) that economic models of the cost of single-payer plans are not published in academic journals. We conducted all components of our search from June 1 to December 31 of 2018.

We searched in PubMed, Google Scholar, and Google, using combinations of ("Single-payer" OR "single-payer") AND ("cost" OR "model" OR "economic" OR "cost-benefit"). We limited our Google search to 10 pages of results. We consulted existing lists maintained by Physicians for a National Health Program and Healthcare-NOW [21,22]. We asked a convenience sample of 10 single-payer experts. We also searched the websites of leading advocacy and industry-sponsored groups in favor of single-payer reform (Physicians for a National Health Plan and Healthcare-NOW) and in opposition to single-payer reform (Partnership for America's Health Care Future). Additional search details are provided in Table B in S1 Appendix. A PRISMA flow diagram is provided in Fig 1. A PRISMA checklist can be found in Table G in S1 Appendix.

Inclusion and exclusion

"Single-payer" has a wide range of definitions, both in the US and internationally. We chose inclusion and exclusion criteria that were most consistent with single-payer plans that have been proposed in the US. For example, while some single-payer plans internationally have included private intermediaries within a unified payment system, US proposals have omitted a role for private insurers. Thus, we use private intermediaries as an exclusion criterion. Notably, recent healthcare proposals such as "Medicare Extra for All" would not meet our inclusion criteria [23].

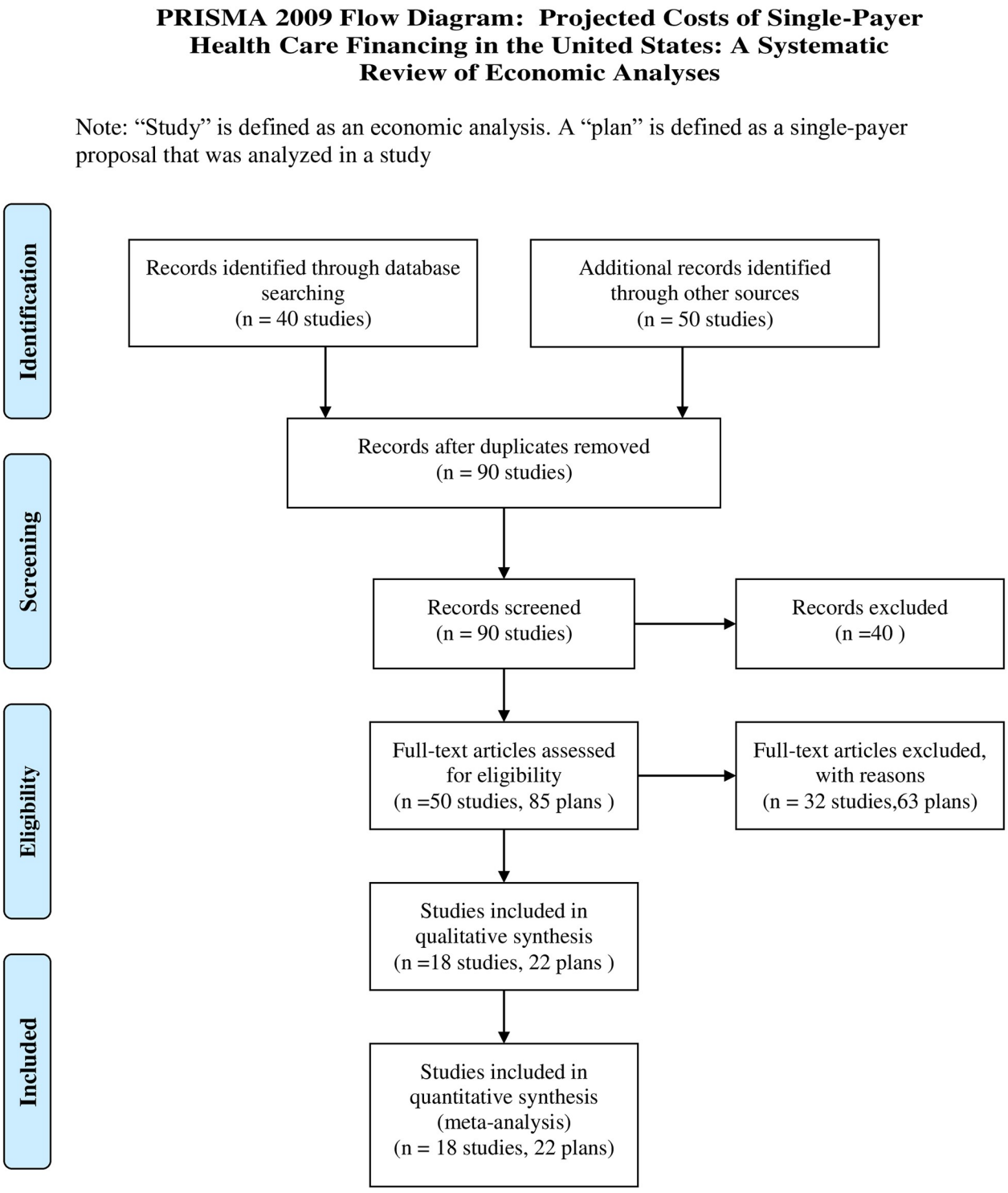

Fig 1. PRISMA flow diagram.

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Study inclusion required appropriateness of both the plan and the analysis. Specific inclusion criteria for the plan were that (1) all legal residents are permanently covered for a standard comprehensive set of medically appropriate outpatient and inpatient medical services under one payer and (2) the payer is a not-for-profit government or quasi-government agency. Other

central single-payer features, such as providers being entirely in or out, uniform payments with no balance billing, and use of a drug formulary, are often unspecified and thus were assumed present (and thus not a basis for exclusion) unless explicitly omitted. Some plans include undocumented immigrants, and some exclude them. Exclusion criteria were (1) use of large cost-sharing measures such as deductibles (some US single-payer plans include small copays, e.g., $5–$10 for an outpatient visit, which was not considered grounds for exclusion) and (2) an explicit role for non-uniform payment levels (i.e., payments differing by patient), balance billing, multiple payment systems, multiple drug formularies, or private insurers or intermediaries. Importantly, we applied these criteria to the modeled plan, so models incorporating any of these features when analyzing an otherwise qualifying single-payer plan would be excluded. These excluded studies are listed in Table C in S1 Appendix. Finally, we excluded 12 plans from 11 studies that met inclusion criteria but were redundant to newer studies of similar single-payer plans by the same analysis teams already included (Table D in S1 Appendix). Net savings from these excluded studies were similar to those from the included studies (Table E in S1 Appendix).

For the analysis, all studies were required (1) to specify input assumptions and values based on transparent review of empirical evidence and (2) to report (a) increases in utilization and costs due to improved insurance/access, (b) savings due to simplified payment administration (a single payment process using one set of coverage and reimbursement rules), lower drug prices, and other specified reasons, and (c) total system costs and net costs of the single-payer plan.

For this report, we did not require or consider financing (revenue) plans, which turn on an entirely different set of technical issues. We also did not seek analyses of broader economic effects, such as de-investing in the private insurance market or facilitation of labor mobility and start-ups through delinking of insurance and employment. Our analysis also omits long-term effects on medical innovation.

Studies were reviewed by at least 2 team members before finalizing inclusion or exclusion. Uncertain decisions (e.g., regarding adequacy of technical information or severity of deviation from the study definition of single-payer) were discussed with the entire team.

Extraction

We extracted the following information from each study: annual healthcare costs without single-payer (specified for the year and setting, at the national or state level), initial-year annual cost under single-payer, cost increase due to utilization growth, and savings (from all sources and 4 specific categories: simplified payment administration, lowered costs for medications [and for durable medical equipment, if bundled together], reduced clinical inefficiency [i.e., unneeded procedures] and fraud, and a switch to Medicare payment rates, which are lower than private insurance rates). We did not report transition costs such as purchases of for-profit businesses and training (which were, in any case, rarely assessed), and no study quantified the costs of potential first-year implementation challenges. If available, we extracted longer term costs and savings, defined as costs or savings accumulated subsequent to the first year of implementation. We also extracted or calculated the utilization increase assumed for newly insured individuals.

Each study was reviewed by 2 team members, and all study extractions were reviewed by the senior investigator (JGK), who requested refinements and further documentation for unclear or unexpected values. When we had questions due to omissions or ambiguity in the report, we attempted to contact study authors. We also sent them, when successfully located, a report draft for review.

Analysis

We standardized all cost numbers to percentage of contemporaneous total health system costs, to allow for direct comparison across times and locations. This approach obviated the need for inflation adjustments. We standardized costs due to increased utilization as the increase in annual cost for the newly insured divided by the mean cost for the already insured. We examined results visually, ordered by year and by net cost (highest net cost to highest net savings).

To assess the association of net cost with plan and analysis features (e.g., whether drug price reductions were considered), we used a visual method (color-coding analysis features). We also conducted univariate and multivariate linear regressions with net savings or cost as the outcome and with the following predictors: utilization increase, specific savings categories, type of funder organization, and type of analyst organization. In the multivariate analysis, we assigned dummy variables for missingness of the utilization predictor.

Results

Studies identified

We reviewed 90 studies and included primary analyses of 22 single-payer plans from 18 studies, published between 1991 and 2018, including 8 national and 14 state-level plans (Massachusetts, California, Maryland, Vermont, Minnesota, Pennsylvania, New York, and Oregon). Included studies are listed in Table F in S1 Appendix. Analysis teams included US government agencies, business consultants and research organizations, and academics. Nine single-payer plans (from 6 studies) were excluded for the following reasons: age limits on single-payer, varied benefits across individuals, balance billing, inclusion of private insurers or intermediaries in the plan or analysis, and lack of specification of assumptions regarding utilization and savings. Twelve studies were not reviewed because of duplication (same author, different state, earlier, $n = 11$) and age (1971, $n = 1$).

Projected costs and savings

Net cost or savings in the first year of single-payer operation varies from an increase of 7.2% of system costs to a reduction of 15.5% (Fig 2). The median finding was a net savings of 3.5% of system costs, and analyses of 19 of 22 plans found net savings. Net costs reflect the balance of added costs due to higher utilization (by eliminating uninsurance and in some studies also capturing the increase due to ending underinsurance) and savings (via payment simplification, lower drug prices, and other factors). Higher utilization increases costs by 2.0% to 19.3% (median 9.3%). Total savings range from 3.3% to 26.5% (median 12.1%).

The cost increase due to expansion of insurance coverage varies due to the number of newly covered individuals and generosity of coverage benefits, but also reflects policy components and expert assessment. For example, study estimates of increased utilization by newly covered individuals range from 25% to 80% of the costs for those already insured, reflecting varied assessments of uninsured individuals' healthcare access and health status. Additionally, cost-control choices such as copays vary across plans.

The mix of projected savings from single-payer shows both consistent and variable elements across studies (Fig 3). All studies estimate lower costs due to simplified payment administration, but vary in the size of these savings and in the inclusion and magnitude of other savings. Administrative savings vary from 1.2% to 16.4% (median 8.8%) of healthcare spending. Savings from lowered prices for medications and durable medical equipment are included in 12 models and range from 0.2% to 7.9%. Savings from reduced fraud and waste are included in 10 models and range from 0.4% to 5.0%. Savings due to a shift to Medicare payment rates

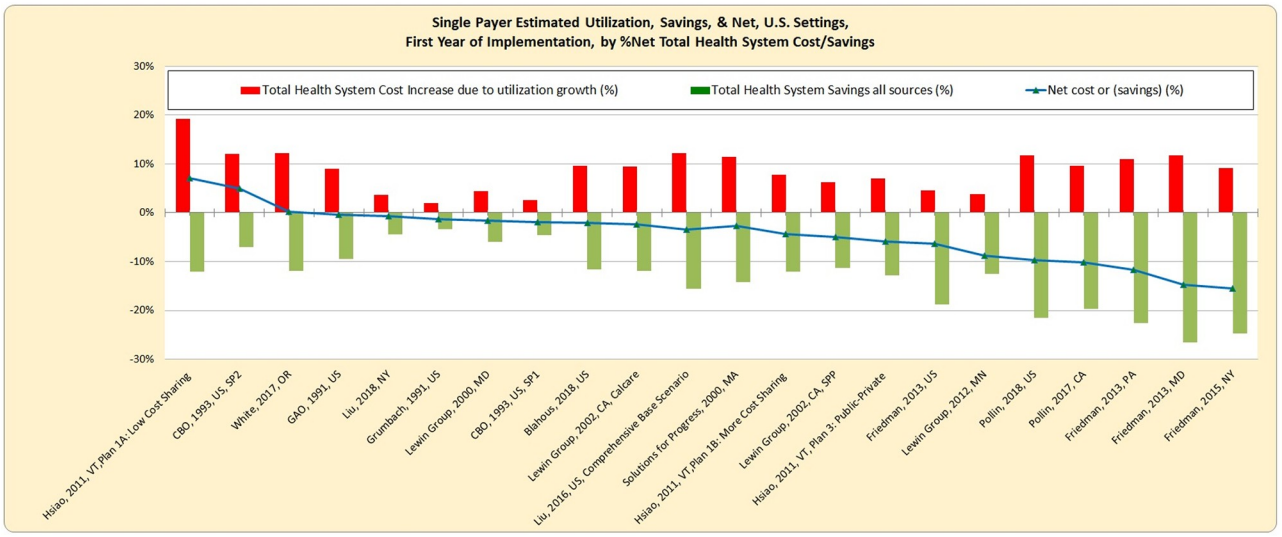

Fig 2. Net savings for single-payer in first year of implementation, sorted by net cost/savings. The median finding was savings (−3.46% of total health system costs), and analyses of 19 of 22 plans found net savings.

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are included in 8 models and range from 1.4% to 10.0%. Over time, utilization increases are stable and projected savings grow, leading to larger estimates for potential savings.

In the long term, projected net savings increase, due to a more tightly controlled rate of growth. For the 10 studies with projections for up to 11 years, each year resulted in a mean

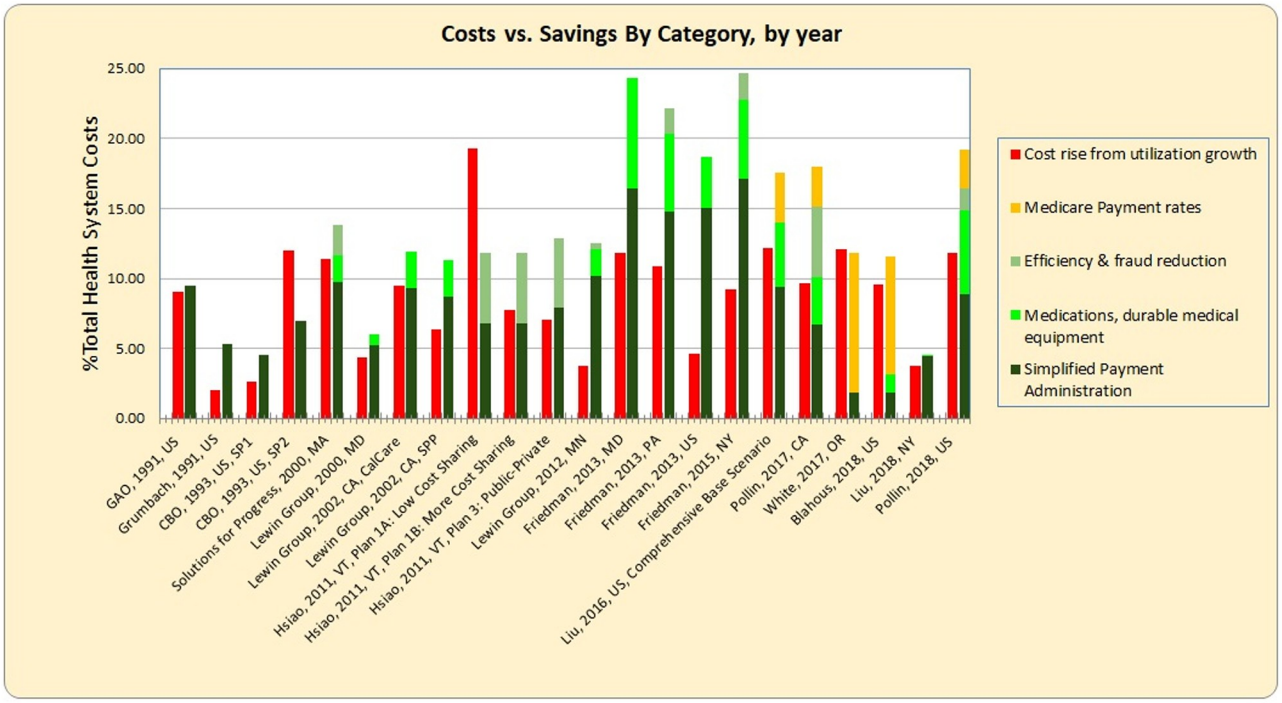

Fig 3. Costs versus savings for single-payer by category. Plans listed in order by year. Simplified payment administration was the greatest source of savings, for a median of 8.8%.

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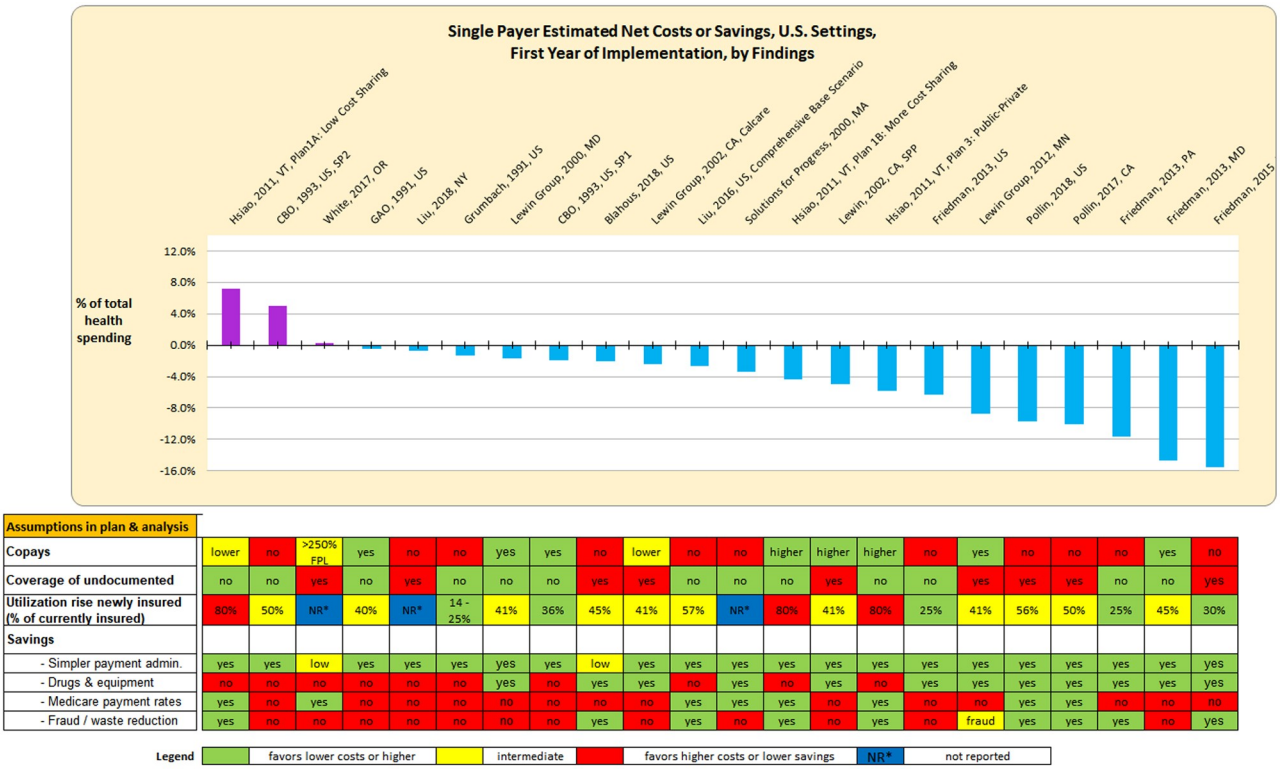

Fig 4. Net costs or savings versus assumptions in plans and analyses, sorted by net costs/savings. The 3 models that found net costs in the first year (Hsiao 2011 Low Cost Sharing, CBO 1993 SP2, and White 2017) shared specific policy choices including low or no cost sharing (copays), rich benefit packages, and a lack of savings captured from reduced medication/medical equipment costs.

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1.4% shift toward net savings (Text A and Figs A and B in S1 Appendix). At this rate, the 3 studies that find net costs in the first year would achieve net savings by 10 years.

Influence of plan and analysis features on findings

Fig 4 presents net costs or savings alongside a color-coded summary of key plan features and model assumptions. The 3 of 22 models that found net costs in the first year shared specific policy choices including low or no cost sharing (copays), rich benefit packages, and a lack of savings predicted from reduced medication/medical equipment costs. Two of these models (Hsiao 2011 Low Cost Sharing and CBO 1993 SP2) are estimated for additional scenarios that yield net savings.

We next assessed whether the inclusion of different analysis features (yes or no) was associated with net costs, based on univariate regressions (Fig 5). Cost sharing did not have a significant association with net costs across all studies (2.0 points, 95% CI −3.1 to 7.1, $p = 0.43$); 11 of 19 analyses showing net savings in the first year included no or low cost sharing in their plans. Similarly, the association between inclusion of undocumented individuals and net costs was not statistically significant (−2.7 points, 95% CI −7.8 to 2.4, $p = 0.28$). Inclusion of medication and equipment savings in the model was associated with lower net costs by 7.0 points (95% CI −11.1 to −3.0, $p = 0.002$), and inclusion of efficiency gains and fraud reduction was associated with lower net costs by 4.3 points but not significant (95% CI −9.1 to 0.6, $p = 0.08$). Inclusion of a shift to Medicare payment rates was not a strong predictor of net costs. We cannot assess the association between net costs and presence or absence of administrative savings in these

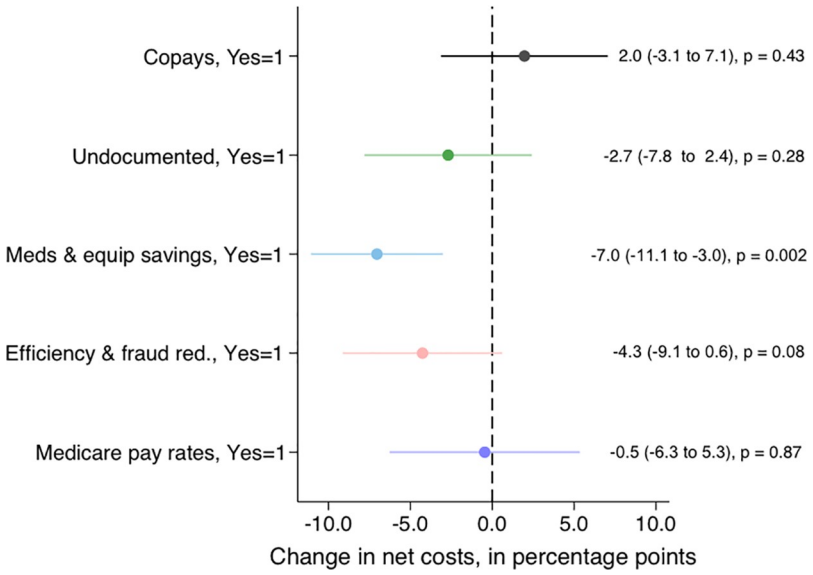

Fig 5. Net costs versus the inclusion of different analysis features. Each estimate comes from a separate linear regression of net costs and a binary predictor. Error bars represent 95% confidence intervals.

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dichotomous analyses because all studies include these savings. The number of different analysis features included in the model was also associated with lower net costs. For each additional analysis feature included, net costs were reduced by 2.3 points (95% CI −4.3 to −0.3, $p = 0.02$).

In univariate regressions of net savings against the magnitude of inputs, several relationships emerge (Fig 6). A 1-point increase in utilization rate was associated with higher net costs of 9.9 points; however, this relationship did not reach statistical significance (95% CI −6.3 to 26.0, $p = 0.22$). In contrast, the magnitude of net savings was associated with higher savings in administrative costs (net cost −0.85 points, 95% CI −1.3 to −0.4, $p = 0.01$) and in medication and equipment costs (−1.79 points, 95% CI −2.43 to −1.16, $p < 0.0001$). Net savings were not strongly related to Medicare payment rates or efficiency gains/fraud reduction.

In a multivariate regression (limited by small sample size), we found that net costs were associated with medication and equipment cost savings (−1.5 points, 95% CI −2.6 to −0.4, $p = 0.01$); other analysis features did not strongly predict net costs. Lower net costs were associated with funder type (left-leaning versus right-leaning: −6.7 points, 95% CI −11.5 to −1.8, $p = 0.009$) and analyst type (academic versus other: 7.6 points, 95% CI 0.4 to 14.9, $p = 0.04$) in bivariate regressions, but not in multivariate regressions, perhaps due to reduced precision due to the sample size. Tables H and I in S1 Appendix report the multivariate regression details.

Discussion

We identified 22 credible economic models of the cost of single-payer financing in the US, from a variety of government, business consultant, and academic organizations. We found that 19 (86%) predict net savings in the first year of operations, with a range from 7% higher net cost to 15% lower net cost. Increases in cost due to improved insurance coverage and thus higher utilization were 2% to 19%. Savings from simplified payment administration at insurers and providers, drug cost reductions, and other mechanisms ranged from 3% to 27%. The largest net savings were for plans with reductions in drug costs. Net savings accumulate over time

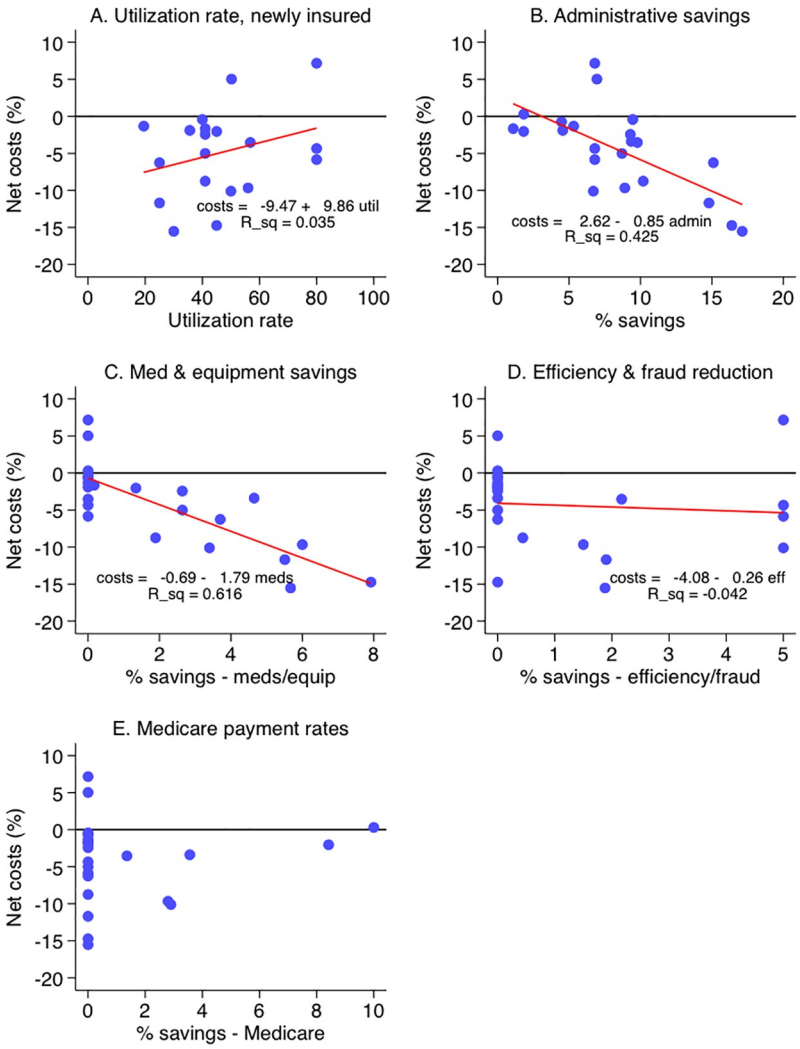

Fig 6. Net cost (%) versus utilization rise and savings magnitude. (A) Utilization rate; (B) administrative savings; (C) medicine and equipment savings; (D) efficiency gains and fraud reduction; (E) Medicare payment rate. Each dot represents 1 model. The red lines represent linear regressions, with displayed results indicating the regression equation (including intercept and slope) and R^2 (proportion of variation explained). The regression line for Medicare payment rate (E) was omitted due to the preponderance of 0 values (73%, or all but 6, of the 22 models). Higher utilization was associated with greater costs, whereas the magnitude of administrative and medication/equipment savings was associated with reduced net costs.

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at an estimated 1.4% per year. Of note, we excluded 2 widely publicized studies [20,24], both of which found net costs, on the grounds that these studies made assumptions that included private insurance intermediaries (i.e., not a single-payer) or lacked technical detail for evaluation.

These analyses suggest that single-payer can save money, even in year 1, incorporating a wide range of assumptions about potential savings. More aggressive measures to realize cost reductions are projected to yield greater net savings. This implies that concerns about health system cost growth with single-payer may be misplaced, though costs to government are likely to grow as tax-based financing replaces private insurance premiums and out-of-pocket spending.

Empirical evidence for model assumptions

The results of these economic models depend on input assumptions regarding the effect of single-payer provisions. In particular, the magnitude of net savings reflects the quantitative effects of utilization rises due to increased insurance and savings strategies. Reasonable analysts may differ on these assumptions based on plan features, setting, and evidence available at the time of modeling. There is growing empirical evidence for each provision, which we review below.

Utilization increases due to new and improved insurance drive the cost growth effects of single-payer. There is strong evidence over decades that the newly insured roughly double their healthcare utilization [25–27]. Medicaid expansion under the Affordable Care Act appears to demonstrate a mix of utilization effects [28,29]. Moreover, in a single-payer system, the newly insured may be younger and healthier than the already insured, meaning that utilization may not increase to the levels of the already insured. Evidence on utilization increases for the underinsured are mixed [30–32]. Importantly, there is evidence that when uninsured individuals gain insurance, increases in utilization for the newly insured are balanced by slightly lower utilization for the already insured, due to supply-side constraints [33–35]. However, with a decrease in billing-related administrative burden for clinicians, a 10% or greater rise in physician clinical capacity may occur, which would accommodate additional care utilization. Finally, increases in utilization for the uninsured and underinsured are likely to result in increased use of preventive services, which should lead to some future cost saving [25,36].

Simplified payment administration represents the largest type of savings from single-payer. There is very strong evidence that billing and insurance-related administrative burden is higher in the US than in Canada (which has single-payer) by 12%–15% of total healthcare costs [13]. The excess administrative costs are split roughly 50% at insurers and 50% at providers. Studies of hospitals find consistent large differences in administrative costs between the US and single-payer systems in Europe [37]. There is no direct evidence of ability to capture all of this excess, but solid empirical data from Canada and other Organisation for Economic Co-operation and Development (OECD) countries support the intuition that administrative costs would sharply decrease with elimination or streamlining of existing onerous payment processes.

Lower drug spending is typically the second largest source of savings with single-payer, and predicts large net savings. The US Veterans Administration (VA) gets a 30% discount on prescription medications compared to private Medicare Advantage Plans [38,39]. US per-capita drug spending exceeds that of any other country [38,39]. Drug prices are the primary driver of higher cost, with the US spending $1,011 annually per capita on prescription drugs compared to the OECD average of $422 [11].

Research estimates savings of 30% for diabetes drugs through use of drug formularies, due to medication choice and prices [40]. Drug companies argue that reducing prices will reduce research and innovation. However, many more expensive drugs offer limited medical benefits [38,41,42]. Further, drug firms often raise prices after recovering development costs. Research and development costs for 10 companies that launched new cancer agents were $9 billion, while revenue exceeded $67 billion [43]. Perhaps most tellingly, Fortune 500 drug companies had a mean profit reported in 2019 of 24% compared to 9% for all corporations [38,44,45]. Drug companies claim that if the entire health system gets the same discount as the VA, the discount levels will substantially decrease. However, if Medicare adopted the VA's tighter drug formulary, the savings would be roughly $505 per capita annually [46]. Overall, there is strong evidence of the potential for a substantial reduction in drug costs, with magnitude likely a function of political choices and dynamics. A portion of these savings could also be realized if the government negotiated for lower drug prices in the existing Medicare program.

Reports estimate that up to 20%–40% of US healthcare spending is fraudulent or wasteful [47,48]. However, there is little evidence on how to avoid this spending. The Affordable Care Act set up accountable care organizations (ACOs), groups of healthcare providers responsible for a defined set of patients and contracting with a payer (usually Medicare) for a payment structure tied to performance metrics, in an effort to reduce costs. Recent ACO demonstration projects found minimal savings, potentially less than the cost of administering programs, leading to overall net 0 savings [49]. ACOs that are "two-sided" (using both penalties and shared savings) reduce service costs by a mean of 0.7% yet require on average about 2% costs to administer [50,51]. Overall, between 2013 and 2017, ACOs increased total costs to Medicare by 70 billion when bonuses were taken into account [52]. Recent analysis suggests modestly growing savings, in physician if not hospital groups, potentially more than administration costs [53,54]. Single-payer may facilitate efforts to reduce fraud and waste by providing comprehensive and consistent clinical encounter data within the single billing system (including diagnoses and services, as well as clinical outcomes). Thus, single-payer might bolster the marginally effective efforts in this area. Still, the evidence to support large reductions in waste and fraud is tenuous. Furthermore, a reliance on ACO incentive approaches (which require large patient panels and specific payment structures) could undermine desired features of a single-payer program, such as free choice of provider, substantial use of fee-for-service billing in some plans, and hospital global budgeting. In light of these uncertainties, most economic models do not anticipate reductions in fraud or waste, and those that do generally assume only a modest reduction.

Limitations

Our analysis has several important limitations. First, the included economic studies varied in methodological rigor and quality of reporting, funding sources, political motivations, and amount of evidence cited to support claims. Although we tried to classify studies by major single-payer and analysis characteristics, uncaptured variations may have added noise in the comparison. Relatedly, the diversity of plans under study did not allow for a formal meta-analysis, which is designed to integrate empirical evaluations of standardized interventions, especially using measures of association such as odds ratios.

Second, we did not apply quality rating scores for the included economic studies. We found no quality rating scores for health system modeling, as existing scores are intended for evaluation studies, empirical measurements of costs and effects, or decision analyses [55–57]. A quality rating system could be useful. Included studies all lacked sensitivity analyses, and the selection of the most appropriate data source for input values could be subjective. For example, studies varied in what percentage of savings could be achieved through simplification of payment administration. We are unaware of studies analyzing the effects of other key inputs, such as reductions in reimbursement rate. Future research is needed to assess the quality of single-payer studies, analyze key model inputs, and analyze proposed ranges for sensitivity analyses. In terms of the potential for financial conflict of interest bias, we were reassured that a prominent health business consultant (Lewin Group, with several included analyses), presumably with clients that stand to lose money with single-payer, nonetheless found net savings.

Third, no single-payer system has been implemented in the US, due to lack of government approval even for demonstration projects. Thus, there is no domestic, large-scale empirical example to properly test the economic models. Much of the research on single-payer is based on evidence from single-payer nations such as Canada, Australia, and Taiwan. As reviewed above, US health systems that approximate single-payer, such as the VA, and other empirical studies provide support for model assumptions. Ultimately, our goal was not to compare cost

models with (nonexistent) empirical benchmarks, but to assess the consistency of inputs across models and with empirical evidence, and to characterize patterns in model findings. Assuming that US single-payer demonstrations are coming, economic models can be tested and refined. Until then, the relative consistency of existing models is the best evidence available.

Fourth, our study was limited to proposals of single-payer as defined in the US, with a single (government) payer, and meeting specified criteria. Our results are not generalizable to multi-payer "universal coverage" reforms, which would likely show substantially smaller savings and thus increases in net cost [58]. The Maryland all-payer model, for example, showed 2.7% savings after 3 years, a figure that is significantly lower than the average savings from single-payer systems we found in our review [59]. Multi-payer systems have higher costs in part due to increased cost shifting. Our analysis is not able to quantify precisely the effects of reduced cost sharing. A unified provider payment system, as opposed to a single-payer system, may accomplish substantial cost savings, but our analysis only considered the latter. Indeed, many OECD countries have a unified payment system with a standard benefits package, a single payment process, a single formulary, and not-for-profit insurers, which shares many features with "single-payer." Finally, despite the drawbacks of our narrow inclusion criteria, a benefit is that our results provide a clearer and more relevant assessment of the economic impact of a single-payer system in the US.

Fifth, in addition to saving costs, unified payment models such as single-payer have the potential to foster quality and efficient care through payment signals, as well as to monitor trends in care patterns via rapid access to highly standardized claims data. For example, in Japan's unified payment system, price incentives are used to promote public health goals, such as increasing preventive care [60]. The use of price incentives to drive performance is common in high-income countries [61]. However, studies did not include this in their analysis, so we deemed it outside the scope of our study.

Sixth, as with any review, our search period is time-limited, ending in December 2018. We are aware of 1 study in 2019 [62], but did not systematically search for other studies. We limited our Google searches to 10 pages. However, we never found a relevant study after page 2 of search results, increasing our confidence that a 10-page review was adequate. We will update this analysis in coming years.

Finally, we examined only economic studies of system operating costs, in the first year and over time. We ignored one-time transition costs (in particular, purchase of for-profit entities, unemployment and pension benefits, and retraining of displaced workers). Informal review of existing evidence suggests that these costs are small in comparison to health system spending, which is 18% of the economy. We also did not examine financing, e.g., taxation strategies. These are important next steps.

Policy implications

This review highlights a high degree of analytic consensus that single-payer financing would result in a favorable outcome for system financial burden: efficiency savings exceed added costs. A net cost reduction of 3%–4% is likely initially, growing over time. Net savings would be expected to occur, if not immediately, certainly within a few years. However, maximizing performance and savings will require optimized implementation. Payment procedures must be as simple as in other countries, drug prices a substantial reduction from contemporary levels, and comprehensive clinical data used in sophisticated ways to identify and reduce inappropriate care. The logical next step is real-world experimentation, including evaluation and refinement to minimize transition costs and achieve modeled performance in reality.

Supporting information

S1 Appendix. Additional detail on methods and findings.
(DOCX)

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The Commonwealth Fund

States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership

January 15, 2020 | Justin Giovannelli, JoAnn Volk, and Kevin Lucia

ABSTRACT

- **Issue:** The individual health insurance markets of most states are stable but face ongoing challenges. Federal policies to promote limited-coverage products for sale outside the individual market, concerns about the affordability of comprehensive coverage, and uncertainty about the durability of the Affordable Care Act have put the onus on state policymakers from across the political spectrum to explore options for safeguarding and improving their residents' coverage.
- **Goal:** Understand actions states have taken to affect access to and affordability of comprehensive health coverage.

- **Methods:** Analysis of applicable laws, regulations, and guidance of the 50 states and the District of Columbia, as well as of relevant legislation proposed in these jurisdictions during the 2018 and 2019 legislative sessions.
- **Key Findings and Conclusions:** Most states have adopted one or more policy initiatives designed to make comprehensive coverage more affordable, such as a reinsurance program, financial incentives for individuals to maintain coverage, or increased oversight of skimpy, short-term insurance products. However, most effective reforms will require a sustained and significant financial commitment that states may have difficulty securing. Lasting solutions are likely to require federal action.

Background

Though the Affordable Care Act (ACA) significantly changed how individual market health insurance is regulated, it preserved states' power to implement policies designed to make that coverage more affordable.[1] Recent regulatory changes by the Trump administration to promote limited-benefit products not governed by ACA rules have provided states still more policy choices to consider.[2]

States have increasing reason to exercise this authority. Though most states' individual markets are experiencing a second year of stability, premiums and cost-sharing continue to impose significant financial burdens on many Americans.[3] The administration's loosening of rules governing limited-benefit products did not just give states additional policymaking flexibility — it also exposed states' insurance markets and consumers to substantial new risks that have drawn policymakers' attention. Meanwhile, uncertainty about the durability of the ACA drags on; a federal lawsuit brought by Republican state officials and supported by the Trump administration seeks to have the courts strike down the ACA's preexisting condition protections, premium subsidies, and Medicaid expansion.[4] Together, these developments have challenged state lawmakers from across the political spectrum to explore options for safeguarding and improving residents' coverage.

In 2018, we examined what states had done to improve access to comprehensive individual market coverage in seven key policy areas over which they exercise authority.[5] At that time, nearly half of states had adopted one or more policy

initiatives in these areas, such as a reinsurance program, financial incentives for individuals to maintain coverage, or increased oversight of skimpy, short-term insurance products.[6]

This brief updates our analysis of state efforts to strengthen individual market coverage and finds that at least a dozen states have enacted legislation within the past year to make comprehensive coverage more affordable (Exhibit 1).

Findings

REINSURANCE: REDUCING PREMIUMS AND MARKET VOLATILITY

The ACA's temporary federal reinsurance program lowered premiums and stabilized markets between 2014 and 2016; premium hikes in the following year were attributable in part to the program's end.[7] Though many state policymakers and stakeholders have urged that the program be reestablished, proposals to do so stalled in the last Congress.[8] In the absence of federal action, a diverse group of states has moved ahead. In 2017 and 2018, seven states established their own reinsurance programs, funded in part through the ACA's Section 1332 waiver program.[9] These initiatives have lowered individual market premiums by an average of 20 percent, primarily benefiting consumers who are not eligible for federal subsidies and who bear the full brunt of premium increases.[10] During 2019, five additional states — Colorado, Delaware, Montana, North Dakota, and Rhode Island — secured approval to launch their own programs in 2020, while two others (Georgia and Pennsylvania) signaled they will seek federal sign-off for a reinsurance waiver for 2021 (Exhibit 2).

While waiver-supported reinsurance has become a fairly straightforward policy option, states have innovated with implementation and funding. In Colorado, policymakers structured the program to provide the greatest level of assistance to the geographic areas hardest hit by high premiums. The state also initially sought to fund the program by requiring hospitals to bring their reimbursement rates into

line with an external benchmark (i.e., Medicare plus a percentage). Because the Trump administration signaled it would not approve a waiver that included such a payment regulation, Colorado ultimately adopted alternative funding mechanisms, including an assessment on hospitals. In Pennsylvania, policymakers enacted bipartisan legislation that directs the state to assume control of its ACA marketplace from the federal government, operate it at a lower cost, and use the savings to cover the state's share of reinsurance program funding.

REQUIREMENTS TO MAINTAIN COVERAGE: BROADENING THE RISK POOL

Since Congress eliminated the ACA's tax penalty for individuals who fail to maintain coverage in the 2017 tax bill, at least 10 state legislatures weighed whether to adopt state versions of the individual mandate. Though politically divisive at the national level, these requirements help make markets more stable and premiums more affordable by expanding the risk pool.[11] A mandate also can give states flexibility to discourage individuals from switching between skimpy coverage products when healthy and comprehensive coverage when sick. For instance, a state can define the types of coverage that satisfy its mandate by excluding products, such as short-term plans and health care sharing ministries, which discriminate based on health status. Doing so may reduce the risk that such arrangements segment the market between healthy and sick, driving up costs and reducing plan choices for residents who need comprehensive coverage.

Four states and the District of Columbia have now established tax penalties for people who can afford to maintain health coverage but choose not to (Exhibit 3).[12] Taking advantage of the flexibility to craft the penalty to suit state needs, New Jersey and Rhode Island use revenue raised by the mandate to help fund their reinsurance programs, while California will use penalty dollars to provide greater financial assistance to people who buy coverage. In Maryland, efforts to pass an individual mandate foundered. As an alternative, the state adopted a program to facilitate enrollment by allowing uninsured tax filers to begin the process of signing up for ACA marketplace or Medicaid coverage by checking a box on their tax return.[13] The new law also obligates state government to establish processes for implementing a tax penalty in the future and requires study of the issue.

COVERAGE SUBSIDIES: IMPROVING AFFORDABILITY

The ACA's premium and cost-sharing subsidies have helped make health insurance more affordable for millions of Americans. But there are funding and eligibility limits: the program provides substantially less generous assistance for those with incomes above 250 percent of the federal poverty level and phases out entirely at four times the threshold. This has meant that many people still face difficulty affording coverage.[14] Accordingly, states have considered whether to provide additional help, by using state dollars to 1) increase the amount of assistance available to low- and middle-income individuals, for whom the current federal subsidy may be insufficient, and/or 2) offer subsidies to residents who are ineligible for federal assistance.

In June 2019, California enacted a law that does both. Starting in 2020, the state began providing wraparound subsidies to individuals receiving ACA tax credits as well as financial assistance to residents whose incomes (between 400% and 600% of poverty) render them ineligible for the federal subsidy program (Exhibit 4).[15] This measure is expected to make coverage more affordable for nearly a million Californians and, together with the state's other reforms, newly insure more than 200,000.[16]

STATE COVERAGE OPTIONS: INCREASING ACCESS, REDUCING COSTS

Policymakers in states that have embraced the ACA increasingly have worked to develop a government-sponsored coverage option to achieve more affordable coverage, greater marketplace competition, and improved access to care. More than a dozen states considered whether to establish or study the implementation of a public option or a public coverage "buy-in" program during the most recent legislative session; five states have already published reports analyzing such proposals.[17]

In May 2019, Washington became the first and only state to approve a public option (Exhibit 5). The Washington model — known as Cascade Care — is effectively a hybrid public–private coverage program in which the state will contract with private insurers to administer and sell standardized health plans on

the ACA marketplace. The public-option plans are intended to reduce health care costs by capping payments to providers at an average of 160 percent of Medicare rates. This benchmark pricing mechanism is expected to produce modestly lower plan premiums when the coverage becomes available in 2021, helping individual market consumers who are not eligible for coverage subsidies. Subsidized consumers also may benefit, because the plans will follow standardized designs that ease cost-sharing requirements for high-value care and, over time, increase plan competition because of the expanded risk pool.

STANDARD PLAN DESIGNS: PROMOTING VALUE-BASED CARE, HELPING CONSUMERS SHOP FOR COVERAGE

The ACA requires all individual market health plans to cover broadly similar benefits, adhere to limits on cost-sharing, and fall within standard actuarial value tiers. This is in large part to ensure coverage meets consumers' needs, but also to make it easier for consumers to understand and choose among their coverage options. Back when these protections were first implemented, six states and the District of Columbia decided to require plans to incorporate standardized cost-sharing parameters, such as uniform deductibles and copayments for certain services (Exhibit 6).[18] States hoped the standard designs would further improve consumers' experiences by facilitating apples-to-apples comparisons of plans' premiums, networks, and quality. Some policymakers also viewed standardization as an opportunity to ensure plans provide sufficient up-front value to enrollees by, for example, requiring that high-value services, such as primary care, not be subject to a deductible.

Though initial attempts to operationalize standardized designs during the rollout of the ACA marketplaces seemed to have little effect on consumers' shopping experiences, states have continued to refine their approaches. For its part, the federal government unveiled standard plan designs and shopping tools on HealthCare.gov in the fall of 2016 before a new administration changed course and eliminated the policy in 2018.

Still, cost-sharing standardization continues to attract state interest, particularly as a way of addressing affordability challenges and promoting high-value care. Washington became the eighth state to adopt this policy, making standard plan designs a pillar of its Cascade Care reforms. Meanwhile, Colorado policymakers also hope to implement standard plan designs as part of a public option program that the state's legislature will consider in early 2020.

REGULATION OF NON-ACA-COMPLIANT COVERAGE: REDUCING MARKET SEGMENTATION AND CONSUMER CONFUSION

Short-term, limited-duration insurance is exempt from the ACA's reforms. These products can deny coverage, limit benefits, or charge a higher premium to consumers with a preexisting condition. Because of these limitations, healthy people who enroll generally incur a lower upfront cost than they would with unsubsidized ACA-compliant coverage. In 2018, the Trump administration relaxed federal regulations to allow these short-term products to have an initial term of 364 days and, with renewal, last for up to 36 months.

Since this change was announced, 12 states and the District of Columbia have strengthened consumer protections and set a tighter duration limit for short-term products (Exhibit 7). They have done so to guard against the likelihood that such plans will siphon healthy risks from their ACA markets, potentially raising prices and decreasing choice for those who remain, and to protect consumers from inadequate coverage and misinformation. Most of these states have limited the duration of these products so consumers may use them as a short-term coverage option and not a long-term replacement for comprehensive insurance. Some states also have required the plans to comply with additional consumer protections, cover specified benefits, or adhere to marketing restrictions. For example, Maine requires in-person sales to address concerns about online and phone sales, while Washington prohibits the sale of short-term products during the annual enrollment period for ACA plans.[19] California and Rhode Island have gone further and effectively ban short-term products, joining three states — Massachusetts, New York, and New Jersey — that prohibited the plans even before the federal rule change. In contrast, three states — Arizona, Indiana, and

Oklahoma — opted to embrace the opportunity to promote these skimpier products by revising state law to conform with the new, more permissive federal rule.[20]

Add to ChartCart

Discussion

The individual markets of most states are stable. Rates have continued to moderate and, in many places, decrease, while insurer participation on the marketplaces increased again in 2020.[21] Still, comprehensive coverage remains unaffordable for many and there is no indication that the federal government will implement policies to address this issue. To the contrary, the administration remains committed to policies likely to increase market segmentation, making comprehensive coverage more expensive.

Against this backdrop, an increasing number of states have acted in ways likely to improve affordability and plan choice. In 2020, states will continue to pursue reinsurance, respond to the effects of skimpy coverage products on their health insurance markets, and study other states that have undertaken broader reforms to bring comprehensive coverage within reach of all residents.

But there are limits to states' authority and resources. While the Trump administration has encouraged federal waivers to promote skinny plans, it has made clear in agency guidance and the statements of high-ranking officials that such flexibility is not available for states interested in offering residents a public coverage option. Meanwhile, many effective state reforms will require a sustained and significant financial investment. California's groundbreaking efforts to improve coverage likely will cost more than $400 million. While the cost of other states' reforms will not likely approach this magnitude, state budgetary constraints make financing coverage improvements difficult in many places. Lasting solutions are likely to require federal commitment.

ACKNOWLEDGMENTS

The authors thank Sabrina Corlette for her thoughtful comments and suggestions. We also thank Emily Curran, Maanasa Kona, and Rachel Schwab for their valuable contributions to the research for this brief.

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15. The new law puts California in the company of Massachusetts and Vermont, states that for years have provided wraparound benefits to individuals eligible for federal coverage subsidies. Other states are weighing whether to follow. Minnesota, which provided a one-time premium subsidy to residents in 2017, this year debated a plan put forward by the state's governor to offer more robust coverage assistance. A budget agreement ultimately directed funds towards renewing the state's reinsurance program, instead. Meanwhile, recently enacted legislation directs Washington's state marketplace to develop a plan, to be completed by late 2020, for implementing state premium subsidies for individuals with incomes up to 500 percent of FPL.

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The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid

Rachel Garfield, Kendal Orgera, and Anthony Damico

While millions of people have gained coverage through the expansion of Medicaid under the Affordable Care Act (ACA), state decisions not to implement the expansion leave many without an affordable coverage option. Under the ACA, Medicaid eligibility is extended to nearly all low-income individuals with incomes at or below 138 percent of poverty ($17,236 for an individual in 2019[1]). This expansion fills in historical gaps in Medicaid eligibility for adults and was envisioned as the vehicle for extending insurance coverage to low-income individuals, with premium tax credits for Marketplace coverage serving as the vehicle for covering people with moderate incomes. While the Medicaid expansion was intended to be national, the June 2012 Supreme Court ruling essentially made it optional for states. As of January 2020, 14 states had not expanded their programs.[2]

Medicaid eligibility for adults in states that did not expand their programs is quite limited: the median income limit for parents in these states is just 40% of poverty, or an annual income of $8,532 for a family of three in 2019, and in nearly all states not expanding, childless adults remain ineligible.[3] Further, because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults, including all childless adults, fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the poverty level, which is the lower limit for Marketplace premium tax credits (Figure 1).

This brief presents estimates of the number of people in non-expansion states who could be reached by Medicaid if their states adopted the expansion, and discusses the implications of them being left out of ACA coverage expansions. An overview of the methodology underlying the analysis can be found in the Data and Methods, and more detail is available in the Technical Appendices.

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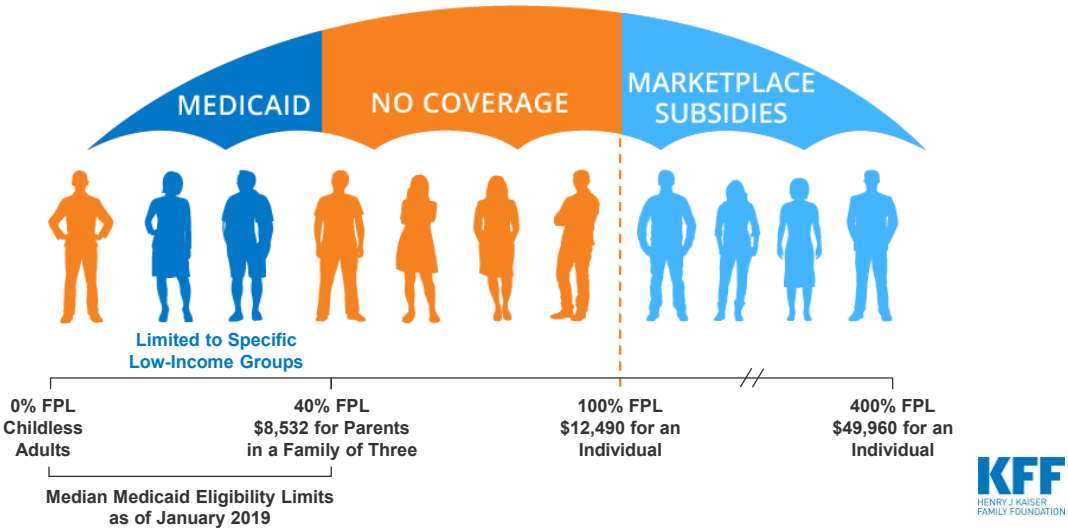
Figure 1

Gap in Coverage for Adults in States that Do Not Expand Medicaid Under the ACA



How Many Uninsured People Who Could Have Been Eligible for Medicaid Are in the Coverage Gap?

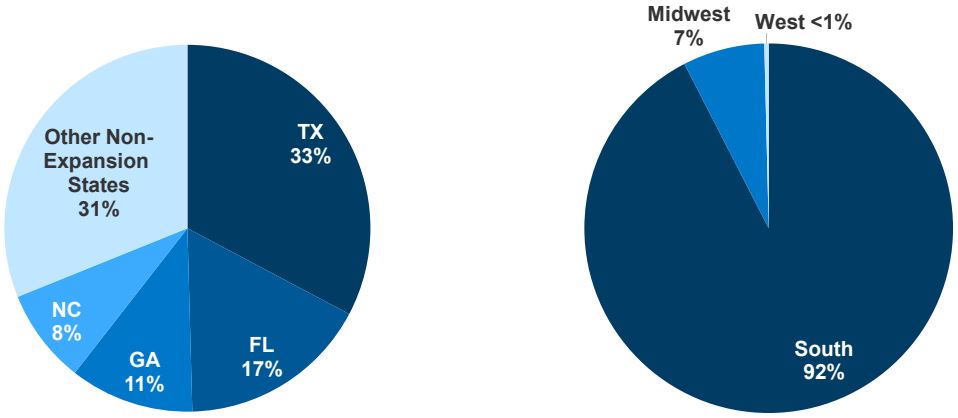
Nationally, more than two million[4] poor uninsured adults fall into the "coverage gap" that results from state decisions not to expand Medicaid (Table 1), meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would be eligible for Medicaid had their state chosen to expand coverage. Reflecting limits on Medicaid eligibility outside ACA pathways, most people in the coverage gap (76%) are adults without dependent children.[5]

Adults left in the coverage gap are spread across the states not expanding their Medicaid programs but are concentrated in states with the largest uninsured populations. A third of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 2). Seventeen percent live in Florida, eleven percent in Georgia, and eight percent in North Carolina. There are no uninsured adults in the coverage gap in Wisconsin because the state is providing Medicaid eligibility to adults up to the poverty level under a Medicaid waiver.

The geographic distribution of the population in the coverage gap reflects both population distribution and regional variation in state take-up of the ACA Medicaid expansion. The South has relatively higher numbers of poor uninsured adults than in other regions, has higher uninsured rates and more limited Medicaid eligibility than other regions, and accounts for the majority (9 out of 14) of states that opted not to expand Medicaid.[6] As a result, more than nine in ten people in the coverage gap reside in the South (Figure 2).

Figure 2

Distribution of Adults in the Coverage Gap, by State and Region, 2018



Total = 2.3 Million in the Coverage Gap

NOTE: Totals may not sum due to rounding. There are no individuals in the coverage gap in the Northeast as all states in the Northeast expanded Medicaid.
SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.

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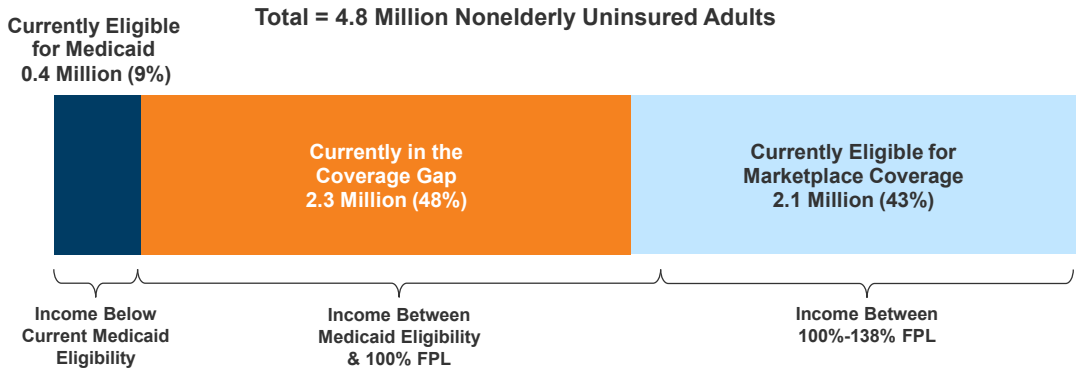
What Would Happen if All States Expanded Medicaid?

If states that are currently not expanding their programs adopt the Medicaid expansion, all of the 2.3 million adults in the coverage gap would gain Medicaid eligibility. In addition, 2.1 million uninsured adults with incomes between 100 and 138% of poverty[7] (most of whom are currently eligible for Marketplace coverage) would also gain Medicaid eligibility (Figure 3 and Table 1). Though most of these adults are eligible for substantial tax credits to purchase Marketplace coverage,[8] Medicaid coverage would likely provide more comprehensive benefits and lower premiums or cost-sharing than they would face under Marketplace coverage. For example, research from early implementation of the ACA showed that coverage of behavioral health services, prescription drugs, rehabilitative and habilitative services, and long-term services and supports may be more limited in the Marketplace compared to Medicaid.[9,10] In addition, research examining the population with incomes between 100-138% FPL in expansion and non-expansion states finds that Medicaid expansion coverage produced far greater reductions than subsidized Marketplace coverage in average total out-of-pocket spending, average out-of-pocket premium spending, and average cost-sharing spending.[11]

Figure 3

Nonelderly Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded, 2018



NOTE: Total may not sum to 100% due to rounding. The "100%-138% FPL" category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of potential Medicaid expansions but also with sufficient resources to avoid the coverage gap.
SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.

A smaller number (about 418,000) of uninsured adults in non-expansion states are already eligible for Medicaid under eligibility pathways in place before the ACA. If all states expanded Medicaid, those in the coverage gap and those who are instead eligible for Marketplace coverage would bring the number of nonelderly uninsured adults eligible for Medicaid to more than 4.8 million people in the fourteen current non-expansion states. The potential scope of Medicaid varies by state (Table 1).

Discussion

The ACA Medicaid expansion was designed to address the high uninsured rates among low-income adults, providing a coverage option for people with limited access to employer coverage and limited income to purchase coverage on their own. In states that expanded Medicaid, millions of people gained coverage, and the uninsured rate dropped significantly as a result of the expansion.[12] However, with many states opting not to implement the Medicaid expansion, millions of uninsured adults remain outside the reach of the ACA and continue to have limited options for affordable health coverage. From 2017 to 2018, non-expansion states saw a significant increase in their uninsured rate, while expansion states did not.[13]

By definition, people in the coverage gap have limited family income and live below the poverty level. They are likely in families employed in very low-wage jobs, employed part-time, or with a fragile or unpredictable connection to the workforce. Given limited offer rates of employer-based coverage for employees with these work characteristics, it is likely that they will continue to fall between the cracks in the employer-based system.

It is unlikely that people who fall into the coverage gap will be able to afford ACA coverage, as they are not eligible for premium subsidies: in 2020, the national average unsubsidized premium for a 40-year-old non-smoking individual purchasing coverage through the Marketplace was $442 per month for the lowest-cost silver plan and $331 per month for a bronze plan,[14] which equates to nearly eighty percent of income for those at the lower income range of people in the gap (below 40% FPL) and nearly a third of income for those at the higher income range of people in the gap.

If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require and receive medical care, potentially serious financial consequences. While the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be an important source of care for the remaining uninsured under the ACA, this system has been stretched in recent years due to increasing demand and limited resources.

Most people in the coverage gap live in the South, leading state decisions about Medicaid expansion to exacerbate geographic disparities in health coverage. In addition, because several states that have not expanded Medicaid have large populations of people of color, state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans.[15] As a result, state decisions about whether to expand Medicaid have implications for efforts to address disparities in health coverage, access, and outcomes among people of color.

There is no deadline for states to opt to expand Medicaid under the ACA, and debate continues in some states about whether to expand. For example, legislatures in Kansas and Wyoming are likely to take up the issue in the upcoming 2020 session.[16] Further, initiatives in several states, including Missouri, Oklahoma, and South Dakota, may put the question of Medicaid expansion on the ballot in upcoming elections. The three states (Idaho, Nebraska, and Utah) that adopted the Medicaid expansion via ballot

initiative in the November 2018 election all plan to implement expansion in 2020 with state Medicaid waiver proposals that condition the scope and structure of expansion. The Trump Administration has indicated to states that it is open to these types of proposals, which may lead additional states to consider extending coverage. However, some proposed waivers that could expand coverage for some people in the coverage gap also place new restrictions or requirements on that coverage.[17] Thus, it is uncertain what insurance options, if any, adults in the coverage gap may have in the future, and these adults are likely to remain uninsured without policy action to develop affordable coverage options.

Table 1: Uninsured Adults in Non Expansion States Who Would Be Eligible for Medicaid if Their States Expanded, by Current Eligibility for Coverage, 2018

State	Total	Currently Eligible for Medicaid	Currently in the Coverage Gap (<100% FPL)	Currently May Be Eligible for Marketplace Coverage (100%-138% FPL**)
All States Not Expanding Medicaid	4,850,000	418,000	2,324,000	2,108,000
Alabama	242,000	17,000	134,000	91,000
Florida	846,000	42,000	391,000	414,000
Georgia	518,000	44,000	255,000	219,000
Kansas	87,000	7,000	40,000	40,000
Mississippi	186,000	16,000	100,000	70,000
Missouri	217,000	13,000	113,000	92,000
North Carolina	389,000	32,000	194,000	163,000
Oklahoma	197,000	20,000	95,000	82,000
South Carolina	214,000	20,000	101,000	93,000
South Dakota	35,000	5,000	14,000	16,000
Tennessee	260,000	39,000	117,000	103,000
Texas	1,553,000	99,000	761,000	693,000
Wisconsin*	88,000	64,000	0	24,000
Wyoming	18,000	N/A	9,000	7,000

NOTES: * Wisconsin provides Medicaid eligibility to adults up the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin. ** The “100%-138% FPL” category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of potential Medicaid expansions but also with sufficient resources to avoid the coverage gap. Totals may not sum due to rounding. N/A: Sample size too small for reliable estimate. SOURCE: KFF analysis based on 2019 Medicaid eligibility levels and 2018 American Community Survey.

Data and Methods

This analysis uses data from the 2018 American Community Survey (ACS). The ACS provides socioeconomic and demographic information for the United States population and specific subpopulations. Importantly, the ACS provides detailed data on families and households, which we use to determine income and household composition for ACA eligibility purposes.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. The ACS questionnaire captures the relationship between each household resident and one household reference person, but not necessarily each individual to all others. Therefore, prior to estimating eligibility, we implement a series of logical rules based on each person's relationship to that household reference person in order to estimate the person-to-person relationships of all individuals within a respondent household to one another. We then assess income eligibility for both Medicaid and Marketplace subsidies by grouping individuals into household insurance units (HIUs) and calculate HIU income using the rules for each program. For more detail on how we construct person-to-person relationships, aggregate Medicaid and Marketplace households, and then count income, see the detailed Technical Appendix A.

Undocumented immigrants are ineligible for federally-funded Medicaid and Marketplace coverage. Since ACS data do not directly indicate whether an immigrant is lawfully present, we draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. al.[18,19] This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to ACS, controlling to state-level estimates of total undocumented population from Pew Research Center. For more detail on the immigration imputation used in this analysis, see the Technical Appendix B.

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance (ESI) are still potentially MAGI-eligible for Medicaid coverage, but they are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since ACS data do not designate policyholders of employment-based coverage nor indicate whether workers hold an offer of ESI, we developed a model that predicts both the policyholder and the offer of ESI based on the Current Population Survey (CPS). Additionally, for families with a Marketplace eligibility level below 250% FPL, we assume any reported worker offer does not meet affordability requirements and therefore does not disqualify the family from Tax Credit eligibility on the Exchanges. For more detail on the offer imputation used in this analysis, see the Technical Appendix C.

As of January 2014, Medicaid financial eligibility for most nonelderly adults is based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state's reported eligibility levels as of January 1, 2019, updated to reflect state Medicaid expansion decisions as of January 2020 and 2018 Federal Poverty Levels.[20] Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.[21]

An individual's income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move and out of the coverage gap as their income fluctuates.

Starting with our of estimates of ACA eligibility in 2017, we transferred our core modeling approach from relying on the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to the American Community Survey (ACS). ACS includes a 1% sample of the US population and allows for precise state-level estimates as well as longer trend analyses. Since our methodology excludes a small number of individuals whose poverty status could not be determined, our ACS-based population totals appear slightly below CPS-based totals and some ACS population totals published by the Census Bureau. This difference is in large part attributable to students who reside in college dormitories. Comparing the two survey designs, CPS counts more of these individuals in the household of their parent(s) than ACS does.

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[4] National and state-by-state estimates of the number of people in the coverage gap may change from year to year due to several factors, including differences in the underlying data, small changes in state Medicaid eligibility, and declines in the number of uninsured people by state as economic conditions change.

[5] Kaiser Family Foundation analysis of 2018 American Community Survey (ACS), 1-Year Estimates.

[6] Kaiser Family Foundation analysis of the 2018 American Community Survey (ACS), 1-Year Estimates.

[7] The "100%-138% FPL" category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of potential Medicaid expansions but also with sufficient resources to avoid the coverage gap.

[8] The vast majority of these people are eligible for tax credits to subsidize the cost of coverage in the Marketplace, though some (e.g., people with an offer of employer coverage) may not qualify for tax credits.

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[12] Ibid.

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[14] The methods for arriving at this estimate can be found on the Kaiser Family Foundation Subsidy Calculator and the Kaiser Family Foundation "Change in Average Marketplace Premiums by Metal Tier", available here: http://www.kff.org/interactive/subsidy-calculator/ and https://www.kff.org/health-reform/state-indicator/change-in-average-marketplace-premiums-by-metal-tier/.

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[17] Kaiser Family Foundation, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," (Washington, DC, Kaiser Family Foundation, December 2019), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

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[21] Non-MAGI pathways for nonelderly adults include disability-related pathways, such as SSI beneficiary; Qualified Severely Impaired Individuals; Working Disabled; and Medically Needy. We are unable to assess disability status in the ACS sufficiently to model eligibility under these pathways. However, previous research indicates high current participation rates among individuals with disabilities (largely due to the automatic link between SSI and Medicaid in most states, see Kenney GM, V Lynch, J Haley, and M Huntress. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." Inquiry. 49:231-53 (Fall 2012)), indicating that there may be a small number of eligible uninsured individuals in this group. Further, many of these pathways (with the exception of SSI, which automatically links an individual to Medicaid in most states) are optional for states, and eligibility in states not implementing the ACA expansion is limited. For example, the median income eligibility level for coverage through the Medically Needy pathway is 38% of poverty in states that are not expanding Medicaid and that use this eligibility pathway. (See: MACPAC, *Medicaid Income Eligibility Levels as a Percentage of the FPL for Individuals Age 65 and Older and Persons with Disabilities by State, 2019.* Available at: https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-37.-Medicaid-Income-Eligibility-Levels-as-a-Percentage-of-the-Federal-Poverty-Level-for-Individuals-65-and-Older-and-Persons-with-Disabilities-by-State-2019.pdf.

SPECIAL ARTICLE

Health Care Hotspotting — A Randomized, Controlled Trial

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ABSTRACT

BACKGROUND

There is widespread interest in programs aiming to reduce spending and improve health care quality among "superutilizers," patients with very high use of health care services. The "hotspotting" program created by the Camden Coalition of Healthcare Providers (hereafter, the Coalition) has received national attention as a promising superutilizer intervention and has been expanded to cities around the country. In the months after hospital discharge, a team of nurses, social workers, and community health workers visits enrolled patients to coordinate outpatient care and link them with social services.

METHODS

We randomly assigned 800 hospitalized patients with medically and socially complex conditions, all with at least one additional hospitalization in the preceding 6 months, to the Coalition's care-transition program or to usual care. The primary outcome was hospital readmission within 180 days after discharge.

RESULTS

The 180-day readmission rate was 62.3% in the intervention group and 61.7% in the control group. The adjusted between-group difference was not significant (0.82 percentage points; 95% confidence interval, −5.97 to 7.61). In contrast, a comparison of the intervention-group admissions during the 6 months before and after enrollment misleadingly suggested a 38-percentage-point decline in admissions related to the intervention because the comparison did not account for the similar decline in the control group.

CONCLUSIONS

In this randomized, controlled trial involving patients with very high use of health care services, readmission rates were not lower among patients randomly assigned to the Coalition's program than among those who received usual care. (Funded by the National Institute on Aging and others; ClinicalTrials.gov number, NCT02090426; American Economic Association registry number, AEARCTR-0000329.)

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Health care spending in the United States is heavily concentrated, with 5% of the population accounting for 50% of annual spending and 1% accounting for almost a quarter of annual spending.[1] There is therefore substantial interest in interventions that can reduce spending and improve health care quality by targeting "superutilizers" of the health care system. Such programs have received considerable positive attention from the media[2-7] as well as support from the federal government.[8,9]

Since being profiled in Atul Gawande's seminal *New Yorker* article, "The Hot Spotters,"[10] the program created by the Camden Coalition of Healthcare Providers (hereafter, the Coalition) has been a flagship example of a promising superutilizer program. The Coalition's Camden Core Model uses real-time data on hospital admissions to identify patients who are superutilizers, an approach referred to as "hotspotting." Focusing on patients with chronic conditions and complex needs, and starting with the premise that navigation of the standard system is difficult for these patients, the program uses an intensive, face-to-face care model to engage patients and connect them with appropriate medical care, government benefits, and community services, with the aim of improving their health and reducing unnecessary health care utilization.

The program has been heralded as a promising, data-driven, relationship-based, intensive care management program for superutilizers, and federal funding has expanded versions of the model for use in cities other than Camden, New Jersey.[7-16] To date, however, the only evidence of its effect is an analysis of the health care spending of 36 patients before and after the intervention[17] and an evaluation of four expansion sites in which propensity-score matching was used to compare the outcomes for 149 program patients with outcomes for controls.[18] More broadly, there are a number of promising observational studies of other superutilizer programs.[12,17,19-21] However, regression to the mean — the tendency for patients selected for the exceptionally high cost of their care at a moment in time to move closer to average cost over time — may bias observational studies of superutilizer programs toward spurious results.[22,23]

Although there is limited rigorous evidence of the effectiveness of superutilizer programs, several randomized trials of care-transition programs — which, like the Camden Core Model, start with patients in the hospital and work with them after discharge — have shown substantially reduced readmissions.[24-29] However, the Camden Core Model targets a much more heterogeneous population with greater social and medical complexity and substantially higher health care utilization. Therefore, the Coalition partnered with investigators to design a prospective, randomized evaluation of this nationally recognized program.

METHODS

TRIAL DESIGN

This investigator-initiated, randomized, controlled trial was approved by institutional review boards at Cooper University Hospital, the National Bureau of Economic Research, Kennedy Health, and Our Lady of Lourdes Medical Center. The trial protocol, available with the full text of this article at NEJM.org, and planned analyses were publicly prespecified in March 2014 in consultation with Dr. Jeffrey Brenner, then director of the Coalition. Minor departures from the plan developed before analysis are described in the Supplementary Appendix, available at NEJM.org. The Coalition staff implemented the protocol and administered the intervention for patients in the treatment group but were unaware of the results until the trial was completed.

PROGRAM

Eligibility

The Camden Core Model is a care-transition program designed to improve patient health and reduce hospital use among some of the least healthy and most vulnerable adults in the United States. Eligibility for trial participation was limited to adults 18 to 80 years of age living in Camden, New Jersey, which is one of the most economically depressed cities in the country and has a high rate of violent crime[10]; in 2017, 37% of Camden residents lived below the poverty line as compared with 15% of persons in the United States overall.[30]

The intervention targeted superutilizers of the health care system — persons with medically and socially complex needs who have frequent hospital admissions. The inclusion criteria were at least one hospital admission at any of four Camden-area hospital systems in the 6 months before the index admission, when patients were enrolled; at least two chronic conditions; and at least two of

the following traits or conditions: use of at least five active outpatient medications, difficulty accessing services, lack of social support, a coexisting mental health condition, an active drug habit, and homelessness. Patients were excluded if they were uninsured, had cognitive impairment, or were receiving oncologic care or had been admitted for a surgical procedure for an acute health problem, for mental health care (with no coexisting physical health conditions), or for complications of a progressive chronic disease for which limited treatments were available. The eligible population composed less than 0.5% of the Camden population but accounted for 11% of the city's hospital expenditures (see the Supplementary Appendix).

Intervention

The time-limited intervention had intensive clinical and social components. Patients were enrolled while in the hospital. Once they returned home, patients worked with a multidisciplinary team that included registered nurses, social workers, licensed practical nurses, community health workers, and health coaches. The team conducted home visits, scheduled and accompanied patients to initial primary and specialty care visits, coordinated follow-up care and medication management, measured blood pressure and blood sugar levels, coached patients in disease-specific self-care, and helped patients apply for social services and appropriate behavioral health programs. The intervention contained many characteristics considered important for successful care-transition programs for high-cost, high-need patients.[31,32] The Supplementary Appendix includes more details on the intervention.

The control group received usual postdischarge care, which may have included home health care services or other forms of outreach. We were unable to measure the postdischarge services received by the control group.

RECRUITMENT AND RANDOMIZATION

Recruitment took place at Cooper University Hospital and Our Lady of Lourdes Hospital. Using the Camden Coalition Health Information Exchange database — which provided daily updates from hospital electronic medical records at these hospitals and the Virtua Health System and the Kennedy Health System (as of July 2014) — staff selected potentially eligible patients, who formed the triaged population. A Coalition recruiter approached these patients in the hospital, confirmed their eligibility, obtained written informed consent, and conducted a baseline survey. The recruiter then used a tamper-proof and externally recorded randomization process to assign treatment or control status and informed the patient of the assignment. All patients who completed the baseline survey were compensated with $20 for their time. Details regarding recruitment and randomization are available in the Supplementary Appendix.

The trial population was enrolled from June 2, 2014, through September 13, 2017. Of the 1520 patients triaged, recruiters deemed 1442 eligible for participation; 809 patients consented, and half were randomly assigned to treatment. Subsequently, 5 of the 809 patients were excluded at their request; the last 4 patients enrolled were excluded in order to reach the target trial population of 800 (Fig. 1).

DATA SOURCES

The primary data were hospital discharge data collected through March 31, 2018, from the four Camden hospital systems; these accounted for 98% of New Jersey hospital discharges of Camden residents (see the Supplementary Appendix). The discharge data contained admission and discharge dates, diagnoses, discharge destination, charges and payments received, and patients' identifying information.

We supplemented these data with data from several other sources. The Camden Coalition Health Information Exchange database contained additional demographic information and a record of the patient's index admission (where recruitment occurred). We matched 782 of the patients (98%) in the trial to the discharge record for their index admission; match rates were balanced between the treatment group (98.5%) and the control group (97.0%). The baseline survey provided additional socioeconomic information on patients. The Coalition recorded staff contacts with patients in the treatment group. Administrative data from the state of New Jersey provided information on social services received by trial participants (specifically, the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and General Assistance), and the National Death Index provided mortality data. (See the Supplementary Appendix for additional details.)

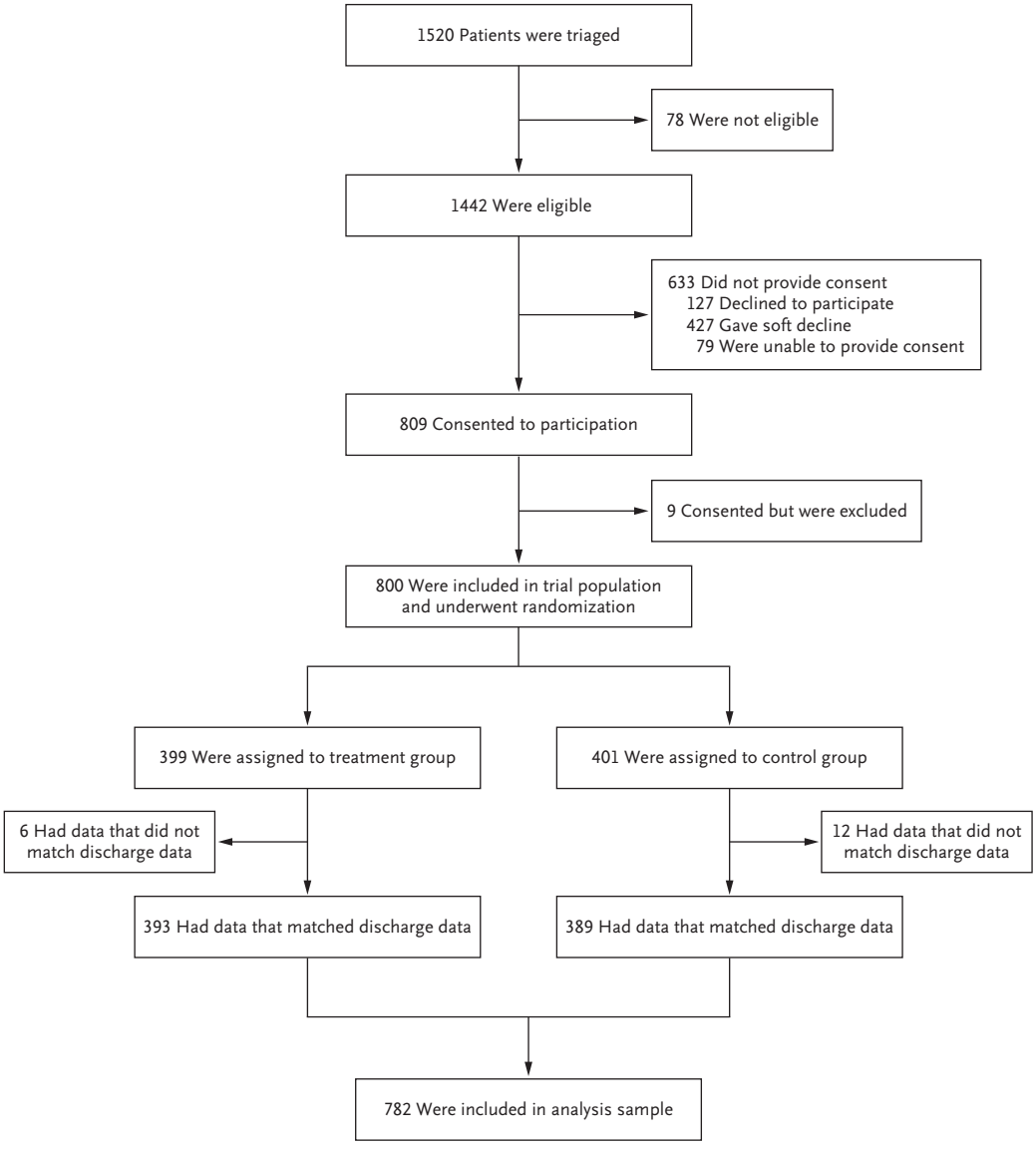

Figure 1. Screening, Randomization, and Analysis.

Data are from the Camden Coalition Health Information Exchange. Patients who declined to participate explicitly said "no" to the offer of randomization. Patients who gave a soft decline did not provide consent when approached but did not decline to participate and could be approached again during future hospitalizations if they were otherwise eligible. Patients who were unable to provide consent were either discharged or died before they could be reached or were unable to consent for reasons such as being asleep. Patients who consented but were excluded included 5 patients who consented and later asked to be removed from the trial and the last 4 patients enrolled in the trial who were excluded to keep the trial population at the target of 800 patients. For patients in the trial population to be included in the analysis sample, a record of their index admission had to have been found in the hospital discharge data. Further information is provided in the Supplementary Appendix.

OUTCOMES

The primary outcome was readmission within 180 days after hospital discharge. Secondary outcomes were the number of readmissions, the proportion of patients with two or more readmissions, hospital days, charges, payments received, and mortality — all measured 180 days after discharge — as well as readmission rates at shorter

Table 1. Characteristics of the Patients at Baseline.*

Characteristic	Overall (N=782)	Treatment (N=393)	Control (N=389)
Age at index admission (%)			
≤44 yr	17.1	16.0	18.3
45–64 yr	55.4	55.0	55.8
≥65 yr	27.5	29.0	26.0
Race or ethnic group (%)			
Non-Hispanic black	54.9	57.8	51.9
Hispanic	29.5	26.7	32.4
Non-Hispanic white	15.1	14.8	15.4
Asian, multiracial, or other	0.5	0.8	0.3
Inpatient admissions before index admission (no.)			
0–6 mo before	1.75	1.72	1.78
7–12 mo before	0.74	0.74	0.75
Primary payer (%)			
Medicaid	44.6	43.0	46.3
Medicare	48.2	47.6	48.8
Other	7.0	9.2	4.9
Employment status (%)			
Currently employed	5.5	4.8	6.2
Not employed	94.0	94.9	93.1
No response	0.5	0.3	0.8
Mental health diagnoses at index admission (%)			
Depression	30.2	32.3	28.0
Substance abuse	44.0	41.2	46.8

* Data on age, number of admissions before the index admission, primary payer, and mental health diagnoses were obtained from hospital discharge data, and data on race, ethnic origin, and employment status were obtained from a survey conducted at baseline. The analysis sample (782 patients) excluded 18 patients with missing outcome data because they could not be matched to the discharge record for their index admission. Percentages may not sum to 100 because of rounding.

and longer time horizons. We also analyzed the primary outcome according to prespecified subgroups. With the exception of receipt of social services and mortality, all outcomes were based on hospital discharge data.

STATISTICAL ANALYSIS

We used linear regressions to compare outcomes for patients in the treatment and control groups. To increase precision, we included prespecified covariates for age (with patients grouped in 5-year increments), sex, indicators for non-Hispanic black and Hispanic origin, and measures of health care utilization less than 6 months and 7 to 12 months before the index admission. We also report differences in means for patients in the treatment and control groups without adjustment for covariates. We conducted a sensitivity analysis with the use of multiple imputation to account for missing outcome data for 18 patients who could not be matched to the discharge record for their index admission.[33]

Initially, we determined that a population of 800 would provide 80% power to detect a decrease of 9 percentage points in the 180-day readmission rate (at a two-sided significance level of 0.05). Subsequently, data from the actual study population — whose readmission rate was twice what we had assumed — indicated power to detect a decline of 9.6 percentage points in the primary outcome (see the Supplementary Appendix). There was no prespecified plan to adjust for multiple comparisons; therefore, we report P values only for the primary outcome and report 95% confidence intervals without P values for all secondary outcomes. The confidence intervals have not been adjusted for multiple comparisons, and inferences drawn from them may not be reproducible.

RESULTS

TRIAL POPULATION

The trial population averaged 1.8 hospital admissions in the 6 months before the index admission (Table 1) as compared with less than 0.1 admissions in the general adult Camden population (see the Supplementary Appendix). The trial population was 50% male; 40% were younger than 55 years of age and 30% were older than 65 years of age; 55% were non-Hispanic black, 30% were Hispanic, and 15% were non-Hispanic white. Our prespecified covariates were balanced between the treatment and control groups (Table S2).

Tables S1 and S2 in the Supplementary Appendix show that three quarters of the trial population were unmarried, one half did not have a high school diploma, and three fifths reported needing help with mobility. Nearly the entire population (95%) was not employed, and 40% received a diagnosis of substance abuse during the index admission. Medicare was the primary payer for 48% of the trial population, and Medicaid was the primary payer for 45% of the population.

PROGRAM IMPLEMENTATION

Table 2 shows measures of program implementation. Among patients in the treatment group, 95% had at least three encounters with program staff after enrollment; on average, a patient received 7.6 home visits and 8.8 telephone calls from staff and was accompanied on 2.5 physician visits, and 90% worked with the Coalition for more than 30 days. The median duration of program participation was 92 days. The Coalition set ambitious goals for connecting patients to care quickly after discharge.[34] These goals included a home visit from program staff within 5 days after a patient's arrival at home and a provider visit within 7 days after arrival at home; the first goal was met for 60% of patients, the second goal was met for 36% of patients, and both goals were met for 28% of patients. Three quarters of the patients received both a home visit within 14 days and a provider visit within 60 days.

Receipt of government benefits during the 6 months after discharge was the one metric of program implementation observed in both the treatment and control groups (Table 3). Rates of participation in both Temporary Assistance for Needy Families and General Assistance were low and did not significantly change with the intervention; the adjusted difference in participation in the Supplemental Nutrition Assistance Program associated with the intervention was 4.6 percentage points (95% confidence interval [CI], 0.5 to 8.6).

Table 2. Program Metrics in the Treatment Group.*

Metric	Values
Encounters	
Home visits — mean no. (median)	7.6 (5)
At least one — %	88.8
At least three — %	70.7
Telephone calls — mean no. (median)	8.8 (5)
At least one — %	88.0
At least three — %	65.4
Primary care provider and specialist visits — mean no. (median)	2.5 (2)
At least one — %	84.7
At least three — %	29.5
Other types of visits — mean no. (median)	5.7 (1)
At least one — %	65.1
At least three — %	36.1
Total no. of encounters — mean no. (median)	28.1 (17)
At least one — %	98.7
At least three — %	95.2
Length of intervention, measured from discharge home — %	
>30 days	89.8
>90 days	50.5
>180 days	17.0
Median — days	91.5
Timing of service provided, measured from day of discharge home — %	
Camden Coalition home visit	
Within 5 days	58.6
Within 14 days	83.0
Office visit with PCP or specialist	
Within 7 days	36.0
Within 14 days	60.2
Within 60 days	83.3
Both home visit within 5 days and office visit with PCP or specialist within 7 days	28.0
Both home visit within 14 days and office visit with PCP or specialist within 60 days	76.1

* Data on program metrics are from the records of the Camden Coalition of Health Care Providers and the 393 patients in the treatment group. Data on timing of services are missing for 4 patients, and data on length of intervention are missing for 11 patients.

EFFECTS OF THE INTERVENTION

Table 4 shows the effects of the intervention. The 180-day readmission rate was 62.3% in the treatment group and 61.7% in the control group. The intervention had no significant effect on this primary outcome: the adjusted difference in the probability of readmission was 0.82 percentage points higher in the treatment group than in the control group (95% CI, −5.97 to 7.61; P=0.81). This finding is robust to the use of multiple imputation to account for missing data (adjusted difference, 0.64 percentage points; 95% CI, −6.12 to 7.40) (see Table S6 for details). The intervention also had no effect on any of the secondary outcomes or within any of the prespecified subgroups (Table 4).

Results for the primary outcome were not sensitive to alternative specifications or measurement over alternative horizons. The intervention had no significant effects when the hazard rate of readmission (with either a Cox proportional-hazards model or a competing-risks model accounting for mortality), 180-day mortality, or post hoc subgroups were analyzed; results differed slightly according to hospital of index admission,

Table 3. Benefit Participation during 6 Months after Enrollment.*

Metric	Control Group (N=389)	Treatment Group (N = 393)	Unadjusted Difference (95% CI)	Adjusted Difference (95% CI)
	percent			
Participation in supplemental nutrition assistance program	50.13	58.52	8.4 (1.43 to 15.36)	4.59 (0.52 to 8.65)
Receipt of temporary assistance for needy families	1.03	1.78	0.75 (–0.9 to 2.4)	0.69 (–0.34 to 1.71)
Receipt of general assistance	6.94	6.87	–0.07 (–3.63 to 3.49)	0.68 (–1.82 to 3.18)

* Data on benefit participation are from the New Jersey Department of Human Services and consist of the analysis sample (782 patients). Shown are the mean values for each outcome in the control group and the treatment group. Calculation of the unadjusted between-group difference was based on an indicator for the treatment group from an ordinary least-squares regression of the outcome, with no other covariates. Calculation of the adjusted between-group difference was based on an indicator for the treatment group from an ordinary least-squares regression of the outcome with prespecified covariates. All confidence intervals (CIs) were calculated with the use of heteroskedasticity-robust standard errors. Prespecified covariates included the dependent variable 0 to 6 months before the index admission, the dependent variable 7 to 12 months before the index admission, and indicators for age (grouped in 5-year increments), male sex, black non-Hispanic origin, and Hispanic origin. Measurement of covariates was based on hospital discharge data except for the characteristic of race or ethnic origin, which was reported from data in the baseline survey.

but the estimates were quite imprecise (Tables S6 and S8 and Fig. S5).

BEFORE AND AFTER ANALYSIS OF THE INTERVENTION GROUP

In contrast with the results of the randomized, controlled trial, a comparison of admission rates for the intervention group alone in the 6 months before and after enrollment misleadingly suggested a substantial decline in admissions in response to the intervention because it did not account for the similar decline in the control group. Figure 2 shows the average number of admissions per quarter before and after the index admission. In both the intervention and control groups, admissions rose sharply in the 6 months before the intervention and fell rapidly afterward.

In addition, estimates of the change in hospital admissions before and after the intervention that were based only on the intervention group were very sensitive to the definition of the period before the intervention. There was a 38-percentage-point decrease in the probability of a hospital admission during the 6 months after the intervention as compared with the 6 months preceding the intervention, but there was a 29-percentage-point increase in the probability of a hospital admission in the 6-month period after the intervention as compared with the 12-to-18-month period that preceded the intervention (Table S5).

DISCUSSION

In this randomized evaluation involving 800 trial participants, the Camden Core Model had no significant effect on participants' 180-day readmission rate. The 95% confidence intervals rule out a decrease in readmission rates of more than 6 percentage points as compared with a control mean of 62%; this finding rules out the reductions in readmissions of 15 to 45% in the Medicare population reported in randomized evaluations of other care-transition programs.[24-29] The Camden model targets a different population: one that was younger, with more diverse medical needs, greater social complexity, and much higher health care utilization; previous hospital use was nearly twice that in most previous successful programs involving care transition.

Our results suggest that there are challenges for superutilizer programs aimed at medically and socially complex populations. They are consistent with the mixed results on hospital admissions from randomized evaluations of care-management programs for chronically ill populations, although those programs, unlike the Camden model, did not focus on the postdischarge transition.[35,36,37] It is possible that approaches to care management that are designed to connect patients with existing resources are insufficient for these complex cases. The Coalition has continually worked to adapt the model to the needs of

Table 4. Effects of Intervention in the Treatment Group, 180 Days after Discharge.*

Effect	No. of Patients	Control Group	Treatment Group	Unadjusted Between-Group Difference (95% CI)	Adjusted Between-Group Difference (95% CI)
		mean			
Readmission in total sample					
Any (%)		61.70	62.34	0.64 (–6.17 to 7.46)	0.82 (–5.97 to 7.61)
No. of readmissions		1.54	1.52	–0.02 (–0.29 to 0.26)	0.01 (–0.25 to 0.27)
≥2 readmissions (%)		36.25	36.39	0.14 (–6.61 to 6.89)	0.27 (–6.22 to 6.77)
Days in hospital		9.95	9.36	–0.59 (–2.49 to 1.31)	–0.32 (–2.17 to 1.53)
Hospital charges ($)		114,768	116,422	1,654 (–25,523 to 28,831)	3,722 (–23,438 to 30,882)
Hospital payments received ($)		17,650	18,130	480 (–3,613 to 4,573)	680 (–3,415 to 4,775)
Any readmission according to subgroup (%)					
No. of admissions in previous yr					
2	336	52.12	52.63	0.51 (–10.2 to 11.22)	0.78 (–10.35 to 11.91)
≥3	446	68.75	69.82	1.07 (–7.51 to 9.65)	1.27 (–7.38 to 9.92)
Preferred language					
English	638	63.11	62.61	–0.49 (–8.01 to 7.02)	0.1 (–7.42 to 7.61)
Other	144	56.25	60.94	4.69 (–11.58 to 20.96)	8.49 (–9.08 to 26.06)

* Data consist of the analysis sample (a total of 782 patients), and outcomes are measured with the use of hospital discharge data. For the unadjusted difference, the coefficient and 95% confidence interval are shown on the basis of an indicator for treatment group from an ordinary least-squares regression of the outcome, with no other covariates. For the adjusted difference, the coefficient and the 95% confidence interval are shown on the basis of an indicator for treatment group from an ordinary least-squares regression of the outcome, with prespecified covariates. All confidence intervals were calculated with the use of heteroskedasticity-robust standard errors. Prespecified covariates include the number of admissions less than 6 months before the index admission, the number of admissions 7 through 12 months before the index admission, and indicators for age (grouped in 5-year increments), male sex, black non-Hispanic origin, and Hispanic origin. With the exception of race and ethnic origin, for which data was obtained from the baseline survey, covariates were measured on the basis of hospital discharge data. For three of the outcomes (days in hospital, hospital charges, and hospital payments received), the number of admissions from 0 to 6 months before the index admission and from 7 to 12 months before the index admission were replaced with the values of the dependent variable over those two time periods. The P value for the primary outcome (any readmission) for the adjusted difference was 0.81.

its patient population, and both the Coalition and others are exploring models that involve more complete redesigns of care provision.[6,38] (See also Comprehensive Care Physician: Integrated Inpatient and Outpatient Care for Patients at High Risk of Hospitalization [ClinicalTrials.gov number, NCT01929005].)

Engagement with the program was high (95% of patients had at least three encounters with program staff), and patients received an intensive intervention (averaging 7.6 home visits), but two program goals related to the timing of services — a home visit within 5 days after hospital discharge and a visit to a provider's office within 7 days after discharge — were achieved less than 30% of the time. Challenges in reaching these goals included patients' lack of stable housing or a telephone and their behavioral health complexities and providers' few available appointments. The difficulties that this pioneering, data-driven organization had in achieving rapid assistance for patients may portend difficulties in achieving it at scale.

Our findings may also reflect fundamental challenges with the strategy of targeting superutilizers: many patients whose medical costs are high today will not be as high in the future — and this trend becomes even more pronounced as one goes higher in the cost distribution.[22,39,40] Moreover, for patients with medical costs that are persistently high, few of those costs may be related to potentially preventable hospitalizations.[39-41]

Such regression to the mean also underscores the importance of rigorous evaluation through

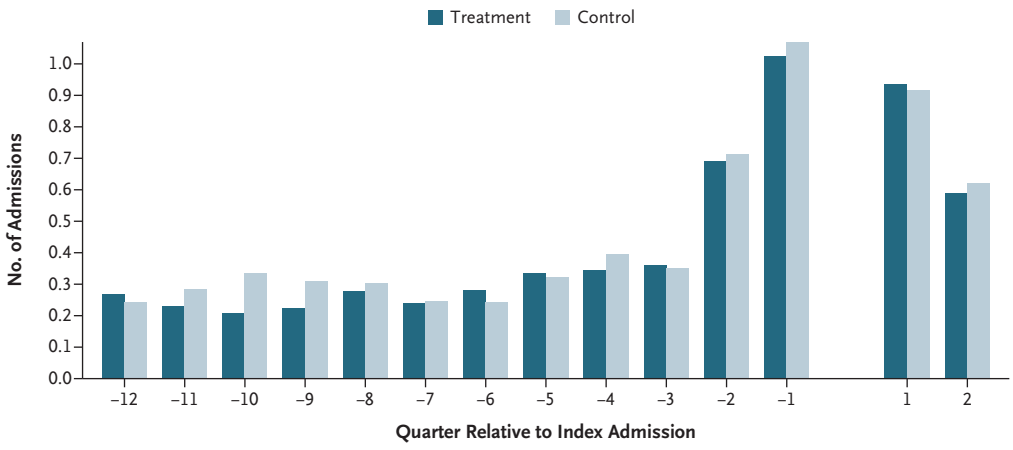

Figure 2. Average Number of Inpatient Admissions per Quarter.

All data are from hospital discharge data and cover the analysis sample of 782 patients. Treatment data are from 393 patients, and control data are from 389 patients. Quarter 1 begins with the discharge date from the index admission, whereas quarter −1 is the quarter ending the day before the index admission. The index admission is excluded from the figure.

randomized trials, since observational evaluations of superutilizer programs will be prone to the detection of spurious effects.[18,22,23] This danger was illustrated in our program by the similar reduction in readmissions in both the treatment and control groups.

Our trial has several limitations. It was powered to detect whether this care-transition program could achieve reductions in readmissions as compared with similar programs focused on patients with less complex health care needs. However, the trial was not powered to detect smaller reductions that could be clinically meaningful, nor was it powered to analyze effects within specific subgroups, where there could be differential effects. The data did not permit evaluation of potential nontangible benefits such as improved relationships with providers.[42] Nor did the data allow comparison of outpatient care for the treatment and control groups. Usual care in Camden was evolving during the trial period, multiple other care-management programs were starting,[43-46] and the Coalition was leading a citywide campaign to connect patients with primary care within 7 days after hospital discharge.[47]

Despite these limitations, the trial provides rigorous evidence of the effect of a nationally recognized program aimed at superutilizers of the health care system that has been expanded to other cities. The results suggest both the challenges of reducing readmissions in a medically and socially complex superutilizer population and the importance of conducting randomized evaluation of interventions such as this one, which, because they target high-cost patients, are likely to show substantial regression to the mean in observational studies.

The findings and conclusions expressed are solely those of the authors and do not represent the views of their funders.

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A data sharing statement provided by the authors is available with the full text of this article at NEJM.org.

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The Commonwealth Fund

Can Value-Based Payment Improve Health Care and Lower Costs?

January 8, 2020

| Joseph P. Newhouse, Mary Price, John Hsu, Bruce E. Landon, and J. Michael McWilliams, M.D.

The Issue

The goal of accountable care organizations (ACOs) and other plans that shift financial risk from insurers to those delivering health care is to provide better, more coordinated patient care while saving money through the elimination of unnecessary services, like duplicated tests or treatments of little value.

A new study in the *American Journal of Managed Care* by Commonwealth Fund–supported researchers compares the effectiveness of a Medicare ACO with traditional Medicare, which has been confirmed in earlier research, as well as with

a private Medicare Advantage (MA) plan. The researchers used data from one large delivery system — Banner Health, headquartered in Phoenix, Arizona — between 2010 and 2014.

What the Study Found

- For each year during this period, MA hospitalization rates for the MA plan were below those for the ACO and traditional Medicare comparison groups. The differences narrowed over time, but in the final year the MA rate remained about 10 percent below the other two groups.

From 2010 to 2014 at one large delivery system, hospitalization rates for the Medicare Advantage (MA) plan were below those for the system's ACO and traditional Medicare plans.

Share

- Rates of skilled nursing facility days in both the ACO and traditional Medicare groups were about twice the rate for the MA plan. However, the MA plan rate rose steadily over the four years, while the rates in the other two fell.
- There were no noticeable trends in office visits or emergency department visit rates.
- The MA group had the lowest risk-adjusted spending in all years, although its spending rose consistently throughout the period. Spending in the traditional Medicare and ACO groups did not vary nearly as much.

The Big Picture

Adjusted rates of hospital and skilled nursing facility stays, as well as spending rates, were notably lower in Banner Health's MA plan compared to its Medicare ACO. But there was some narrowing of these differences over the observation period.

The Bottom Line

The findings of lower utilization and spending rates in the MA plan support efforts by the Center for Medicare and Medicaid Services to shift Medicare reimbursement away from traditional fee-for-service payment.

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Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act

Published: Jan 03, 2020

On December 18, 2019, a federal appeals court panel (http://www.ca5.uscourts.gov/opinions/pub/19/19-10011-CV0.pdf) ruled that the Affordable Care Act's (ACA) individual mandate is unconstitutional, since Congress has set the mandate tax penalty to zero. The appeals court sent the case back to the lower court to determine how much of the rest of the ACA should be overturned. The case was brought by a number of (https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-5th-circuit-appeal-in-the-case-challenging-the-aca/) Republican state attorneys general and other plaintiffs, who argue that the rest of the ACA is not severable from the mandate and should therefore be invalidated. The Trump administration now argues that nearly all of the ACA should be overturned, but previously argued that only the ACA's pre-existing condition protections should be overturned.[1] Pending a final decision on the case, the Trump administration has continued to enforce the ACA.

The number of non-elderly Americans who are uninsured decreased by 18.6 million (https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/) from 2010 to 2018 as the ACA went into effect. While the ACA's changes to the individual insurance market – including protections for people with pre-existing conditions and premium subsidies for low and modest income people – have been the focus of much policy debate and media coverage, the law made other sweeping changes that impact nearly all Americans. These include: the expansion of Medicaid eligibility for low-income adults; required coverage of preventive services with no cost sharing in private insurance, Medicare, and for those enrolled in the Medicaid expansion; new national initiatives to promote public health and quality of care; and a variety of tax increases to finance these changes.

The ACA's reforms affect nearly everyone in some way, and a court decision that invalidated the ACA would have complex and far-reaching impacts throughout the health care system. The following table summarizes the major provisions of the ACA, illustrating the breadth of its changes to the health care system, and public attitudes towards those changes.

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
		Expanded Eligibility for Health Coverage
Medicaid Eligibility Expansion – Medicaid eligibility is expanded to include adults with income up to 138% FPL; however, the Supreme Court ruling in 2012 essentially made Medicaid expansion optional for states. – The federal government paid 100% of the cost of the expansion initially; this share phases down to 93% in 2019 and 90% in 2020 and beyond	– In FFY 2017, there were more than 17 million (https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) Medicaid expansion enrollees in the 32 states and DC that had adopted the expansion. Of those enrollees, 12.7 million were newly eligible due to the ACA's Medicaid expansion	– 87% say it of the law th cover more unconstituti finding/kff- – 59% of see their (https://ww november-
Subsidies for Non-Group Health Insurance – Eligible individuals who buy coverage through the Marketplace receive subsidies based on	– As of February 2019, 9.3 million (https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/) Marketplace enrollees received premium tax credits and 5.5 million (https://www.cms.gov/sites/default/files/2019-08/08-12-2019%20TABLE%20Early-2019-2018-Average-Effectuated-Enrollment.pdf) received cost-sharing reductions	– 85% say it part of the l Americans v unconstituti finding/kff-

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
income: premium tax credits for those with income 100-400% FPL; cost-sharing subsidies for those with income 100-250% FPL – States can also elect to run a subsidized Basic Health Plan for people with income between 133%-200% FPL	– In 2019, there were about 0.9 million (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment) people enrolled in the Basic Health Plans in Minnesota (92,561) and New York (790,152)	
Dependent Coverage to 26 – All non-grandfathered private group and non-group health plans must extend dependent coverage to adult children up to the age of 26	– About 2.3 million (https://aspe.hhs.gov/system/files/pdf/111826/ACA%20health%20insurance%20coverage%20brief%2009212015.pdf) young adults gained coverage as a result of this provision	– 78% of the important" (parents' insu unconstituti finding/kff-
Health Insurance Marketplace – Establish new marketplaces where qualified health plans are offered to individuals	– 10.6 million (https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/) individuals had effectuated coverage through the Marketplace as of the first quarter of 2019 –67% (https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/) of Marketplace enrollees will have a choice of three or more insurers in 2020	– 82% of the view of crea can shop fo finding/kff- future-aca-

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
– Marketplaces certify that qualified health plans meet all ACA requirements, provide subsidies to eligible individuals, operate a website to facilitate application and comparison of health plans, provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators	– 26 insurers (https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/) are entering state Marketplaces for 2020 – Individual market gross profit margins (https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-early-2019/) have been higher, on average, in 2017-2019 than before the ACA was implemented	– 45% say working v working v finding/kff- – 52% say state are well. Tho likely to s healthcar (https://ww november-
	Federal Minimum Standards for Private Health Insu	
Protections for Pre-existing Conditions – All non-grandfathered plans are prohibited from	– 54 million (https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/) people (27% of the non-elderly population) have a pre-existing condition that would have been deniable in the pre-ACA individual market	– Majorities insurance co (64%) remai (https://ww july-2019/)

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
discriminating against individuals based on their health status – Insurers in the non-group, small group, and large group market must guarantee issue coverage – Large group, small group, and non-group health plans are prohibited from applying pre-existing condition exclusions – Insurers in the non-group and small group market may not vary premiums based on health status or gender or any other factor except: – Premiums can vary by age (by a factor of 3:1), geography, family size, and tobacco use	– 45% (https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/) of non-elderly families have at least one adult member with a pre-existing condition	-62% ove want to s people w (November health-trac – 57% of pre-exist (https://ww april-2019/ – 57% are that they Supreme protectio finding/kff- – 62% are that they coverage pre-exist (https://ww april-2019/

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
– Rescission of coverage is prohibited in the non-group, small group, and large group market		
Preventive Services – All non-grandfathered group and non-group plans must cover preventive health services without cost sharing – Covered services include breast, colon, and cervical cancer screening, pregnancy-related services including breastfeeding equipment rental, contraception, well-child visits, adult and pediatric immunizations, and routine HIV screening. In addition, it was recently recommended	– 87% (http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019) of covered workers with employer-sponsored insurance (approximately 133 million people) were enrolled plans that must provide free preventive services as of 2019 – 12.7 million (https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/) people were enrolled in individual market plans required to provide free preventive services, as of February 2019 – 17 million enrollees in Medicaid expansion states received coverage for preventive services in 2017 – Prior to the ACA, 1 in 5 women (https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-for-women-covered-by-private-health-plans-under-the-affordable-care-act/) reported that they postponed or went without preventive care due to cost – The share of reproductive age women with private insurance reporting that their insurance covered the full costs of their prescription contraception rose (https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2017-kaiser-womens-health-survey/) from 45% in 2013 to 75% in 2017	– 89% say it part of the A cost for mos is ruled unc finding/kff-

Table 1. Summary of Key Provisions of the ACA, Their Impact,

Key Provision	Impact	
that pre-exposure prophylaxis (PREP) to prevent HIV infection be included as well and if finalized, would be offered at no cost		
Essential Health Benefits – All ACA compliant health plans in the individual and small group market must cover 10 categories of essential health benefits (EHB), including hospitalization, outpatient medical care, maternity care, mental health and substance abuse treatment, prescription drugs, habilitative and rehabilitative services, and pediatric dental and vision services	– In 2013, before the ACA EHB requirements took effect, 75% (https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/) of non-group health plans did not cover maternity care, 45% did not cover substance use disorder treatment, and 38% did not cover mental health services	– 66% of federal g a certain finding/ medicai

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
Annual and Lifetime Limits – All group and non-group plans (including non-grandfathered) are prohibited from placing lifetime or annual limits on the dollar value of coverage for essential health benefits	– Prior to the ACA, in 2009, 59% (https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7936.pdf) of covered workers' employer-sponsored health plans had a lifetime limit – 153 million (https://www.kff.org/report-section/ehbs-2019-summary-of-findings/) people (57% of the U.S (https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/). non-elderly population) had employer coverage as of 2019	– 62% of the prohibits pr much they v law is ruled reform/pol – 51% of the ACA t from sett your cove unconstit finding/kff-
Cap on Out-of-Pocket Cost Sharing – All non-grandfathered private health plans must limit cost sharing for essential health benefits covered in network – The annual maximum for 2020 is $8,150 for an individual; $16,300 for family coverage	– Prior to the ACA, in 2009, 19% (https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-7-employee-cost-sharing/attachment/figure-7-43-2/) of covered workers had no limit on out-of-pocket expenses. Among those with out-of-pocket maximums, not all expenses counted toward the limit. For example, in 2009, among workers in PPOs with an out-of-pocket maximum, 85% were in plans that did not count prescription drug spending when determining if an enrollee had reached the out-of-pocket limit	
Minimum Medical Loss Ratios – Require all non-grandfathered private plans to	– In total, over $5 billion (https://www.kff.org/private-insurance/issue-brief/data-note-2019-medical-loss-ratio-rebates/) in medical loss ratio rebates have been issued across (https://fas.org/sgp/crs/misc/R42735.pdf) the individual, small group, and large group markets, from 2012 to 2019 (based on insurer financial results from the 2011-2018 plan years)	– 62% of the requiring ins services and customers a (https://kai t2.pdf)

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
pay a minimum share of premium dollars on clinical services and quality – Insurers must provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets		
Consumer Information and Transparency – All non-grandfathered health plans must provide a brief, standardized summary of coverage written in plain language – All non-grandfathered health plans	– Transparency data collected by CMS for PY 2017 indicate that, on average, healthcare.gov issuers deny 18% (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/) of in-network claims, and that consumers rarely appeal denied claims	– 79% of the 68% of Reps (https://kai

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
must periodically report transparency data on their operations (e.g., number of claims submitted and denied)		
		Other Provisions Affecting Employers/Group Health
Large Employer Mandate – Requires employers with at least 50 full time workers to provide health benefits or pay a tax penalty		– Favored by including 88 (https://ww november-
Waiting Periods – Employers that impose waiting periods on eligibility for health benefits (e.g., for new hires) must limit such periods to no more than 90 days	– Prior to the ACA, in 2009, 29% (https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-3-employee-coverage-eligibility-and-participation/attachment/figure-3-13/) of covered workers faced a waiting period of 3 months or more	
		Consumer Assistance
State Consumer Assistance Programs – Authorize federal grants for state Consumer	– CAPs were established in most states in 2010, though no appropriations for CAPs have since been enacted. Today 36 CAPs (https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc) are in operation	

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
Assistance Programs (CAPs) to advocate for people with private coverage. – Notice of claims denials by non-grandfathered private plans must include information about state CAPs that will help consumers file appeals	– A report (https://www.cms.gov/CCIIO/Resources/Files/Downloads/csg-cap-summary-white-paper.pdf) on the first year of CAP operations found the programs helped 22,814 individuals successfully challenge their health plan decisions and obtained more than $18 million on behalf of consumers	
	Other Medicaid Provisions	
Simplification of Enrollment Processes – States are required to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges	– Prior to the ACA in 2013, 27 states had an asset test and 6 required face-to-face interviews for parents; only 36 states had an online Medicaid application and 17 states allowed individuals to apply by phone. As of January 2019 (https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/), individuals can apply for Medicaid online and by telephone in all states for the first time, and all states had eliminated asset tests and face-to-face interviews	
Long-term Care Services and Supports – Expands financial eligibility for	– 16 states (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/) elected the option to expand eligibility for 1915(i) HCBS services as of 2017. 70,000 individuals received services and over $594 million was spent on these services	

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
1915(i) home and community-based services (HCBS), creating a new eligibility pathway to allow people not otherwise eligible to access full Medicaid benefits, allows states to target services to specific populations, and expands the services covered – Creates a new Medicaid state plan option to cover attendant care services and supports with 6% enhanced FMAP	– As of 2017, 8 states (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/) elected the option to cover attendant care services. 366,000 individuals received services and $5.8 billion was spent on these services	
Behavioral Health Parity – Mental health and substance use disorder services must be included in Medicaid Alternative Benefit Packages (ABPs) provided to Medicaid expansion adults	– 17 million Medicaid expansion enrollees receive services through an ABP	

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
and other adults, and the services must be covered at parity with other medical benefits		
Medicaid Eligibility for Former Foster Care Youth up to Age 26 – Requires states to provide Medicaid to young adults ages 21 through 26 who were formerly in foster care.		
Medicaid Drug Rebate Percentage – Increase Medicaid drug rebate percentage for most brand name drugs to 23.1% and increase Medicaid rebate for non-innovator multiple source drugs to 13%. Extend drug	– CBO (https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf) estimated federal savings of $38 billion over 10 years from the Medicaid prescription drug provisions in the ACA, including increases in the drug rebate percentage	

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
rebate program to Medicaid MCOs		
	Medicare Provisions	
Part D Coverage Gap[2] Gradually close the Medicare Part D coverage gap ("doughnut hole"): – Phase down the beneficiary coinsurance rate for brand and generic drugs In the Medicare Part D coverage gap from 100% to 25% by 2020 – Require drug manufacturers to provide a 50% discount on the price of brand-name and biologic drugs in the coverage gap – Reduce the growth rate in the catastrophic coverage threshold amount between 2014 and 2019 to provide	– 45 million people were enrolled in Medicare Part D in 2019 – In 2017, nearly 5 million Part D enrollees without low-income subsidies (LIS) had spending in the coverage gap and received manufacturer discounts averaging $1,184 on brand-name drugs – Reinstating the coverage gap would increase costs incurred by Part D enrollees who have relatively high drug spending	– 81% of the closes the M people on M medications reform/pol congress-fu

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
additional protection to enrollees with high drug costs		
Preventive Services – Eliminate cost sharing for Medicare covered preventive services. Authorize coverage of annual comprehensive risk assessment for Medicare beneficiaries	– 60 million people have access to free preventive services; of these, Medicaid pays Medicare cost sharing for about 9 million dual eligibles (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources)	
Cost Sharing in Medicare Advantage (MA) – Prohibit MA plans from imposing higher cost-sharing requirements than traditional Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services deemed appropriate by the Secretary of HHS. This prohibition was	– 22 million (https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/) people enrolled in Medicare Advantage plans in 2019	

Table 1. Summary of Key Provisions of the ACA, Their Impact, and

Key Provision	Impact	
extended to most Medicare-covered services		
Restructure Medicare Advantage Payments – Reduce federal payments to Medicare Advantage plans to bring payments closer to the average Medicare spending for beneficiaries in traditional Medicare – Provide quality-based bonus payments to Medicare Advantage plans – Require Medicare Advantage plans to maintain a medical loss ratio of at least 85 percent; the administration extended this requirement to all Part D plans	– CBO estimated (https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf) repeal of the ACA Medicare Advantage payment changes would increase Medicare spending by about $350 billion over 10 years (2016-2025) – 74 percent (https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/) of Medicare Advantage enrollees were in plans that were eligible for bonus payments in 2019; Bonus payments summed to $6.3 billion in 2018 (https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/) – Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund	
Other Provider Payments	– CBO estimated (https://www.cbo.gov/publication/50252) repeal of the ACA provider payment reductions would increase Medicare spending by another approximately $350 billion over 10 years (2016-2025)	

Table 1. Summary of Key Provisions of the ACA, Their Impact,

Key Provision	Impact	
– Reduce the rate at which Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers are updated annually – Reduce Medicare Disproportionate Share Hospital (DSH) payments that help to compensate hospitals for providing care to low-income and uninsured patients – Allow providers organized as Accountable Care Organizations (ACOs) that meet quality thresholds to share in cost savings they achieve for the Medicare Program	– Eliminating the Medicare Shared Savings Program ACOs could affect around 10.5 million Medicare beneficiaries (https://www.kff.org/faqs-medicare-accountable-care-organization-aco-models/) who were attributed to a MSSP ACO, as of 2018 – Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund	

Table 1. Summary of Key Provisions of the ACA, Their Impact,

Key Provision	Impact	
Medicare Income-related Premiums[3] – Freeze threshold for income-related Medicare Part B premiums for 2011 through 2019 – Establish new income-related premium for Part D, with the same thresholds as the Part B income-related premium	– As originally enacted in the ACA, CBO estimated (https://www.cbo.gov/publication/21351) $35.7 billion in savings from these provisions over 10 years – According to Medicare's actuaries, 3.7 million people paid an income-related Part B premium and 3.0 million paid an income-related Part D premium in 2018	

Additional Provisions

Beyond coverage-related provisions, the ACA made numerous other changes in federal law to safeguard individual civil rights, authorize new programs and agency activities, and finance new federal costs under the law. The Court ruling finding the ACA unconstitutional could also result in an end to these provisions. They include:

Nondiscrimination

The ACA prohibits discrimination against individuals on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, under Section 1557, which builds on long-standing and familiar Federal civil rights laws. In addition to enforcement (https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html) by the Office of Civil Rights at the US Department of HHS, individuals can file a civil lawsuit to challenge a nondiscrimination violation under Section 1557.

Regulations implementing Section 1557 issued by the Obama Administration further defined these protections to include gender identity and pregnancy status. One federal district court has vacated the gender identity and pregnancy protections in the regulations, while other courts have relied on Section 1557 itself

to grant relief to individuals alleging discrimination based on gender identity. In addition, the Trump Administration has proposed changes (https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/) to the regulations that would eliminate protections for gender identity; adopt blanket abortion and religious freedom exemptions for health care providers; and eliminate or substantially change provisions on health insurance benefit design; language access; notices, grievance procedures, and enforcement; and which entities are covered by Section 1557. The Administration also has proposed eliminating explicit nondiscrimination protections related to gender identity and sexual orientation in separate regulations governing Medicaid managed care entities, state Medicaid programs, PACE organizations, group and individual health insurance issuers, marketplaces, qualified health plan issuers, and agents and brokers that assist with marketplace applications and enrollment.

FDA Approval of Biosimilars

The ACA authorized the U.S. Food and Drug Administration (FDA) to approve generic version of biologics (biosimilars) and grant biologics manufacturers 12 years of exclusive use before generics can be developed. As of November 2019, the FDA has approved (https://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvala 25 biosimilar products used in the treatment of cancer, rheumatoid arthritis, and other health conditions.

Innovation Center

The law also established an Innovation Center within the Center for Medicare and Medicaid Services (CMS) to test, evaluate and expand different payment structures and methods to save costs while maintaining or improving quality of care. Payment and delivery system models (https://innovation.cms.gov/) supported by the Innovation Center focus on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), for example, include care delivery for children (https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/) and pregnant women (https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/) affected by the opioid crisis, and models to reduce prescription drug costs.

Prevention and Public Health Fund

The ACA established the Prevention and Public Health Fund with a permanent annual appropriation to support activities related to prevention, wellness and public health activities. The law appropriated $7 billion annually through 2015 and $2 billion for each fiscal year thereafter, although Congress has since voted several times to redirect (https://www.apha.org/-/media/files/pdf/factsheets/pphf_fact_sheet.ashx?

la=en&hash=8AD9EFD10E474FC3DDFD5C750BBEDC85A424F35F) a portion of funds from the Prevention and Public Health Fund for other purposes. Fund resources support (https://www.hhs.gov/open/prevention/index.html) federal, state, and local programs to fight obesity, curb tobacco use, prevent the onset of chronic conditions such as diabetes and heart disease, promote immunization, detect and respond to infectious diseases and other public health threats, and other initiatives.

Nonprofit Hospitals

The ACA set new requirements (https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r) for non-profit hospitals in order to retain their tax exempt status. These include a requirement to conduct a community needs assessment every 3 years and adopt a strategy to meet identified needs. Hospitals also must adopt and widely publicize financial assistance policies on the availability of free or discounted care and how to apply. In addition, hospitals must limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and must make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions.

Breastfeeding breaks & separate rooms

Employers with 50 or more employees must now provide adequate break time for breastfeeding women and a private space that is not a bathroom for nursing and pumping.

Menu labeling

Restaurants and retail food establishments with 20 or more locations and owners of 20 or more vending machines must include nutrition information, including calories, for their standard menu items.

Revenue Provisions

Many of the revenue provisions enacted under the ACA remain in effect but presumably would end if the law were found unconstitutional. For example, the ACA included a tax on pharmaceutical (https://www.irs.gov/affordable-care-act/annual-fee-on-branded-prescription-drug-manufacturers-and-importers) manufacturers and importers (generating annual fees of $2.8 billion in 2019 and thereafter) and a tax on health insurers (https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010) (generating annual fees of $14.3 billion in 2018, indexed annually by the rate of premium growth, but subject to a moratorium in 2019). The law also imposed a new medical device (https://www.irs.gov/newsroom/medical-device-excise-tax-frequently-asked-questions) excise tax of 2.3%, which Congress has voted several times to delay.

Financing provisions also included a 10% tax on indoor tanning services (https://www.irs.gov/businesses/small-businesses-self-employed/indoor-tanning-services-tax-center), and limits on the deductibility of compensation of insurance company executives (https://www.irs.gov/instructions/i1120) (limited to $500,000 per individual per year). Under the ACA, the Medicare payroll tax (https://www.irs.gov/affordable-care-act/affordable-care-act-tax-provisions) was increased for high income earners (over $200,000 by individuals, $250,000 for married couples filing jointly), and a new 3.8% tax on net investment income (https://www.irs.gov/individuals/net-investment-income-tax) applied for higher income taxpayers. Finally, the ACA imposed the so-called Cadillac tax (https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/congress-delays-cadillac-tax-until-2022.aspx) on high-value employer-sponsored health plans, which Congress has also voted to delay, most recently, until 2022.

Endnotes

1. A number of Democratic state AGs are defending the ACA as interveners in the case, arguing in part that Congress intended to keep the ACA in place when it set the individual mandate penalty to zero while leaving the rest of the law intact.

   ← Return to text (https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/#endnote_link_441254-3)

2. Some of the coverage gap provisions were subsequently modified by the Bipartisan Budget Act of 2018. The BBA closes the Part D coverage gap in 2019 instead of 2020 by accelerating a reduction in beneficiary coinsurance from 30 percent to 25 percent in 2019; also increases the discount provided by manufacturers of brand-name drugs in the coverage gap from 50 percent to 70 percent, beginning in 2019. In 2019 and later years, Part D plans will cover the remaining 5 percent of costs in the coverage gap, which is a reduction in their share of costs (down from 25 percent).

   ← Return to text (https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/#endnote_link_441254-1)

3. Some of the Medicare income-related premium provisions have been modified by subsequent laws. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made changes to Medicare's income-related premiums by requiring beneficiaries with incomes above $133,500 ($267,000 for married couples) to pay a larger share of Part B and Part D program costs than under the original MMA and ACA provisions. Under MACRA, beginning in 2018, beneficiaries with incomes above $133,500 and up to $160,000 ($267,000-$320,000 for married

couples) were required to pay 65 percent of Part B and Part D program costs, up from 50 percent prior to 2018, while beneficiaries with incomes above $160,000 and up to $214,000 ($320,000-$428,000 for married couples) were required to pay 80 percent of Part B and Part D program costs, up from 65 percent. The most recent change to Medicare's income-related premiums was incorporated in the Bipartisan Budget Act of 2018 (BBA). This change will affect beneficiaries with incomes above $500,000 ($750,000 for married couples) by requiring them to pay 85 percent of program costs beginning in 2019, up from 80 percent prior to 2019.

← Return to text (https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/#endnote_link_441254-2)

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By Anna L. Goldman and Benjamin D. Sommers

Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act

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ABSTRACT **Coverage disruptions and coverage loss occur frequently among Medicaid enrollees and are associated with delayed health care access and reduced medication adherence. Little is known about the effect on churning of the expansion of eligibility for Medicaid under the Affordable Care Act (ACA), which had the potential to reduce coverage disruptions as a result of increased outreach and more generous income eligibility criteria. We used a difference-in-differences framework to compare rates of coverage disruption in expansion versus nonexpansion states, and in subgroups of states that used alternative expansion strategies. We found that among low-income Medicaid beneficiaries ages 19–64, disruption in coverage decreased 4.3 percentage points in the post-ACA period in expansion states compared to nonexpansion states, and there was a similar decrease in the share of people who experienced a period without any insurance. Men, people of color, and those without chronic illnesses experienced the largest improvements in coverage continuity. Coverage disruptions declined in both traditional expansion states and those that used Section 1115 waivers for expansion. Our quasi-experimental study provides the first nationwide evidence that Medicaid expansion led to decreased rates of coverage disruption. We estimate that half a million fewer adults experienced an episode of churning annually.**

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Disruptions in coverage, often referred to as "churning," are a persistent problem in Medicaid.[1–3] People who experience coverage disruptions are more likely to delay care, receive less preventive care, refill prescriptions less often, and increase the number of emergency department visits.[4–6]

A common cause of coverage disruption is income fluctuation that leads to changes in Medicaid eligibility from month to month.[7] Low-income adults are more likely to have irregular sources of employment, which results in such fluctuation. Other sources of disruption include changes in eligibility that are not related to income (such as the end of a pregnancy), administrative difficulty with reenrolling, and switching to non-Medicaid coverage.[8] Disruptions often lead to periods of uninsurance, but even disruptions due to plan switching can result in impeded access to care because of differing provider networks and drug formularies in various plans.[1]

Several analyses before the implementation of the Affordable Care Act (ACA) projected that churning rates—particularly rates of switching between Medicaid and Marketplace coverage—would increase because of the ACA's use of income cutoffs as the defining feature of eligibility for both Medicaid and subsidized Marketplace coverage.[7,9,10] Projected estimates of churning between Medicaid and Marketplace coverage ranged from 31 percent to 50 percent.[9,10] Further-

more, churning within Medicaid was expected to be higher than that within Marketplace plans because Medicaid eligibility is generally measured monthly, whereas eligibility for Marketplace subsidies is based on a person's annual Modified Gross Adjusted Income.[7]

To counteract the potential increase in disrupted coverage, the ACA created a policy option known as the Basic Health Program. Beginning in 2015, this option allowed states to offer affordable, comprehensive insurance—comparable to Medicaid—to nonelderly adults with incomes of up to 200 percent of the federal poverty level and to institute twelve-month continuous eligibility.[11] One analysis estimated that the adoption of a Basic Health Program on a national level, rather than as a state option, would reduce the number of adults forced to transition between Medicaid and Marketplace coverage by 4 percent per year.[12]

Alternative state Medicaid expansion strategies through Section 1115 waivers also had the potential to affect churning. For example, the "private option" in Arkansas allowed the state to use Medicaid funds to purchase plans on the ACA's Marketplace for Medicaid-eligible adults. This approach was projected to decrease churning, as people could remain in the same plan even if their income fluctuated across the income ranges qualifying for Medicaid coverage or a Marketplace subsidy.[13]

Early evidence from a survey of three states (including Arkansas) suggested that churning did not increase after the ACA,[14] while another study indicated that the ACA may have shortened the length of uninsured spells.[15] However, to our knowledge, the nationwide effect that the Medicaid expansion and other relevant ACA policies such as the Basic Health Program had on Medicaid coverage continuity has not been studied. Therefore, the objective of this study was to evaluate the impact of the Medicaid expansion, including traditional and alternative approaches, on coverage disruptions and loss among Medicaid enrollees.

Study Data And Methods

STATE POLICIES The ACA allowed states to expand their Medicaid programs to cover adults with family incomes at or below 138 percent of poverty. By the end of our study period in 2016, thirty-one states and the District of Columbia had opted to expand Medicaid, while nineteen states had not. (See online appendix A for the classification of states by expansion status.)[16]

Five of those thirty-one states (Arkansas, Indiana, Iowa, Michigan, and New Hampshire) implemented expansions during our study period using Section 1115 waivers. These states differ in the specific details of their program designs, but certain aspects are common to several of them. For example, Arkansas, Indiana, Iowa, and Michigan all charged some Medicaid enrollees premiums.[17] Indiana and Iowa disenrolled people with incomes above poverty for nonpayment of premiums. Arkansas and New Hampshire used premium assistance programs, in which Medicaid dollars were used to purchase private insurance coverage for certain groups of people eligible for Medicaid, based on income.[18] (Iowa initially had a premium assistance program but ended it in 2015.)

Basic Health Programs create an option for states to offer comprehensive benefits—similar to Medicaid coverage and with minimal or no cost sharing or premiums—both to adults with incomes of up to 200 percent of poverty who are not eligible for Medicaid and to legal permanent residents who have not yet met the five-year waiting period for Medicaid.[11,19] Two states have implemented Basic Health Programs: Minnesota for coverage beginning January 1, 2015, and New York for coverage beginning January 1, 2016. Basic Health Program plans act as a bridge between Medicaid and Marketplace insurance because they allow enrollees to keep the same insurer. In Minnesota any insurance carriers that offer these plans must also offer Medicaid plans. In New York the majority of insurers (eleven out of thirteen) that offer these plans also offer both Medicaid and Marketplace plans, to allow for continuity of coverage despite changes in income-based eligibility.[11] Additionally, both states opted in to offering twelve-month continuous eligibility.[20]

DATA AND STUDY SAMPLE We analyzed data from the Medical Expenditure Panel Survey–Household Component (MEPS-HC), which captured monthly insurance status for the period 2011–16, three years before and three years after the ACA's Medicaid expansion went into effect in 2014. We obtained access to restricted data for MEPS, which allowed us to identify respondents according to state Medicaid expansion policy. In our primary analysis the study population consisted of 14,370 nonelderly adults (ages 19–64) who had family incomes under 138 percent of poverty and reported having had Medicaid for at least one month during the survey year.

Our intervention group included adults who resided in states that had expanded Medicaid before December 31, 2015. Our control states consisted of adults who resided in states that had not expanded Medicaid before that date. We excluded Louisiana and Montana, which expanded Medicaid during 2016.

Our analysis of the effect of Basic Health Pro-

Our results suggest that Medicaid expansion helped healthier people retain more stable coverage.

grams on enrollment in any type of public insurance in Minnesota and New York included adults ages 19–64 who had incomes at or below 200 percent of poverty and at least one month of public insurance—Medicaid, Medicare, or any other government-sponsored hospital or physician insurance programs except TRICARE (military coverage).[21]

OUTCOMES Our two primary outcomes were the annual rate of disruption in Medicaid coverage and the loss of that coverage. The *rate of disruption in coverage* was defined as the proportion of Medicaid enrollees who moved from Medicaid coverage to no coverage or non-Medicaid coverage at any point during the calendar year. *Loss of coverage* was defined as transitioning from Medicaid coverage to uninsurance at any point in the year.

To explore the potential impact of churning on access to care, we analyzed three secondary outcomes using MEPS variables: inability to get necessary care, delays in receiving care, and delays in obtaining prescription medication.

STATISTICAL ANALYSIS We used linear regression to examine changes in our outcomes among Medicaid enrollees in expansion versus nonexpansion states, before and after the ACA's insurance expansions were implemented in January 2014. Our use of linear regression to estimate our binary outcomes allowed for more straightforward interpretation of difference-in-differences results.[22] Our adjusted models included terms for deidentified state of residence, year, age group, sex, race/ethnicity, marital status, family size, pregnancy, presence of dependents in the household, diagnosis with a chronic condition, foreign birthplace, employment, and receipt of Supplemental Security Income (SSI). (See the appendix for additional details on our modeling.)[16]

We performed two sensitivity analyses. In one, we excluded pregnant women. In the other, we excluded disabled adults, defined as people who received SSI payments or had at least one month of Medicare coverage (that is, they were dually eligible for Medicaid and Medicare). All regressions were performed with SAS, version 9.4, using survey-based procedures that accounted for the complex sample design and weights in MEPS.

To elucidate the effects of Medicaid expansion type, we then separately examined states that implemented a traditional expansion through the ACA and states that used a waiver for expansion, comparing both groups to nonexpansion states. We also compared rates of disruption in or loss of any public insurance coverage in the two states with a Basic Health Program—New York and Minnesota—to rates in nonexpansion states, using the population that had incomes at or below 200 percent of poverty and at least one month of public insurance.

To understand whether certain demographic groups experienced disproportionate changes in coverage disruption or loss after the Medicaid expansion, we analyzed our primary outcomes in selected subgroups—men versus women, whites versus nonwhites, and people with versus without a chronic condition—as these factors may affect both the likelihood of coverage changes and their potential implications for health. People with chronic conditions were those who had ever been diagnosed with cancer (excluding nonmelanoma skin cancer), asthma, emphysema, diabetes, hypertension, arthritis, stroke, and heart disease.

Like all difference-in-differences analyses, our study design assumed that the trends in the intervention and control groups were similar before the intervention—in our case, the Medicaid expansion. To test for differential pre-intervention trends, we performed two sets of "placebo" tests that used only pre-ACA data, and we repeated our main difference-in-differences analyses as if the ACA's Medicaid expansion had occurred in January 2012 (for the first set of tests) or January 2013 (for the second set).[23]

LIMITATIONS Our study was limited in several respects. First, because we restricted our study population to people enrolled in Medicaid, the post-ACA intervention group included many people who had higher incomes than, and differed in other demographic characteristics from, the post-ACA control group and the pre-ACA groups. However, the addition of this demographically distinct group probably led us to underestimate the postexpansion decrease in churning, because adults who acquired insurance because of the Medicaid expansion are likely at higher risk of churning. Prior research has shown that receipt of public assistance (such as Temporary Assistance for Needy Families), which many of the adults eligible for Medicaid before the ACA's Medicaid expansion would have

qualified for, greatly lowers the chance of losing Medicaid.[2] Additionally, higher-income adults who acquired coverage because of the Medicaid expansion experience frequent income fluctuations: Among low-income people in the national longitudinal MEPS sample during our study period, adults who had incomes of 100–138 percent of poverty in the first year of of the two-year longitudinal sample were nearly twice as likely as those who had incomes below 50 percent of poverty to have an income above 138 percent of poverty in the following year. This was a consistent pattern both before and after the Medicaid expansion (appendix I).[16]

Second, the monthly insurance variables that we used to define disruption and coverage loss were self-reported and therefore subject to error. However, the MEPS data on insurance status are verified whenever possible by survey administrators[24,25] and have been used previously for pre-ACA assessments of churning.[2]

Third, for confidentiality reasons, the Agency for Healthcare Research and Quality does not allow researchers working with restricted data to identify certain states. Instead, it provided us with several aggregate groupings necessary for our analysis (expansion states versus nonexpansion, waiver, and Basic Health Program states). Therefore, we were not able to distinguish between states that expanded Medicaid in 2014 versus 2015, so we grouped together all states that done so before the end of 2015. Similarly, we were able to analyze the five waiver states only in the aggregate, even though the specifics of their programs differed. We felt that this approach was reasonable because several of their programs had common themes such as premium assistance programs or premium requirement for enrollees, as described above.

Fourth, we included five states in our expansion group (Alaska, Indiana, Michigan, New Hampshire, and Pennsylvania) that expanded Medicaid after January 2014. As a result, our analysis may have underestimated the impact of the expansion on coverage continuity. However, we could not identify individual states for confidentiality reasons (as explained above), and we therefore classified these states in the expansion group.

Finally, income as measured in MEPS might not map directly to state eligibility requirements for Medicaid. Accordingly, we tested a model in which our sample used a slightly relaxed income threshold of 150 percent of poverty. The results were quite similar to those of our main analysis.

EXHIBIT 1

Characteristics of the study cohort before the implementation of the Affordable Care Act's Medicaid expansion, by state expansion of eligibility for Medicaid

Characteristic	Nonexpansion states	Expansion states
Sample size		
Weighted	12,221,206	28,315,803****
Unweighted	2,026	4,762****
Female	67.2%	64.8%
Older than age 40	42.9	43.9
Race/ethnicity[a]		
Hispanic	16.2	26.3**
Black	31.5	24.5**
Asian	1.6	5.2***
White	47.5	41.5
Other	3.1	4.4
Married	24.1	26.2
Born in the US	72.3	63.5****
Employed	25.1	30.0**
Receives Supplemental Security Income	21.4	19.9
Has dependents in household	25.4	24.2
Pregnant	15.2	10.8****
Has chronic disease diagnosis	61.2	58.4

SOURCE Authors' analysis of data for 2011–13 from the Medical Expenditure Panel Survey–Household Component. **NOTES** Nonexpansion states were the nineteen states that had not expanded eligibility for Medicaid by 2016, listed in appendix A (see note 16 in text). Expansion states were the twenty-nine states and the District of Columbia that had expanded Medicaid programs before December 31, 2015. Two states (Louisiana and Montana) that expanded Medicaid in 2016 were excluded. [a]Groups other than Hispanic are non-Hispanic. **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

Study Results

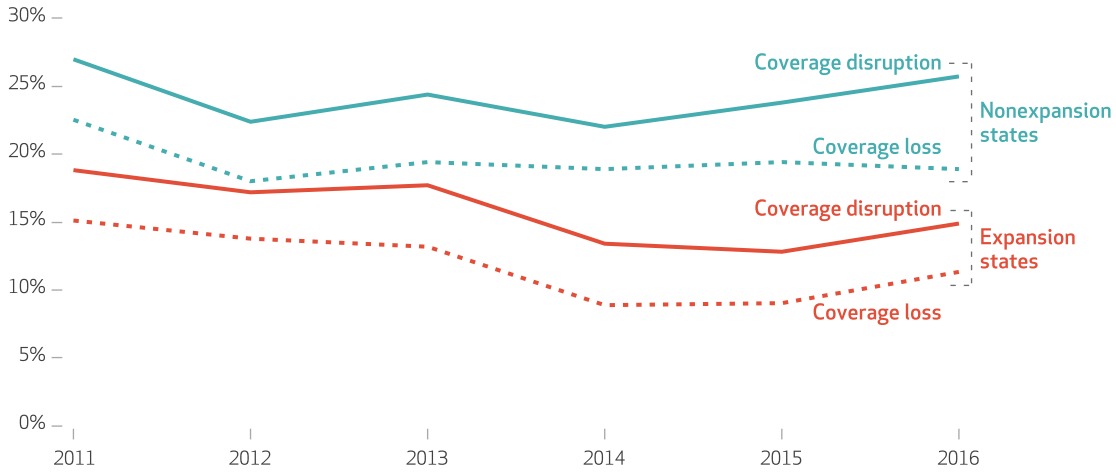
SUMMARY STATISTICS Our study population included 3,986 adults who resided in states that had not expanded Medicaid and 10,384 adults in states that had done so. In the pre-ACA cohort, those living in expansion states ($n = 4,762$) were more likely to be nonwhite, born outside of the US, and employed and less likely to be pregnant compared to adults in nonexpansion states ($n = 2,026$) (exhibit 1).

DISRUPTIONS AND LOSS OF COVERAGE Annual rates of disruption in coverage were lower in expansion states compared to nonexpansion states before 2014 but followed a similar trend in that period (exhibit 2), which was confirmed by our placebo testing (appendixes E–G).[16] Annual rates of coverage loss also show a similar trend in both study groups in the same period. In both groups the majority of people who experienced a coverage disruption also experienced coverage loss: 81.0 percent in nonexpansion states and 78.4 percent in expansion states before 2014 and 80.6 percent in nonexpansion states and 74.7 percent in expansion states after 2014 (data not shown).

In our primary adjusted analysis, the annual rate of coverage disruption among Medicaid enrollees in all expansion states was 17.9 percent in the pre-ACA period, and it declined by 4.3 percentage points in the post-ACA period compared

EXHIBIT 2

Annual rates of Medicaid coverage disruption and loss among nonelderly adult enrollees, by state expansion of eligibility for Medicaid, 2011–16



SOURCE Authors' analysis of data for 2011–16 from the Medical Expenditure Panel Survey–Household Component. **NOTES** Coverage disruption occurs when a person moves from Medicaid coverage in one month to another type of coverage or no coverage in the next consecutive month. Coverage loss occurs when a person moves from Medicaid coverage in one month to no coverage in the next consecutive month.

to nonexpansion states (exhibit 3). Loss of coverage was experienced by 14.0 percent of Medicaid enrollees in all expansion states in the pre period, and this rate also decreased by 4.3 percentage points in the post period. Analyses that excluded people with disability or pregnant women produced similar results (appendix C).[16]

STATE SUBGROUPS: MEDICAID EXPANSION TYPE

Within the subgroup of states that implemented traditional Medicaid expansions, the annual rate of coverage disruption was 17.2 percent before the ACA and decreased by 4.3 percentage points, compared to nonexpansion states (exhibit 3). The rate of coverage loss was initially 13.5 percent and declined by 4.4 percentage points. In the subgroup of states that expanded Medicaid using Section 1115 waivers, the rate of disruption was 22.5 percent in the pre-ACA period and decreased by 4.6 percentage points, compared to nonexpansion states. The rate of coverage loss

EXHIBIT 3

Changes in rates of Medicaid coverage disruption and loss among nonelderly adult Medicaid enrollees after implementation of the Affordable Care Act's Medicaid expansion, by state expansion of eligibility for Medicaid

	Pre-ACA	Post-ACA	Within-group difference[a]	Pre-ACA	Post-ACA	Within-group difference[a]	Difference in differences (percentage-point change)	
Had any:	**Nonexpansion states**			**All expansion states**			**Unadjusted**	**Adjusted**
Disruption in coverage	24.5%	23.8%	−0.7	17.9%	13.7%	−4.2	−3.4*	−4.3**
Coverage loss	19.9	19.1	−0.8	14.0	9.7	−4.3	−3.5*	−4.3**
	Nonexpansion states			**Traditional expansion states**			**Unadjusted**	**Adjusted**
Disruption in coverage	24.5%	23.8%	−0.7	17.2%	13.1%	−4.1	−3.4*	−4.3**
Coverage loss	19.9	19.1	−0.8	13.5	9.2	−4.3	−3.5*	−4.4**
	Nonexpansion states			**Waiver expansion states**			**Unadjusted**	**Adjusted**
Disruption in coverage	24.5%	23.8%	−0.7	22.5%	18.8%	−3.7	−3.0****	−4.6****
Coverage loss	19.9	19.1	−0.8	17.3	14.1	−3.2	−2.4****	−3.7****

SOURCE Authors' analysis of data for 2011–16 from the Medical Expenditure Panel Survey (MEPS)–Household Component. **NOTES** This analysis includes adults ages 19–64 with family incomes below 138 percent of the federal poverty level who had Medicaid for at least one month during the calendar year. The years 2011–13 constitute the period before implementation of the Affordable Care Act (pre-ACA), while the years 2014–16 constitute the post-ACA period. Expansion, nonexpansion, traditional expansion, and waiver expansion states are defined in the text and described in greater detail in appendix A (see note 16 in text). Adjusted analyses controlled for state of residence, year, age, sex, race/ethnicity, marital status, family size, pregnancy, presence of dependents in household, diagnosis with a chronic condition, foreign birthplace, employment, and receipt of Supplemental Security Income. All models used survey weighting and accounted for the complex survey design of MEPS. [a]Percentage points. *$p < 0.10$ **$p < 0.05$ ****$p < 0.001$

was 17.3 percent and decreased by 3.7 percentage points.

In our analysis of states with a Basic Health Program (Minnesota and New York), disruptions in coverage occurred in 13.6 percent of adults per year before the ACA and declined by 1.7 percentage points after the ACA, compared to nonexpansion states (appendix B).[16] The rate of coverage loss did not change.

DEMOGRAPHIC SUBGROUPS In our subgroup analysis stratified by sex, men experienced an 8.2-percentage-point decrease in the rate of disruption in coverage and a 7.2-percentage-point decline in the rate of coverage loss, while women experienced no significant change in coverage disruptions or loss (exhibit 4). Nonwhites also experienced substantial declines in disruptions (−5.9 percentage points) and coverage loss (−4.7 percentage points), whereas whites experienced no significant change in either measure. Lastly, adults without chronic conditions had large reductions in both disruptions (−9.9 percentage points) and coverage loss (−10.4 percentage points), while adults with chronic conditions did not experience significant changes in these outcomes.

ACCESS OUTCOMES Access-to-care outcomes did not improve significantly in expansion states in comparison to nonexpansion states (appendix D).[16] One measure, "unable to get necessary care," decreased significantly in nonexpansion states but was unchanged in expansion states, which led to a significant increase in the difference-in-differences estimate. The other two access measures showed no change.

PLACEBO ANALYSIS Our placebo tests showed no significant differential changes in disruptions or coverage loss in the pre-ACA period for expansion versus nonexpansion states overall (appendixes E–G).[16] with small point estimates close to zero. Placebo tests comparing the group of traditional expansion states to the group of nonexpansion states also showed no change in either outcome. However, among the Section 1115 waiver expansion states, tests that used a 2012 start date for the placebo expansion showed a small decrease (1.5 percentage points) in churning, while tests that used a 2013 start data showed a significant increase. This pattern of a decrease followed by an increase in churning provides no evidence of a consistent trend in the pre-ACA period. Furthermore, the

EXHIBIT 4

Rates of Medicaid coverage disruption and loss among nonelderly adult enrollees after implementation of the Affordable Care Act's Medicaid expansion, by subgroup and state expansion of eligibility for Medicaid

	Nonexpansion states			Expansion states			Difference-in-differences (percentage-point change)	
Subgroup	Pre-ACA	Post-ACA	Within-group difference[a]	Pre-ACA	Post-ACA	Within-group difference[a]	Unadjusted	Adjusted
SEX								
Had any disruption in coverage								
Male	21.1%	23.0%	1.9	20.3%	14.9%	−5.4	−7.4**	−8.2**
Female	26.2	24.1	−2.1	16.6	13.0	−3.6	−1.5	−2.2
Had any coverage loss								
Male	16.8	18.1	1.3	16.0	10.2	−5.8	−7.1**	−7.2**
Female	21.4	19.5	−1.9	12.9	9.4	−3.5	−1.6	−2.3
RACE/ETHNICITY								
Had any disruption in coverage								
Nonwhite	25.9%	26.5%	0.6	17.9%	13.4%	−4.5	−5.1**	−5.9**
White	23.1	20.6	−2.5	17.9	14.0	−3.9	−1.5	−2.5
Had any coverage loss								
Nonwhite	21.9	21.7	−0.2	14.8	10.7	−4.1	−3.9*	−4.7**
White	17.6	16.0	−1.6	12.9	8.6	−4.3	−2.7	−3.8
CHRONIC CONDITIONS								
Had any disruption in coverage								
No chronic condition	31.7%	34.9%	3.2	20.7%	15.4%	−5.3	−8.4**	−9.9**
Chronic condition	19.7	16.7	−3.0	15.8	12.4	−3.4	−0.4	−1.6
Had any coverage loss								
No chronic condition	28.5	30.8	2.3	17.9	11.7	−6.2	8.6**	−10.4***
Chronic condition	14.1	11.6	−2.5	11.1	8.3	−2.8	0.3	−1.1

SOURCE Authors' analysis of data for 2011–16 from the Medical Expenditure Panel Survey–Household Component. **NOTES** The pre– and post–Affordable Care Act (ACA) periods are explained in the notes to exhibit 3. Adjusted analyses controlled for the variables listed in the notes to exhibit 3. The subgroup with chronic conditions included people who reported a diagnosis of cancer (all types except nonmelanoma skin cancer), asthma, emphysema, diabetes, hypertension, arthritis, stroke, and heart disease. [a]Percentage points. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

Waiver features approved in recent years may partially erode some of the improvements in continuity of coverage.

small point estimates of the decrease in churning in the 2012 placebo tests were all less than half the magnitude of the estimates in our main analysis in the postexpansion period. Overall, the placebo tests did not suggest the presence of an unrelated, pre-ACA factor driving the sizable effect that we identified with our main analysis in the postexpansion period.

Discussion

Using a quasi-experimental approach and nationally representative survey data, we found that the share of low-income adults who experienced disruptions in and loss of Medicaid coverage decreased significantly in states that expanded Medicaid under the ACA, compared to those that did not. These results indicate that part of the ACA's reduction in the US uninsured population by nearly twenty million in 2016, the last year of our study period, can be attributed not just to new enrollment of uninsured people but also to increased retention of Medicaid enrollees. Our point estimate of a 4.3-percentage-point decrease in coverage loss, applied to the population of twelve million nonelderly adult Medicaid beneficiaries in expansion states in 2016, indicates that the ACA expansion has prevented the loss of coverage for half a million adults annually.

There are likely three mechanisms by which the Medicaid expansion decreased churning: The increased income cutoff allowed for greater fluctuations in income without resulting in loss of eligibility; a standardized income cutoff simplified requirements across all states that chose to expand Medicaid; and greater outreach efforts and enrollment assistance generally occurred in expansion versus nonexpansion states.[26] The individual mandate imposed by the ACA, which carried a financial penalty through 2018, may also have motivated some people to maintain enrollment. Our unadjusted models produced smaller estimates than our adjusted models did, which suggests that demographic changes in the population eligible for Medicaid in the post-ACA period did not drive the decrease in churning that we identified.

Our results are consistent with those of a study that found that uninsured periods decreased overall after the ACA,[15] as well as with those of a recent two-state study of Medicaid.[27] Rates of churning in our study population during the pre-ACA period are also consistent with those in prior literature.[2,3]

The overall reduction in churning rates identified by our study was driven by larger decreases in churning among men, people of color, and those with no chronic condition. The larger changes among nonwhite enrollees could be related to previous evidence that people of color experience greater income volatility[28] as well as to evidence that the ACA expansion disproportionately increased coverage rates among nonwhites.[29] The Medicaid expansion is known to have disproportionately increased coverage for low-income men compared to women,[30] because men without dependents generally had very little access to Medicaid before the ACA. Our study provides new evidence that the Medicaid expansion also led to significant improvement in coverage continuity for men. The results of our subgroup analysis of people with and without chronic conditions are consistent with the results of previous analyses that show lower baseline rates of churning among sicker people.[2] Our results suggest that Medicaid expansion helped healthier people—who tend to have less regular contact with the health care system—retain more stable coverage.

States that expanded Medicaid through Section 1115 waivers had higher baseline rates of both disruption and loss of coverage relative to traditional expansion states, and both groups of states experienced decreases in churning of a similar magnitude after the ACA. The improvement seen in the waiver expansion group is especially noteworthy because the premiums required for Medicaid enrollees in four of these five states could have led to increased churning—which would have been consistent with some qualitative or in-depth survey studies in these states.[31,32] However, we found no evidence of this in national data. It is possible that improvements in churning between Marketplace and Medicaid coverage attributable premium assistance programs in two of the waiver states, Arkansas and New Hampshire, are driving some of the decrease. However, given the small size of both states' populations, the two premium assistance programs cannot entirely explain our findings,

and at least one prior study of premium assistance did not find that it reduced churning rates.[14] Features of the Medicaid expansion waiver states that are common to all expansion states, such as the simplified and more generous eligibility criteria, are likely the major drivers of the improvements we identified.

The study states that implemented Basic Health Programs with twelve-month continuous enrollment—Minnesota and New York—experienced a modest decline in enrollment disruptions but not in coverage loss, most likely because both of them already had state health programs very much like the Basic Health Program.[11] In addition, both states had lower rates of coverage disruption and loss compared to other expansion states before the ACA. It is also important to note that the income range for the two states with Basic Health Programs was not the same as that for the rest of our analyses, which precluded direct comparison of the estimates for those groups of states.

While previous studies have found notable improvements in access to care after the Medicaid expansion among low-income adults,[33,34] we did not identify any improvement in access in our population that included only those who had had at least one month of Medicaid coverage. (The previous studies have generally included many low-income adults who were initially uninsured because they were not eligible before the expansion.) One measure, "unable to get necessary care," improved only in nonexpansion states, possibly because of ACA-related factors that were separate from Medicaid—such as increased funding for community health centers.[35] In addition to the fact that our sample excluded many people in the pre-ACA period who became eligible for Medicaid after the expansion, another potential explanation for the lack of positive effects on access is that our outcomes were based on MEPS questions that assessed self-reported access for the entire twelve months preceding the MEPS interview date—and thus may have failed to capture the effects of a few months without insurance, perhaps because of recall bias.[36] Previous literature has shown that access outcomes in the Medicaid population are less responsive than patterns of utilization are to short-term changes in insurance status.[37] Longer-term follow-up of churning may find different results. Additionally, constraints on provider supply may have prevented greater gains in expansion states.[38]

Conclusion

Our study provides new evidence on the effects of the Medicaid expansion and alternative expansion types on coverage continuity. Both disruptions in Medicaid coverage and coverage loss decreased by 4.3 percentage points among low-income adult Medicaid enrollees living in states that expanded Medicaid under the ACA. This effect was driven by improved coverage continuity among nonwhites, men, and people without chronic conditions. Waiver features approved in recent years by the Centers for Medicare and Medicaid Services, including work requirements and premiums in Medicaid, may partially erode some of the improvements in continuity of coverage that we identified here. Our findings make a novel contribution by showing that part of the ACA's overall coverage effect was due not just to new enrollment in Medicaid but also to reduced churning after enrollment. ■

The authors thank Ray Kuntz at the Agency for Healthcare Research and Quality.

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MILLIMAN REPORT

How to equalise risk in healthcare systems

2019 International Health Research papers

January 2020

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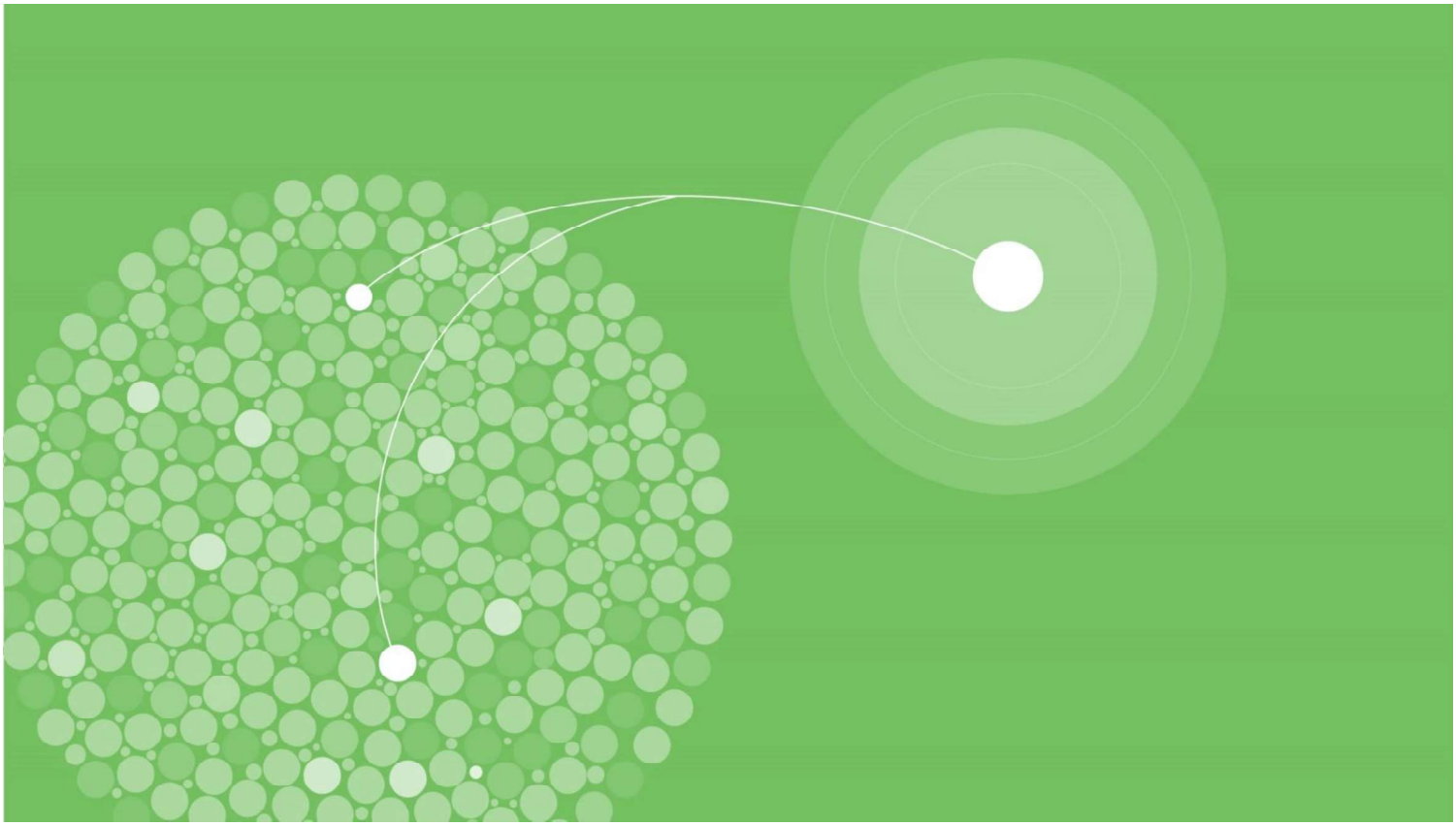

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Table of Contents

1. Introduction

Health insurance, like most insurance, can be priced using risk ratings, where premiums are set based on the relative risk of insured lives and the propensity to claim. However this may result in health insurance being unaffordable for the most high-risk members of society. As a result, many governments restrict the use of risk rating in health insurance markets in favour of 'community rating'—where insured lives pay the same premium regardless of risk.

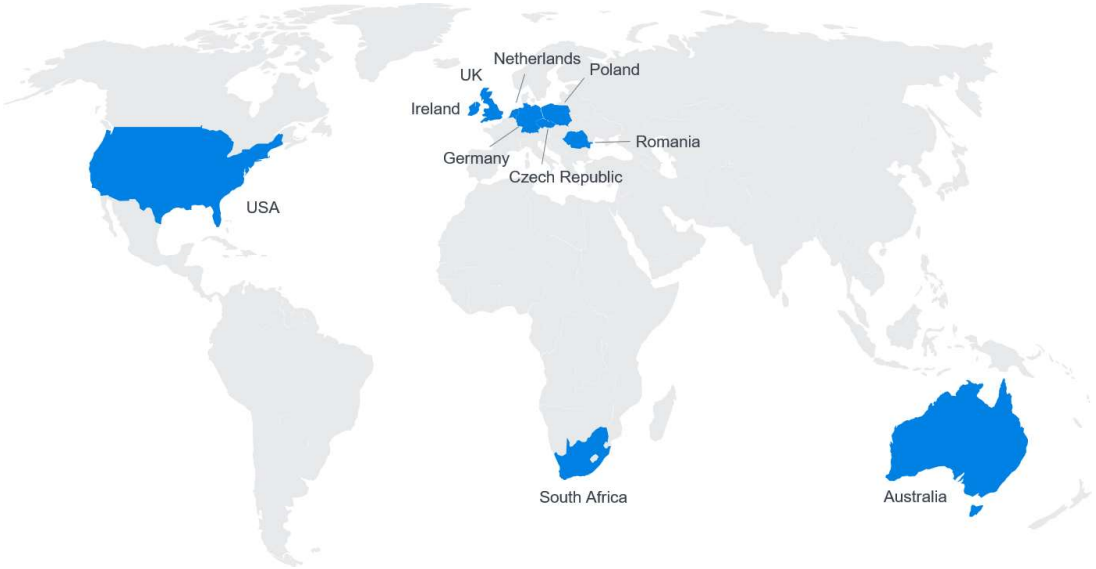
In a community-rated system where all consumers are charged the same premium, many high risk consumers are protected from paying unaffordable premiums. Others consumers, such as healthier or younger individuals, will generally pay a higher premium to subsidise sicker and often older individuals. Consequently, premium revenue collected by insurers or other risk-bearing entities may no longer truly reflect the underlying risk associated with their insured populations. Insurers and risk-bearing entities differ by geographic location, product design, provider networks, reputation, and management efficiency, amongst other things. Community rating removes much of the relationship between premiums and expected claims costs at the individual level, which is where most purchasing decisions are made, and this can lead to an uneven distribution of risk among insured populations. In the absence of a secondary "smoothing" mechanism, those that attract a healthier-than-average population may generate high underwriting surplus, and those that attract a sicker-than-average population may generate financial losses.

In many healthcare systems and health insurance markets around the world where risk rating is not allowed, risk equalisation is used to enhance consumer protection and market stability. Its aim is to compensate for the risk profiles of different groups of the population such that the additional medical expenses assocated with high-risk members are shared amongst healthcare providers or insurance companies. This is generally achieved by the transfer of payments through a risk equalisation pool, or similar mechanism. The exact form of risk equalisation varies from country to country depending on the specific nature of each one's healthcare system and interaction with the private health insurance market.

In this paper we have set out a 'how-to' guide to risk equalisation, or risk adjustment. We have referenced illustrative examples from around the world to explain the challenges and practicalities that should be considered in the design and management of a risk equalisation system.

The countries considered in the illustrative examples outlined in this paper are highlighted in Figure 1. This includes a mix of countries that currently have functioning risk equalisation schemes as part of their healthcare systems as well as countries where healthcare reform or the implementation of risk equalisation was not successful. It is important to consider both successes and failures in understanding the challenges faced in implementing and managing a risk equalisation system.

FIGURE 1: COUNTRIES CONSIDERED IN THIS PAPER



This paper outlines how to implement a risk equalisation system and is structured as follows:

- **Section 2** sets out the rationale for developing a risk equalisation system
- **Section 3** describes the considerations for designing the system, including the following:
  - Choice of algorithm and parameters
  - Calculation approach—prospective or retrospective
  - Solutions for handling exceptionally high claims
  - Competition and efficiency
  - Ongoing management
- **Section 4** sets out some examples of external challenges, including legal, political and general external challenges.
- **Section 5** contains the author' concluding comments

2. Why develop a risk equalisation system?

Before discussing the key considerations for developing a risk equalisation system, we first address the purpose of risk equalisation, why this mechanism exists in various healthcare systems around the world and how it works.

Risk equalisation can exist in various forms and the way in which different healthcare funders share risk varies accor ing to each system's structure, poli ies and o ive . le in some healthcare systems, isk equalisation involves redistributing funds among insurers, e.g., Ireland and the Netherlands, while in other healthcare systems it involves allocating total resources among funders in an equitable way, e.g., the National Health Service (NHS) in the United Kingdom.

Many health insurance markets have restrictions on the ability of insurers to charge premiums that reflect the true underlying risk of each insured life. In these markets, insurers charge a community-rated premium reflecting one or more broad risk characteristics in the market, rather than a risk-rated premium that reflects the risk profile of the individual taking out the policy. This is generally a policy decision aimed at promoting solidarity in the market and ensuring that higher-risk individuals have access to health insurance products.

One challenge that can arise in such a market is the incentive for insurers to target low-risk lives and avoid those who are more likely to make large health insurance claims. This can result in product design, pricing and marketing strategies that serve the needs of the healthy at the expense of those in poor health. These problems can be compounded where there are differences in the risk profiles of the insured population of different insurers. Where an insurer has a higher proportion of unhealthy customers, it would need to charge higher premiums on average to reflect this position. By contrast, an insurer with lower-risk customers can charge lower premiums. This results in the less healthy customers paying higher premiums on average, which is contrary to the one of the key aims of community rating.

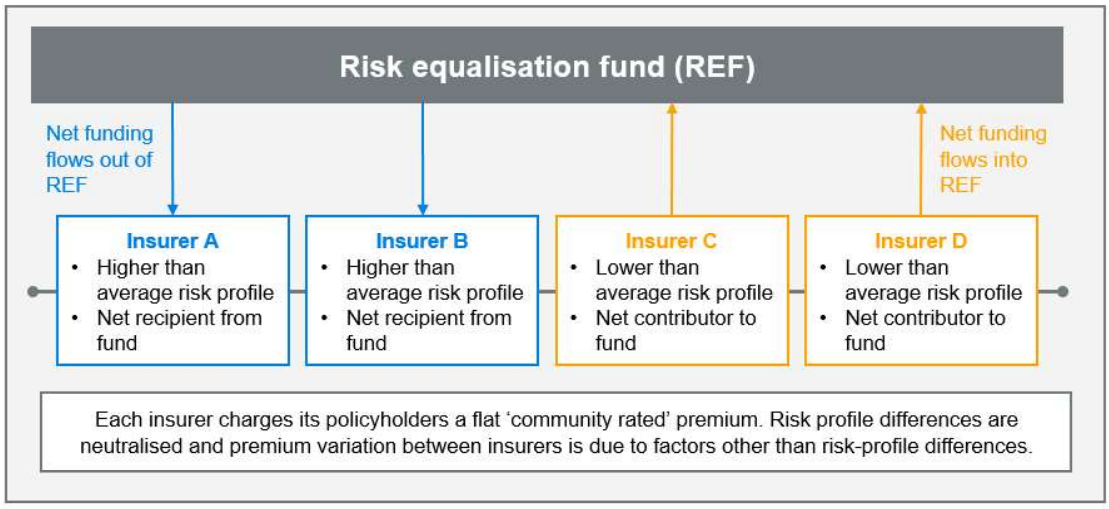
In addition, in a community-rated market, the insurer with low-risk customers can gain a competitive advantage on the other insurers by charging premiums that are marginally lower, but perhaps not as low as the premiums that could be justified based on the risk profile. This could allow an insurer with a low risk membership to generate higher than average underwriting surplus, offer richer benefits to customers, or pay healthcare providers more, while an insurer with a high risk membership could struggle to maintain profit levels, offer robust benefits to customers, or fairly compensate healthcare providers. Without some mechanism to equalise the risk profiles of the two insurers, this approach leads to significant challenges, not just for the high risk insurer, but also for the stability of the market as a whole.

Similarly, hospitals and other healthcare providers may be paid based on the activities they carry out or based on the number of patients treated. If one hospital tends to treat higher-risk patients or those more likely to experience complications, relative to another hospital, then the remuneration received may not adequately reflect the complexity of the activity carried out. A risk equalisation system can help ensure the allocation of resources among healthcare providers more fairly reflects the complexity of the populations covered.

Risk equalisation can also incentivise efficiency. As insurers are less likely to compete on risk selection, they should be encouraged to ensure that delivery of healthcare occurs as efficiently as possible. This could result in lower care costs and lower premiums or better patient outcomes. If the risk equalisation system is effective, and insurers are competing on efficiency rather than risk selection, lives with higher than average healthcare costs should in theory be more appealing to insurers, as there is greater capacity to improve efficiency for lives with higher claims than lives with little or no claims. Moreover, insurers or healthcare providers with an aptitude for serving specific populations or medical needs can focus on what they are good at even if their target population is higher risk. In this type of environment, efficient health insurers or healthcare providers are more likely to hold a better market position than their inefficient counterparts, irrespective of the make-up of their insured population.

Figure 2 illustrates how a risk equalisation system for a health insurance market could work in practice where insurers with higher than average risk profiles are compensated through net transfers from insurers with lower than average risk profiles. Ultimately, risk profile differences among insurers should be neutralised and premium variation among insurers should arise from factors other than differences in risk profile. In practice, it may not be possible to neutralise all risk-profile differences and there will be many practical and political challenges to overcome. These challenges and considerations are discussed in the sections that follow.

FIGURE 2: RISK EQUALISATION FUND TRANSFERS FOR PRIVATE HEALTH INSURERS



In Figure 3, we introduce the risk equalisation systems that will be discussed in this paper and provide some context around why risk equalisation exists in these markets and how it operates.

FIGURE 3: RISK EQUALISATION AROUND THE GLOBE

Irish private health insurance market	In Ireland risk equalisation is used to support a community-rated, voluntary private health insurance market. Each insurer is charged a stamp duty in respect of each insured life. The stamp duties are paid into a central fund. Risk equalisation transfers are made from the fund, via the tax system, in respect of insured lives based on age, gender, product type and utilisation of some healthcare services.
The Netherlands	In the Netherlands, citizens are obliged to purchase basic health insurance. Insurers are not allowed to risk rate premiums and there is an obligation to accept everyone. Prospective morbidity-based risk equalisation is used to support this community-rated, compulsory health insurance market for basic healthcare. Health insurers are compensated based on age, gender and the prevalence of chronic diseases, based on a broad set of morbidity criteria ranging from diagnosis and pharmaceutical claims up to physiotherapy and usage of medical diagnostic devices. The system also allows for other characteristics that have a correlation with health, such as socioeconomic status and source of income.
English NHS	In the English NHS, risk equalisation is used to share out the total available funding between local purchasing bodies—Clinical Commissioning Groups (CCGs)—rather than having a transfer of funds between CCGs. Resources are allocated according to a funding allocation formula that accounts for expected differences in healthcare resource utilisation among CCGs, based on parameters such as population size, age/sex mix, supply-side variables, unmet need/health inequalities and market forces (adjustments for how the cost of providing services differs by area, e.g., land and staff costs).

The United States of America	In the US, risk equalisation is more commonly referred to as risk adjustment and is used in the commercial individual and small employer group markets to transfer funds between insurers based on the riskiness of their members. The transfer formula accounts for health status risk (as measured by pharmacy and diagnosis-based risk scores), geographic variations in cost, and cost and utilisation variations associated with different benefit designs. Risk equalisation between healthcare providers is used in direct government payments under Medicare and Veterans Healthcare Administration. Risk equalisation is also used in government-funded programs with insurance company intermediaries like Medicare Advantage and Medicaid managed care to pay private insurers on a risk-adjusted basis.
Australia	The Australian risk equalisation scheme was introduced in 2007 and has been administered by the Australian Prudential Regulation Authority since 2015. It includes an Age-Based Pool that shares higher than average claims costs of older individuals and a High Cost Claimants Pool (HCCP) for the most expensive claimants. The Age Based Pool is the main component of the risk equalisation scheme while the HCCP is a secondary component, accounting for a much lower percentage of claims.
Czech Republic	In the Czech Republic, the risk equalisation scheme redistributes premiums between sickness funds based on age, gender and pharmaceutical groupings (PCG). In addition, ex post partial compensation is allowed for the most expensive lives. The redistribution is centralised by the General Health Insurance Fund—*Všeobecná Zdravotní Pojišťovna* (VZP)—through a special account.
Germany	The German health insurance system includes both statutory health insurance and private health insurance. In January 2009, a prospective morbidity-based risk equalisation system was implemented for budget allocation across all statutory sickness funds. The model is regression-based, and uses age, gender and 106 hierarchical morbidity conditions (called ‘ ierarc ical con i ion catego ies,’ or HCCs) de ived from all ites of healthcare service. Pharmacy claims are used to validate certain medical diagnoses. In many aspects, the model is similar to what is being used in the US in commercial markets (such as the Department of Health and Human Services Hierarchical Condition Categories, or HHS-HCC) and in Medicare.

3. Designing the system

A key aim of risk equalisation is to spread risk across all insurers or healthcare providers, such that higher-risk customers continue to have access to affordable healthcare. However, it may not be possible or straightforward to define or put a value on 'risk.' Therefore different healthcare systems use different proxies or parameters to estimate the 'riskiness' of insured lives. Riskiness depends on the health status of the insured lives, with healthy individuals being classified as low-risk and individuals in poor health being classified as high-risk, but again this is not something that is necessarily easy to quantify or predict. In reality risk level is not a binary choice between low and ig isk level generally relates to factors that affect the likelihood of future cl ims or healthcare resource use. Risk equalisation systems can try to quantify this by using past medical history including diagnostic reports, hospital utilisation or pharmaceutical records, but this information may not be freely available or recorded in a consistent manner, and may not be fully predictive of future risk.

In designing a risk equalisation system, there are a number of considerations, including:

- The choice of algorithm or model
- The choice of parameters
- The calculation approach—prospective or retrospective
- The impact on market competition, stability and efficiency
- Special considerations for exceptionally high claims
- The impact on competition and efficiency

Many of the considerations above will be influenced by the availability of accurate and relevant data. In this section of the report we look at each of these considerations in more detail.

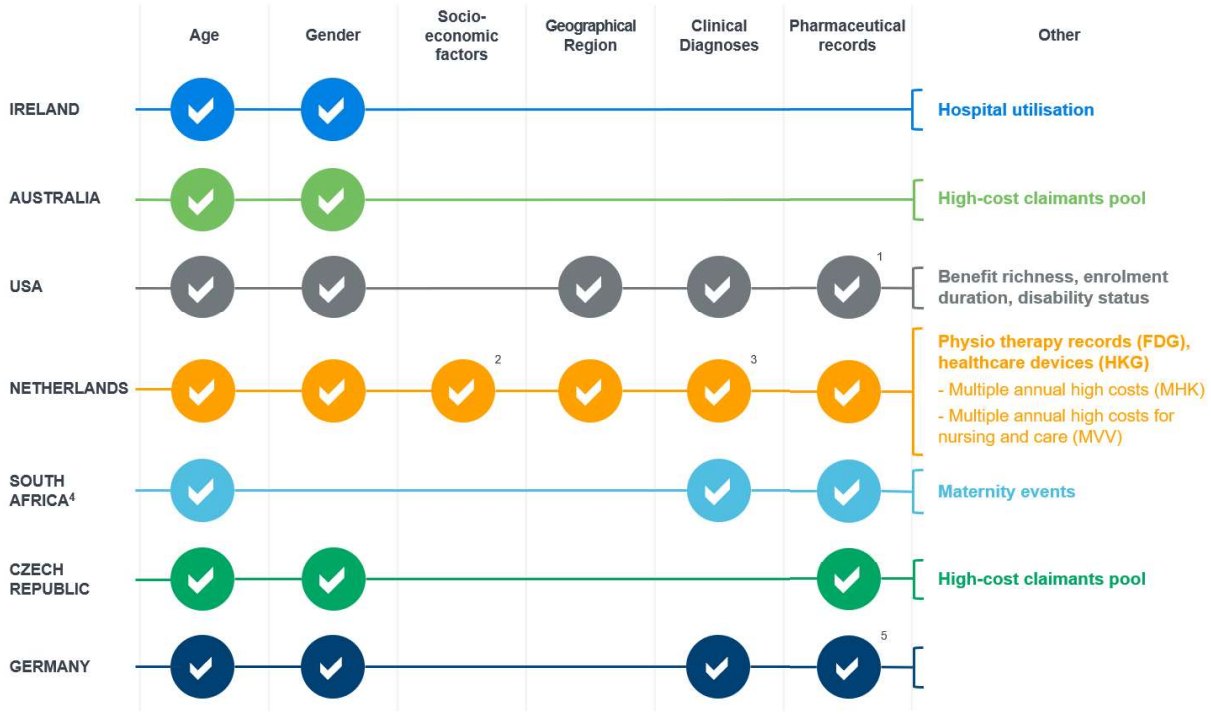
CHOICE OF ALGORITHM AND PARAMETERS

The choice of parameters, or risk adjustors, is a key consideration for a risk equalisation system. Simple risk equalisation systems may use demographic parameters such as age and/or gender as a proxy for health status, perhaps with an additional payment for hospital utilisation, such as the risk equalisation scheme in Ireland, or a High Cost Claimants Pool (HCCP), such as the system in Australia). However, claims costs for two 50-year-old males may vary significantly and therefore other parameters should also be considered. More complex systems use parameters that can more accurately predict claims costs, such as medical or pharmaceutical history, and may even include geographical and socioeconomic parameters to estimate the riskiness of the insured lives.

The number of parameters will affect the complexity of the system. With potentially large amounts of money exchanging hands, it is generally preferable to have a relatively transparent system, which may limit the choice of parameters. Although simplicity is important from a transparency point of view, there is also a balance to be struck between having an overly simplistic system and an accurate one. If the system is not accurate it may not be effective in preventing risk selection and fairly compensating differences in risk. Precision at an individual customer level is not as important as precision at the expected population level when balancing the cost of increased complexity.

The infographic in Figure 4 outlines some of the parameters used in risk equalisation systems around the world.

FIGURE 4: PARAMETERS USED IN RISK EQUALISATION SCHEMES AROUND THE WORLD



1 This is used to a limited extent in commercial (IND/SG), in some Medicaid states, and in managed Medicare.

2 Socioeconomic status x age (SES), source of income x age (AVI) and household composition x age (numbers of persons per address, or PPA).

3 Primary and secondary diagnostic groups (DKGs).

4 Proposed factors of shadow scheme.

5 For validating certain medical diagnoses.

The key challenge in design is identifying the extent to which differences in claims costs are actually caused by differences in risk profile. For example, insurers may have different claims payment approaches or different levels of healthcare management, which may result in higher or lower claims on average for the same risk profile. The richness of benefits can also impact claims costs for individuals with the same risk profile. The risk equalisation system should aim to only equalise differences in claims costs due to differences in risk profile.

The system should isolate differences relating to risk profile from other factors by identifying parameters that can influence risk profile and then equalising claims costs based on those parameters. This can include age, sex or measures of health (e.g., diagnosis with certain medical conditions, pharmaceutical data). Other factors can also be included like geographic location or income level in addition to socioeconomic parameters.

In terms of predictive accuracy, diagnosis-based risk models generally have slightly higher predictive accuracy than pharmacy-based models, as pharmacy-based models can be sensitive to treatment and prescription patterns, where diagnosis-based data is not.[1] The impact of comorbidities may also be considered although it will increase the complexity of the calculation. Despite the increased predictive accuracy, treatment bias may be an issue with diagnosis-based data such as is the hospital diagnostic-related groups (DRGs). For example, DRGs

will only pick up patients who have been treated in a hospital setting, so chronic patients who are treated in hospital will be classified with a certain diagnosis but similar patients being treated by a general practitioner or in a primary care facility may not. Therefore diagnosis-based risk factors, and pharmaceutical-based factors, are sensitive to treatment and prescription patterns.

1 Society of Actuaries (October 2016). Accuracy of Claims-Based Risk Scoring Models, Tables 4.2.1 and 4.2.2. Retrieved 5 December 2019 from https://www.soa.org/globalassets/assets/Files/Research/research-2016-accuracy-claims-based-risk-scoring-models.pdf.

Different algorithms can be used such as a simple algorithm to linear regression models like ordinary least squares (OLS) or more advanced generalised linear models (GLMs). Machine learning techniques can also be used to predict the value of healthcare costs based on a series of parameters, but lack of transparency may be an issue with a model that is based solely on machine learning techniques. All other things being equal, the algorithm underlying the risk equalisation system should in effect estimate the premium that would have been used if insurers were able to risk-rate (and had access to all the relevant data), and to recognise the difference between that and the actual premium charged. However, insurers all operate differently, and as a result differences in efficiency, claims payment procedures and benefit richness should also be allowed for where possible. The more parameters that are taken into account in the algorithm, the higher the potential for a sophisticated and effective system, but with a corresponding increase in complexity at the expense of transparency and ease of understanding of the system.

In the US in particular, some issues arose when the Patient Protection and Affordable Care Act (ACA) was introduced that were due to the lack of predictability in terms of the transfer payments. This is partially because of the use of a concurrent rather than retrospective calculation approach (which is discussed later in this paper). The impact of the lack of predictability is outlined in Illustrative Example 1.

ILLUSTRATIVE EXAMPLE 1: LACK OF PREDICTABILITY

In the US, under the ACA' in i idual and small employer group isk a ' according to a formula that depends on a number of different parameters. This includes average risk scores, premiums, benefit richness, area and other demographic characteristics of each insurer relative to other insurers in the same market. The ACA uses a modified community rating, where premiums are allowed to vary based on a member's age, geograp ic area and tobacco usage in ad i ion to plan design, but are not allowed to vary by gender, health status or other factors. The formula underlying the risk transfers must factor in that some characteristics are already accounted for through premiums, and therefore exclude their impact from the transfer payment . la's reliance on the demograp ic characte is ics of othe insurers and the comple ity of the formula in general, transfers can be difficult to understand, let alone estimate or predict. This is primarily due to the concurrent way in which the transfers are calculated, which is discussed further below.

Transfer payments often account for a mate ial por ion of a insurer's pre ium, ithe increa ing or decreasing revenue significantly, relative to target profit margins. For example, in the 2018 benefit year, the absolute value of transfers was an average of 9% of premium in the individual market and 4% of premium in the small employer market,[2] with many issuers receiving or paying significantly higher transfer amounts. While large transfer payments are a sign that risk equalisation is necessary, the calculation and eventual settlement of transfer payments does not occur until at least six months after the end of each benefit year, thereby complicating premium setting and financial reporting. Furthermore, ACA risk equalisation remains a controversial program in the US, which has resulted in frequent policy changes and seen a number of lawsuits that challenge the implementation and fairness of the program, with mixed outcomes, all of which contributes to the uncertainty of future transfer payments.

The choice of parameters and algorithm will also depend on the level of data available. Data availability may be limited for a number of reasons, for example the specific data required may not be collected, it may not be collected in a consistent or transparent manner or there may be legal restrictions on using it e.g., privacy of medical records. The complexity of national healthcare systems means that it can take a long time to improve the level and quality of data recorded, and in some cases legislative changes are required to allow or compel stakeholders to record data in the required format.

2 Richard C Van Kleef, Rene´ CJA Van Vliet and Wynand PMM Van de Ven. Risk equalisation in the Netherlands: An empirical evaluation.

Data gaps can significantly impair the ability to create good risk equalisation systems, compromising the capacity of the system to facilitate competition and efficiency and prevent risk selection. However, it is possible to create risk equalisation systems when data is limited. Illustrative Example 2 considers the risk equalisation system in Ireland, where lack of data is a challenge.

ILLUSTRATIVE EXAMPLE 2: LACK OF DATA

In Ireland, the risk equalisation scheme was originally developed using age and gender as a proxy for health. A risk equalisation payment was made to insurers based on age and gender, the 'age related credit' (ARC), for older insured lives. One disadvantage of this approach is that the ARC overcompensates for older healthier lives and undercompensates for older sicker lives. In addition, no risk equalisation payments were made in respect of high-risk younger lives.

Lack of data is an issue in Ireland in respect of claims recording. While public hospitals in Ireland record DRGs claims data that allows for consistent analysis of inpatient and day-case claims arising in a public hospital setting, similar data is not recorded on a consistent basis across all private hospitals (nor is it currently recorded in public hospitals in respect of outpatient treatment). It is estimated that there is a significant cost involved for private hospitals to provide relevant and consistent DRG data that is reliable enough to use within the risk equalisation system, and even if the Irish government introduced legislative changes requiring private hospitals to record this data it may take some time to introduce fully.

In order t improve the 'healt status' element of the I ish isk equalisa ion scheme ithout spe i ic cl ims data, a Hospital Utilisation Credit (HUC) was introduced in 2013. The HUC is a payment made to insurers based on hospital utilisation of insured lives. The only data required to implement this change to the risk equalisation scheme was the number of inpatient nights spent in hospital and the number of day-case procedures in a hospital setting split by age and gender. This information was readily available in the claims data provided to insurers.

The HUC has the benefit of redistributing some of the risk equalisation credits from older healthier lives to younger less healthy lives, where healthiness is determined based on hospital utilisation. It has achieved its aim of improving the health status element of the risk equalisation scheme to some extent, but there are limitations to its use. Firstly, the utilisation credit is a flat payment based on whether the patient is seen in an inpatient or day-case setting and therefore does not reflect the varying costs of treatments. Secondly, the possibility of perverse incentives mean that the HUC is kept low to avoid encouraging overutilisation and as a result the scheme does not fully compensate for differences in health status. However, based on estimated figures for 2018, the HUC had redistributed about 30% of the total risk equalisation fund to lives with instances of hospital utilisation, instead of making payments purely based on age and gender.

Where lack of data is not an issue, it is possible to see large improvements in the predictive accuracy of risk equalisation systems through the introduction of additional parameters. The Dutch risk equalisation system is a prime example of how the inclusion of new parameters has improved the accuracy and effectiveness of the system over time. We have looked at this in more detail in Illustrative Example 3.

ILLUSTRATIVE EXAMPLE 3: REDUCING RISK SELECTION THROUGH CONTINUOUS IMPROVEMENTS TO THE MODEL

In the Netherlands, risk equalisation was initially introduced through a simple system using demographic factors (age and gender) in 1993. The introduction of the Health Insurance Act (Zvw) in 2006 was a turning point for risk equalisation in the Netherlands. The Zvw further implemented government policy to compensate health insurers for insuring high-risk individuals but it also focused on preventing risk selection of unhealthy lives and stimulating efficiency in the health insurance market. Health insurers were instructed to specifically limit costs and improve the quality of care. The role of the health insurance company changed substantially, with the focus shifting from selecting and pricing the risks of insured lives to selecting and pricing healthcare providers, with insurers implementing targeted control of healthcare costs.

Since the introduction of the Zvw, the risk equalisation system has been developed to become the sophisticated model that is in place today, which allows for health status through DRGs and Pharmaceutical-based Cost Groups (PCGs) and other parameters such as geographical region and socioeconomic status. The most recent update to the parameters was in 2018 when the risk equalisation system was developed further to allow for multiple prior years' low costs (MLC ists of three different models, one for somatic care (e.g., primary care, hospital care and pharmaceuticals), one for mental health care and one for out-of-pocket payments due to mandatory deductibles. The different models and large number of parameters result in a high number of categories of insured lives, which leads to a complex risk equalisation system. However, there is empirical evidence that developing the system to include the additional parameters has increased the predictive accuracy of the system.[3]

Since 2018, the focus has shifted from improving the accuracy of the model to maintaining the model. However, there is current debate regarding whether continuous improvement is required to minimise the predictability of profits and losses for specific subgroups of the insured population to avoid insurers risk-selecting. While the predictive accuracy of the system has been improved through developing the scheme to include additional parameters, not all the parameters are based on information that is available to the insurers (e.g., some of the socioeconomic parameters). This means that insurers are not able to predict the risk equalisation transfers associated with each specific subgroup.

However, over time, if the system is not continuously developed, insurers may be able to predict the profit and losses for specific subgroups based on past information. This could result in increased risk selection, which is against the ethos of the risk equalisation system in the Netherlands. Recent debate in the Dutch market has pointed to machine learning as a possible mechanism for improving the current model to reduce the predictability of profit making or loss making subgroups by insurers. Up until recently machine learning would not have been considered as a realistic solution for the risk equalisation system in the Netherlands due to a lack of transparency.

To limit the risk of negative risk selection, the Dutch Healthcare Authority, the Nederlandse Zorgautoriteit, recently made a strong call to continue to improve the risk equalisation system and to search for new methods—such as machine learning techniques—in order to minimise predictable profits and losses for specific subgroups and limit risk selection[4]. In this context continuous improvements to the model (by adding more and more parameters and using more advanced, less transparent modelling techniques) seem to be favoured despite the complexity and lack of transparency. In terms of the trade-off between unpredictability and transparency in the Dutch health insurance market at least, transparency seems to be becoming less and less important.

3 Ibid.

4 Monitor Zorgverzekeringen 2019, published by the Nederlandse Zorgautoriteit in September 2019.

When choosing the parameters to include in a risk equalisation system, it is also worth considering what to exclude. For example, claims costs may vary for supply-side reasons unrelated to health status, such as access and capacity, supplier-induced demand or practice pattern variation. Many different factors influence healthcare consumption and, therefore, it can be difficult to isolate instances of supplier-induced demand to exclude it from a risk equalisation system. As the main aim of risk equalisation is to equalise differences in claims costs due to health status, therefore differences due to other factors need to be considered, where possible, when defining the data, parameters or algorithm underlying the risk equalisation system.

Benefit richness can also result in higher claims costs. In some health insurance markets, particularly mandatory insurance markets, there is a standardised benefit package and the risk equalisation system reflects the standard basket of benefits. However, in many private health insurance markets, the level of benefit is variable. Individuals have an opportunity to choose richer or poorer benefit packages with differences in the types of services covered, the hospitals or providers covered, the level of accommodation, the level of copayment required etc. For a risk equalisation system this can raise challenges. The system may aim to equalise differences in risk due to the health status of the insured lives, but would typically not wish to equalise differences caused by richness of benefits. It may be unfair to a low-risk person to cross-subsidise the extra claims costs of a higher-risk person if the higher-risk person has a much richer benefit package driving part of the claims cost differences. Many systems use past claims information to calibrate the payment levels and separating the components of past payments can be a challenge.

As well as the level of benefit that insured lives choose, the insurers may also have differences in claims payment procedures or even simply efficiency, which can affect payment levels. It would be counterproductive to have an insurer that operates efficiently, minimising claims payments, for example, if the benefit of this efficiency was effectively shared with other insurers through a risk equalisation payment.

In the Netherlands, for example, the risk equalisation system is based on a standard basket of benefits that underpin the Dutch universal health insurance system. In this way it is easy to ensure that there are no cross-subsidies for benefit richness. In Ireland, the level of benefit varies across a broad range of health insurance products, making it more challenging to ensure that differences in claims amounts due to benefit richness are excluded from the risk equalisation scheme. This is considered further in Illustrative Example 4.

ILLUSTRATIVE EXAMPLE 4: BENEFIT RICHNESS

In Ireland, consumers can choose between a broad range of health insurance products with varying levels of services covered, hospitals or providers covered, accommodation and copayment required. When setting the risk equalisation credits, health insurance products are categorised based on their levels of cover. The products are categorised as 'advanced' and 'non-advanced' products by the health insurance regulator (the Health Insurance Authority). The 'advanced' products represent about 90% of the market, however these plans include a wide range of benefits. Plans are categorised based on characteristics set out in legislation, with non-advanced plans providing limited payments where inpatient care is provided in a private hospital.

For a number of reasons, the non-advanced population tends to be younger on average than the advanced plan population and they are also generally less risky on average. The parameters for the scheme vary between advanced and non-advanced plans. In setting the non-advanced parameters, the whole population (advanced and non-advanced) is considered, but only non-advanced benefit levels are considered. In this way, the lower-risk (on average) non-advanced lives cross-subsidise the higher-risk advanced plan lives, but only up to a non-advanced benefit level.

When setting the parameters for advanced plans under the scheme, benefits in excess of a standard level are excluded. The standard benefit level broadly reflects the most common inpatient benefit package held by insured lives with advanced plans. In this way the scheme allows for equalisation of risk across the entire population of advanced plan holders but eliminates cross-subsidy of benefits in excess of those most widely held across the population.

CALCULATION APPROACH: PROSPECTIVE OR RETROSPECTIVE

The calculation approach is also an important consideration. Risk equalisation systems can operate on a prospective or retrospective basis.

In a retrospective system, sometimes called a concurrent system, payment transfers occur at the end of a defined period and are calculated according to *actual* risk exposure over the relevant period. In a prospective system, payments are calculated according to *predicted* risk exposure over the period and are generally paid at the beginning of the defined period. Blended or 'hybrid' systems can also exist, which may result in more accurate reflections of the exposure years' expe ience, and hence more accurate cost predictions. For example, in the Irish risk equalisation scheme, the parameters are set prospectively based on predicted risks, but the payments are made retrospectively, at the end of the pe iod, based o insurers' actual insured popula ions. In the US Medicare Advantage market, initial payments are made based on the previous years' expe ience, followed by an interim calculation to reflect the membership mix at the time, and a final settlement to account for the full-year membership exposure.

Figure 5 compares the key advantages and disadvantages of the two methods, ignoring any hybrid solutions.

FIGURE 5: COMPARISON OF PROSPECTIVE AND RETROSPECTIVE RISK EQUALISATION SYSTEMS

CONSIDERATION	PROSPECTIVE RISK EQUALISATION (NO REBALANCING)	RETROSPECTIVE RISK EQUALISATION
Certainty of payments	Funders have more predictability in terms of payment amounts at the beginning of the term and are able to plan accordingly.	Less predictability of payments because risk equalisation only occurs at the end of the term. For shorter time periods, this is less of a concern (e.g., monthly vs. annual payments).
Accuracy	The accuracy of the risk reflected in the transfer payments depends on the accuracy of the risk predictors used to calculate the payments. In a prospective system with no rebalan ing, ther is an opportu ity for funders to ' in' or 'lose' based on the formula used to calculate the payment . le if a insurer's actual is is lower than expected, it will transfer less into the fund or receive more from the fund than it should according to the actual level of risk.	Transfer payments are based on the actual insured lives each funder was exposed to over the relevant period.
Complexity and administration burden	Less complex and lower administration burden because no retrospective reconciliation is required. However, setting the parameters of the system may be more complex than the retrospective approach. Obtaining data from a prior period may be difficult if participants were in a different insurance program.	Both systems will have some level of complexity associated with the calculation and administration of the payment transfers but a retrospective system has the added requirement to reconcile and adjust payments at the end of the period.

In the UK a prospective approach is used to fund the English NHS. This is discussed further in Illustrative Example 5.

ILLUSTRATIVE EXAMPLE 5: USE OF PROSPECTIVE APPROACH IN THE ENGLISH NHS

CCGs receive an annual funding allocation from NHS England (NHSE) to commission services for their registered populations. The level of funding is known two to three years in advance and target funding amounts are calculated as a weighted (risk-adjusted) capitation amount based on the following parameters: population size, age/sex mix, supply-side variables, unmet need/health inequalities and market forces (adjustments for how the cost of providing services differs by area, e.g., land and staff costs).

The actual allocation that a CCG receives may be lower than its target allocation because the total level of fun ing av ilabl is ixe . lloca ions have been calculated, t i is a ' Change Policy,'[5] which aims to move CCG areas closer to their target allocations over time.

The population size of each CCG is estimated according to general practitioner (GP) registration levels and projected using estimates from the Office for National Statistics (ONS). There is no retrospective adjustment to account for differences in predicted and actual experience. Consequently, if a CCG has changes to its population size or risk profile that are different from expected, it could end up receiving a funding allocation different from its actual level of risk. For example, if a CCG has an unexpected decrease in its population size, it would be receiving a funding allocation for more people than it is technically responsible for commissioning services for. This is a disadvantage of the prospective approach without rebalancing.

5 https://www.england.nhs.uk/wp-content/uploads/2016/04/1-allctins-16-17-tech-guid-formulae-v1.pdf

In the Netherlands, a purely prospective (or ex ante) approach is also used. This means that the contributions received by health insurers from the risk equalisation fund are determined prior to the calendar year to which the contributions relate. This exposes the health insurers to financial risk as the risk equalisation contribution and premium income is independent of the actual claims costs incurred in the relevant calendar year. The prospective approach stimulates the health insurers to manage resources as effectively as possible to limit the financial impact of unexpected variance in income (premiums and risk equalisation contributions) and outgo (claims costs).

In contrast, the retrospective approach is used in the US commercial individual and small employer group markets. Illustrative Example 6 provides more detail on this.

ILLUSTRATIVE EXAMPLE 6: USE OF RETROSPECTIVE APPROACH

In the commercial individual and small employer group markets in the US, funds are transferred among plans on a retrospective basis using a concurrent risk adjustment model. Risk scores are calculated for the benefit year using claims data through to April of the year following the benefit year, and transfers are announced in June and paid in September. Premiums are typically set six to nine months in advance of the benefit year, and issuers are required to include the expected risk adjustment receivable or payable in the premiums. So there is at least a twenty-four month lag between when premiums are set and transfer payments are known.

The advantages of this method are that premiums and plan revenue tend to align more closely with the average health status and expenditures of the insured population within a market. Indeed, insurers will likely get credit for high cost individuals through the diagnoses concurrently coded with those claims. This can be particularly important in markets that experience significant turnover of the insured population, such as the individual market. Concurrent risk adjustment models are generally more accurate than prospective,[6] and the risk scores used to calculate the transfer values will reflect the actual population and diagnoses for the benefit year.

However, retrospective risk adjustment methods also present many challenges for insurers, in particular as community-rated premiums must be set, allowing for estimated risk adjustment transfers, prior to open enrolment, i.e., before insurers know the risk profile of their insured lives for a given benefit year.

The retrospective timing of payments may cause liquidity issues for some insurers. If plans are expecting a large risk adjustment receivable, premiums will typically not be sufficient to cover expected claims costs, and these costs will need to be funded by insurers in advance of receiving risk adjustment payments in September of the year following the benefit year. Furthermore, if premiums are priced in anticipation of a large risk adjustment receivable, but ultimately must pay into the risk equalisation pool (for example, due to differences in the risk profiles of members that enroll in the plan compared to assumptions made during pricing), then there is a risk that they will not have sufficient funds to make the required payment.

Conversely, if premiums are priced high in anticipation of making a large payment into the pool, but ultimately see more favourable experience and do not need to make such a payment, the unexpectedly high profit margin may need to be rebated back to customers, causing extra administration and potentially negative publicity toward the insurer.

SOLUTIONS FOR EXCEPTIONALLY HIGH CLAIMS

Another important consideration for a risk equalisation system is whether there needs to be some specific solutions for high-cost claims, as healthcare costs have the potential to be very skewed for very high-risk individuals. While the risk equalisation transfers will be higher for high-risk lives, there still may be a very large gap between actual risk equalisation transfers and claims costs, particularly in the case of catastrophic claims. In some risk equalisation systems a solution in respect of high-cost claims may be an important part of the system as a whole.

The concept of a high-risk pool, or a High Cost Claimants Pool (HCCP), exists in a number of risk equalisation systems around the world. This is typically designed as a risk-sharing pool for low incidence, very expensive claims that its alongside a 'traditional' risk equalisation fund. This is the case in the Australian risk equalisation system, which is considered further in Illustrative Example 8 below.

6 Society of Actuaries, Accuracy of Claims-Based Risk Scoring Models, op cit.

The benefit of a HCCP is that it can target risk equalisation credits towards the most high-risk individuals or catastrophic claimants and can reduc insurer' incen ives to avoid insuring these individuals through segregated products. However, a HCCP may dis-incentivise claims cost efficiency, as insurers may be less likely to challenge high claims costs if they are being reimbursed through the risk equalisation system. This means that a HCCP could have limited benefits in the long term.

ILLUSTRATIVE EXAMPLE 7: HIGH-COST COMPENSATION IN THE NETHERLANDS

In the Netherlands, a High-Cost Compensation (HKC) settlement was included in the risk equalisation system for a number of years following the introduction of the Zvw but has since been removed. In 2012 the HKC was removed from the somatic care model and in 2015 it was removed from the mental healthcare model. The HKC was removed as there was a fear that it reduced the incentive for efficiency. With the abolition of the HKC, the Dutch government aimed to incentivise efficient procurement and volume control. The HKC was replaced by the prospective, or ex ante, Long-Term High Costs (MHK) groups parameter.

However, due to the skewedness of mental healthcare costs, the removal of the HKC resulted in some insurers facing large mental healthcare claims that were not covered by the risk equalisation system, which resulted in incentives for negative risk selection. Prospective payments cannot accurately predict the costs associated with these patients in the short term, due to a lack of data amongst other things. As a result, it was decided to reintroduce the HKC ex post compensation solution for a small group of insured lives with the highest mental healthcare claims. For insured lives with the 0.5% highest mental healthcare costs, 75% of the costs are pooled above the 0.5% percentile value.

In reintroducing the retrospective ex post payment, the competing aims of reducing incentives for risk selection and increasing efficiency were balanced against one another. With a high-cost claims pool, the efficiency incentives are reduced by lower thresholds and higher reimbursement. In the Dutch system, the incentive inefficiency is limited by the very high threshold and the fact that only 75% of claims costs are covered. In addition the retrospective payment is used to redistribute funds within the risk equalisation system, rather than resulting in an increase in the total level of risk equalisation payments.

The reintroduction of the retrospective payment for mental healthcare costs does not mean that this type of payment will be reintroduced elsewhere in the risk equalisation system. Prospective payments are still preferred within the Dutch risk equalisation systems and research is being carried out on the possibility of using a prospective payment in respect of these costs. The results of these investigations will need to be tested against the assessment framework (covered in Illustrative Example 11 below) and the various objectives of the risk equalisation (e.g., equalising effect, efficiency, risk selection and practicability) before any changes are introduced.

It is also difficult to estimate the impact that a HCCP will have on the effectiveness of a risk equalisation system, as this will depend on where the parameters of the HCCP are set. If the claims threshold is set at a very high level, then the HCCP will equalise risk for only the sickest individuals, and it may not be significant enough to improve the effectiveness of the system as a whole. Conversely, if the threshold is set at a lower level, then this HCCP will equalise risk for more individuals but it may result in a significant increase in the cost of risk equalisation, which may affect the sustainability of the market.

However, evidence suggests that a HCCP can increase the overall 'goodness of fit' of a risk equalisation scheme with limited negative impact on an insurer' incen ives.[7]

ILLUSTRATIVE EXAMPLE 8: HIGH-COST CLAIMS POOL IN AUSTRALIA

In Australia, the current risk equalisation system was implemented in 2007 to support the community rating principle. It differentiates two distinct pools: the Age Based Pool (ABP) and the High Cost Claimants Pool (HCCP). The amount of claims costs to be allocated to the ABP depends on specific percentages defined for each of the age cohorts for people aged 55 and over. The percentage varies from 15% of average claims for people aged 55 to 59 to 82% for those aged 85 and over. Insured lives aged 54 and younger are not eligible for the ABP pool.

Claims allocated to the HCCP pool are defined as 82% of the excess of claims over $50,000 after any recoveries from the ABP pool. The concept of the HCCP pool was introduced in 2007. The main aim of the HCCP pool is to cover catastrophic risk. Relative to the system as a whole, the HCCP might be considered immaterial (accounting for about 3% of claims equalised in Australia[8]) but it is a key to the system as a whole. It particularly benefits smaller insurers where the pool of members is not sufficient enough to spread high-cost claims. It is also the only form or risk equalisation for high-risk insured lives aged 54 and younger without the HCCP there would be no compensation under the risk equalisation scheme for these lives.

High claims costs resulting from low incidence events are particularly a problem for smaller insurers. In the absence of a separate equalisation pool for expensive claims smaller insurance companies may indemnify such risks with private reinsurance arrangements. It is common for insurers or other risk-bearing entities (such as self-funded employers or risk-bearing provider organisations in the US) to purchase reinsurance from private reinsurers. Typical private reinsurance arrangements cover specific (individual-level) or aggregate (risk-pool-level) stop-loss amounts. These policies protect insurers from catastrophic claims and exist outside of the risk equalisation system as supplementary risk mitigation.

ILLUSTRATIVE EXAMPLE 9: FEDRAL AND STATE REINSURANCE

In the US there are reinsurance programs operating at federal and state levels, as well as private reinsurance arrangements purchased from private reinsurers. In this example we consider the fed eral and state reinsurance programs.

Federal reinsurance programs

The ACA's tran i ional r insurance program was a temporary isk equalisa ion progra in effect from 2014 to 2016. It was intended to help stabilise premiums in the individual market for the first three years after the ACA's market rules were full implemente . led cont ibu ions from all commer ial insurers (including individual, small employer group, large employer group fully insured and large employer group self-funded plans), and used those contributions to fund reinsurance payments to the individual market.

Beginning in 2018, the Centres for Medicare and Medicaid Services (CMS) introduced a new national high cost risk pool to complement the ACA' in i idua and sma group market isk equa sa ion transfer payment . Premium assessments are used to fund reinsurance in those markets, covering 60% of an individual members annual claims exceeding $1,000,000 (as of 2018). Since the program handles claims above $1,000,000, the risk equalisation can be modelled using truncated claims amounts, which increases the predictive power and stability of the transfer payment formula.

There is also a federal reinsurance program to cover catastrophic claims for insurers offering prescription drug coverage to Medicare beneficiaries.

7 Society of Actuaries in Ireland (26 September 2018). Healthcare Seminar on Risk Equalisation & Regulation in Private Health Insurance. Retrieved 5 December 2019 from https://web.actuaries.ie/sites/default/files/2018-09/180926%20Healthcare%20Seminar%20-%20Full%20Presentation.pdf.

8 Institute of Actuaries of Australia (2011). Risk Equalisation 2020: Is the Current System Sustainable? Retrieved 5 December 2019 from https://www.actuaries.asn.au/library/events/Conventions/2011/Con2011_Paper_Reid.pdf.

State reinsurance programs

The ACA allows states to apply for "stat innova ion w ivers" enabling the use of federal fun ing t implement innovative stabilisation programs in the individual and small employer group markets. Several states have used this waiver to establish reinsurance programs, mainly as a substitute for the federal reinsurance program that ended after 2016. Since the state-based reinsurance program reduces costs for some members who are supported by federal pre ium sub i ies, the federal government's sa ings are then r investe into the program, thereby extending the funds available for reinsurance.

COMPETITION AND EFFICIENCY

Competition among insurers is important in terms of increasing efficiency in healthcare delivery. In order to attract and maintain customers in a competitive market, insurers will need to utilise their resources carefully, ensure that administrative costs are managed efficiently, provide quality customer services and pass available cost savings to insured lives by charging lower premiums. Inefficient insurers will have to charge higher premiums than their competitors and may subsequently risk losing customers. In a competitive market, insurers may be encouraged to be more responsive to customer preferences and more innovative in their product offerings and delivery of services. If consumers are sensitive to price and quality, insurers will need to keep improving quality and minimising costs to maintain or grow their customer bases.

Competition should be based o insurers' freedom to de ign, price and market health insurance products, while avoiding moral hazard and promoting efficiency. However, where premium restrictions exist in health insurance markets, e.g., due to community rating, risk selection may occur. This is where insurers try to compete on the basis of only insuring 'good' risks or healthy lives through designing products to attract low-risk individuals or excluding certain coverage. If insurers can generate profits through risk selection, they may not be sufficiently financially motivated to focus on increasing their efficiency or otherwise innovating in terms of product design or service delivery.

However there are always trade-offs in designing a program intended to remove the impact of risk selection. A fundamental issue relates to defining and placing a value on health risk, which can be difficult to separate from other aspects that might influence health insurance premiums, such as the breadth of healthcare provider networks, the level of compensation to healthcare providers, the level of customer service, or other aspects of cost. Even the concept of inefficiency can have varying interpretations. For example, an insurer that increases its customer service and care coordination staff and pays healthcare providers a higher rate may find a niche in an open marketplace with customers willing to pay a higher premium (e.g. for perceived better value or access to more providers). An effective risk equalisation system should not discriminate against this insurer relative to other more "ef i ient' insurers, howeve in prac ic it ight be if icult to allow for all the ifferent factor influen ing efficiency without an overly complex system.

An effective and robust risk equalisation system should discourage risk selection and allow insurers to compete in other ways. In theory, if high-risk patients are properly catered for within the risk equalisation system then they may become the preferred customer base of an efficient insurer because the potential efficiency gains per person may be higher for the chronically ill, for example, than for healthy lives. This could have the added benefit of reducing risk equalisation payments to inefficient insurers.

However, if the risk equalisation system does not fully compensate for the riskiness of some insured lives, or if the system is designed in such a way that efficiency benefits are shared with other members of the risk equalisation pool, then incentives to innovate and become more efficient are discouraged. This is counter-productive to the ethos underpinning risk equalisation, which is intended to highlight and reward efficiency.

Outside of the risk equalisation system, in the wider healthcare system, insurers also need to have access to tools that allow them to influence healthcare quality and costs and use them to engage in strategic purchasing. To promote efficiency, insurers need to be able to have strong purchasing power to negotiate with healthcare providers.

There is a balance to be struck also to ensure that the risk equalisation system does not encourage inefficient behaviour. This can be difficult to measure and control. It can sometimes be difficult to understand what is driving higher claims costs for a particular insurer; is it simply riskier insured lives or are the higher claims costs due to inefficiencies relative to other insurers in the market? The risk equalisation system needs to be parameterised in such a way to ensure that it is only neutralising risk and not incentivising inefficient behaviour for either insurers or providers.

A recent report by the South African Competition Commission on the Health Market Inquiry noted a number of issues with competition in the South African market that are prevalent in other markets also. We have considered this further in Illustrative Example 10.

ILLUSTRATIVE EXAMPLE 10: CONSIDERATIONS FOR COMPETITION: SOUTH AFRICA

The current health insurance market in South Africa operates in an environment of open enrolment, community rating and the provision of a package of prescribed minimum benefits. A risk equalisation scheme was proposed as part of the move towards social solidarity, but was never introduced—we have commented on this further in Illustrative Example 15 below.

A recent report published by the Compe i ion Com is ion's Healt h Market Inq iry found that the p ivate healthcare market was 'characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilisation without stakeholders having been able to demonstrate associated improvements in health outcomes.' This is partly due to current practices of segmentation and risk selection within the market, due to the lack of an effective risk equalisation system.

The incomplete regulatory framework has meant that 'medical schemes' (the term used to describe health insurers in South Africa) are competing on the risk profile of lives under cover by designing products and benefit options to attract younger and healthier members. The social solidarity principles underlying the health insurance market do not allow the schemes to risk-rate, and therefore risk selection has become the preferred form of competition in the absence of risk equalisation.

The report notes that a consequence of this is increased market segmentation with a proliferation of products on sale in the medical schemes market with generally incomparable benefit options. This has resulted in an inability to easily compare options across schemes, making it more difficult for customers to switch providers. This means that schemes have no incentive to compete on pro-consumer metrics and to offer better products.

The Competition Commission states that these factors 'clearly do not foster an environment conducive to competition on metrics which would result in positive consumer welfare outcomes.' The paper notes that competition should occur on price, cost and quality of services and not risk selection. The introduction of the risk adjustment mechanism is welcomed by the report as an 'essential market mechanism to ensure that purchasing in the market becomes more effective, by forcing funders to compete on value and, therefore, stimulate competition between and the efficiency of providers.'

Similar issues relating to competition and inefficiency can occur in healthcare systems with risk equalisation systems that are not fully effective. For example, the Irish risk equalisation scheme lacks an appropriate parameter for health status and this has resulted in issues similar to those seen in South Africa. Insurers in Ireland continue to compete on the risk profile of insured lives and a significant level of segmentation exists in the market, with approximately 300 health insurance plans on offer from just three insurers.[9]

ONGOING MANAGEMENT

It is equally import to monitor the impact of a system on competition and efficiency on an ongoing basis post-introduction. The impact on competition may be assessed in a number of ways, such as monitoring insurers' cost ratios or profit levels. Other signs of healthy competition include new entrants to the market or new innovative product features, particularly if they are targeted at less healthy lives.

Risk selection may continue to be an issue if the risk equalisation system is not fully effective. Insurers may continue to compete on risk profile to increase profits if they are not being fully reimbursed for high-risk lives. Depending on the parameters and algorithm underpinning the risk equalisation system, segmentation may occur in the insurance market that results in older, sicker lives continuing to pay higher premiums, even if risk equalisation is in place. This is the case in Ireland, where plans with limited orthopaedic benefits are common in the market, while plans with full orthopaedic coverage (which are more likely to appeal to older lives) come at materially higher costs. In effect the higher cost of full orthopaedic cover reflects the risk level of the insured lives taking out the product, rather than the higher benefit coverage. Similarly, low-cost products with high deductibles are also used to segment the market, as they are generally preferred by younger, healthier lives.

9 Based on the Heath Insurance Autho ity's Compa ison Tool as at 23 October 2019.

The risk equalisation system can include features to reduce the risk of segmentation. For example, the Irish risk equalisation scheme uses the concept of an 'overcompensation' test to reduce the capacity for insurers to receive risk equalisation transfers for older, sicker insured lives and also charge them a higher health insurance premium due to segmentation. This test is a statutory retrospective assessment to check the return on earnings (ROE), calculated as a three-year rolling average, of any health insurers in the Irish market that received net transfers under the scheme, against a benchmark. If the ROE is higher than the benchmark, overcompensation is deemed to have occurred and the insurer in question is required to refund the overcompensation identified to the risk equalisation scheme. There are of course some issues with the use of this type of test, specifically around the determination of the benchmark, but it plays an important role in limiting segmentation in the Irish health insurance market.

In order to monitor the system on an ongoing basis, it is important to have a measure to evaluate the effectiveness of the system. However, there may not be one single absolute measure for effectiveness, as the effectiveness of the system may depend on a number of different factors.

Firstly, in order to determine the measure of effectiveness, it will be important to determine exactly what the risk equalisation system is compensating and how this should be measured. For example, if the system compensates based on differences in average claims costs, there may be a number of factors underlying these differences, such as claims management policies and benefit richness in addition to health status. In practice there will be a trade-off between efficiency and effectiveness as a system that equalises 100% of differences in claims costs among insurers may incentivise inefficient behaviour. The assessment and measurement of the effectiveness of the system will need to allow for this trade-off.

Depending on the parameters and algorithm underlying the system, an ordinary least squares model could be used to measure R-squared or goodness of fit, based on the relevant factors. Such a model has the benefit of capturing the impact of factors other than health status, such as region or socioeconomic factors, based on the average for the population as a whole. This approach, however, moves from a closed form solution to a structural form, which may be of limited use in practice due to complexity. In addition the use of such techniques will depend on the level of data available to run the model.

The predictive accuracy of the system may also be used to measure effectiveness. The predictive ratio is a comparison of the predicted risk equalisation transfers with the actual transfers at a cohort level. It can be used to understand whether the risk transfers have been effective for a particular subgroup or cohort. However, depending on the variables used, it may be difficult to justify and may be challenging to ensure that it does not allow for differences in claims management, supply-side issues or benefit richness, in addition to health status. This ratio only measures the predicted transfers versus the actual transfers and does not measure the appropriateness of the predicted transfers relative to the riskiness of the insured population.

Another solution would be to add ex post risk equalisation, where deviations in predicted and actual transfers are shared retrospectively between insurers or payers and the risk equalisation fund system to some extent. The concept of a HCCP mentioned above is an example of an ex post risk equalisation for very high-cost claims. These measures, however, also have a downside as they can limit insurers incentives for efficiency and contribute to the trade-off between efficiency and effectiveness.

In practice, it is difficult to implement a fully effective system and several challenges need to be considered and overcome in order to maintain a balance between the trade-off of efficiency and effectiveness. It is nevertheless important to do so because the more effective the risk equalisation system is, the more likely it is that it will achieve its aims.

Many of the risk equalisation systems in place today are subject to frequent updates, most notably to improve effectiveness. The Dutch scheme, for example, has gone through a significant number of developments and updates since it was introduced in 1993 and especially since the introduction of the healthcare insurance act in 2006. This is considered further in Illustrative Example 11. The Irish risk equalisation scheme is subject to approval by the European Commission (currently every five years) and is regularly updated and developed to increase the effectiveness of the scheme as part of this approval process.

ILLUSTRATIVE EXAMPLE 11: MEASURING THE IMPACT OF CHANGES TO THE DUTCH RISK EQUALISATION SCHEME

In the Netherlands, the impact of changes to the risk equalisation model is evaluated based on a specific assessment framework to measure the impact in terms of the objectives of the risk equalisation scheme. The framework serves as a guideline for the assessment of new parameters, assessing changes to existing parameters, including significant changes and testing variations of the model. The assessment is carried out at various levels, including the impact on the total insured population, the impact on subgroups of the population and the impact on insurers, and is both qualitative and quantitative in nature.

The weighted average absolute standard deviation is measured at all levels. R-squared is the standard measure both at the total popula ion level and at th insurers' level. lthough the R-squared can indicate a high predictive power at a population level, there can be significant differences between the actual and predicted healthcare costs at a subgroup level. The R-squared cannot tell whether the risk equalisation model sufficiently compensates for predictable variation in medical expenses across specific subgroups. On this basis, a further assessment is carried out to analyse the under-compensation or overcompensation at a subgroup level, including specific subgroups that are not explicitly included in the risk equalisation model. The following assessments are carried out:

Equalising effect: Before introducing a new parameter to the scheme, a significance test is performed to assess whether a parameter adds value to the risk equalisation model. The new parameter must improve predictability within a certain threshold. In addition the total additional healthcare costs must be presented at a macro level. This provides insight into the expected effects of the proposed parameter and can support the trade-off between combating risk selection and managing complexity. This is tested through various measures at different levels. The standard measures for both the somatic care and mental healthcare models are the R-squared and Cummings Prediction Measure (CPM) at the total population level and the weighted average absolute deviation at subgroup and insurer levels.

Efficiency: The addition of a new parameter to the risk equalisation scheme should not incentivise perverse behaviour by health insurers or care providers in terms of efficiency. Inefficiency incentives are distinguished between the features of the risk equalisation scheme that result in financial incentives for insurers to declare more healthcare costs and features that deter efficient behaviour (among insurers, healthcare providers and insured lives). Although efficiency can be tested by the earnings ratio, this assessment is generally qualitative in nature.

Managing complexity: Additional parameters and other estimation methods can make the model complex and non-transparent, in addition to leading to instability of the model and the risk equalisation transfers. It is important that the models generate results that can be clearly explained and result in stable and logical risk equalisation transfers, where possible. The complexity of the model is assessed in terms of the number of parameters used, the quality of data and the transparency of the underlying calculations. Significance tests and sensitivity analysis can be used to understand the stability of changes to the model over time.

Validity and measurability: Any changes to the model must be valid and measurable. The addition of a new parameter to the scheme will be deemed valid and measurable if it systematically relates to the healthcare costs for insurers and if it categorises insured lives in an objective and reliable way, without the need for arbitrary decisions. In addition, the data used must be accurate, reliable and available.

4. External challenges

Even if a risk equalisation system is designed to be as effective as possible, there may be some external challenges to overcome before the system can be implemented, or on an ongoing basis once the system is up and running. In this section of the report we have tried to highlight some additional key areas for consideration, including illustrative examples of where challenges have arisen in risk equalisation systems around the world. This includes legal challenges and political uncertainty as well as general implementation challenges.

LEGAL CHALLENGE

Due to the large amounts of money that are transferred between individual insurers or healthcare providers within risk equalisation systems, they are regularly subject to legal challenge. In this section we consider specific legal challenges faced in the implementation of the Irish risk equalisation scheme and ongoing legal challenges faced in the US.

The introduction of the risk equalisation scheme in Ireland is a good example of how legal challenge can disrupt the implementation of a system and how creative solutions can be utilised to enable implementation. We have considered this further in Illustrative Example 12.

ILLUSTRATIVE EXAMPLE 12: LEGAL CHALLENGE IN THE IRISH SYSTEM

When the Irish risk equalisation scheme was introduced in 2003 there was a large state-owned insurer that had been in operation for many years, and a small number of private insurers which were new entrants to the market. The government-owned insurer had a significantly older population than the private insurers. By implementing the risk equalisation scheme, the government was effectively introducing a scheme that would result in large payments from private insurers to the government-owned insurer. This resulted in a considerable amount of legal challenge, particularly from new entrants to the health insurance market that claimed the scheme was anticompetitive. Following a lengthy legal process through the Irish court system, the regulations that were introduced to implement the original risk equalisation scheme were eventually deemed to be ultra vires by the Irish Supreme Court in 2008 and no payments were ever made under the original scheme. The Supreme Court decision found that risk equalisation was introduced on the wrong legal basis, based on the definition of community rating in Irish legislation; it did not rule that the principles of risk equalisation or community rating were illegal.

The revised scheme utilised the tax system to achieve similar results in a more legally robust approach as changes to the tax system are generally more difficult to challenge. The government charged each insurer a flat stamp duty in respect of each life insured. This was used to raise funds for the risk equalisation scheme. The government then paid a tax credit to less healthy individuals, based on a number of risk factors. The tax credits were effectively passed through to the insurers. The premiums net of tax credits were community-rated but insurers received the premium plus the tax credit for riskier lives. Insurers could therefore reflect the combined impact of the stamp duty and tax credits in their pricing. The scheme overall resulted in a transfer from insurers with healthier populations to insurers with less healthy populations, albeit in a more legally robust way than the original scheme.

In the US, there have been a number of legal challenges to the introduction of risk equalisation, both in respect of the algorithm used to calculate the risk transfers and in changes made to state regulations. They are discussed further in Illustrative Example 13.

ILLUSTRATIVE EXAMPLE 13: LEGAL CHALLENGE IN THE US SYSTEM

There have been a number of legal challenges to the ACA in the U.S. since it was introduced. For example, various lawsuits have been filed challenging the risk adjustment program and in particular the decision to base risk adjustment transfers on state-wide average premiums. Some smaller insurers believe that this approach disadvantages them in favour of larger, well-established insurers. Larger insurers will have a larger impact on the state-wide average premium and therefore are less likely to deviate from the average, while smaller insurers with lower enrolment and higher volatility may be more likely to deviate materially from the state-wide average risk level, resulting in large transfers (whether favourable or unfavourable). The legal challenge was resolved without a change in methodology.

Changes to state regulations can also be prone to litigation. In some states, regulators worried that the risk transfer payments were too large and disruptive, so they took emergency action to reduce their financial impact. Some of the emergency regulations introduced were subject to legal challenge, such as the emergency regulation introduced in New York in 2016. In this example, the regulations were ultimately upheld by the New York district court. However in response to the emergency actions, the federal government reached a political compromise, and now all states have the flexibility to reduce the magnitude of transfer payments by up to 50%.

POLITICAL CHALLENGE

In addition to legal challenges from p ivate compa ies, changes to a country's healthcare system can be politically charged and may not always be welcomed by the public. There are many examples of this but we have included two specific illustrative examples in this section where proposed changes to healthcare systems were revoked for political reasons. The first relates to the proposed introduction of a new healthcare bill in Romania at the end of 2011, which resulted in mass protests and was eventually overturned. This is discussed further in Illustrative Example 14.

ILLUSTRATIVE EXAMPLE 14: PROTESTS IN ROMANIA

In late 2011, Romanian politicians introduced a new healthcare bill to reduce state funding, deregulate the health insurance market and privatise hospitals. The change would replace the original system of controlled resource allocation with regulated competition at both the health insurer and service provider levels. The proposal included compulsory insurance, with citizens having the right to choose and change insurers on an annual basis. Insurers were obliged to accept individuals and could not terminate contracts, but could still charge risk-rated premiums.

This was criticized by the International Monetary Fund (IMF), which noted that, among other things, private health insurers could refuse high-risk patients with chronic conditions by imposing very high premiums on them to avoid this risk, Romania needed to redistribute the funds between private insurers based on patient profiles. However, the citizens of Romania were not happy with the proposal to introduce private funds to the Romanian healthcare system. The most vocal opponent of the reform was the Deputy Minister of Health who had founded the emergency services. He stated that privatising the emergency services would destabilise the system and that people who could not afford to pay for an emergency service may be condemned to death.

Romanian citizens took to the street to protest against the reform, resulting in the government resigning and significant changes being introduced to the planned reform, most notably in the area of emergency healthcare.

The second political challenge related to a shadow risk equalisation fund which operated in South Africa for a number of years. For political reasons, no transfers were ever made. This is discussed further in Illustrative Example 15.

ILLUSTRATIVE EXAMPLE 15: UNSUCCESSFUL IMPLEMENTATION IN SOUTH AFRICA

In South Africa, medical insurance is predominantly provided through 'medical schemes' that provide risk pooling for healthcare in the private system. The medical schemes are owned by their members and are nonprofit entities. They are regulated on the basis of social solidarity principles and they operate in an environment of open enrolment, community rating and the provision of a package of prescribed minimum benefits. Since January 2010, medical schemes are not allowed to underwrite or risk-rate their premiums. A risk equalisation 'shadow period' commenced in 2005 and operated for a number of years. During the shadow period, data was collected and a risk adjustment structure developed. However, no transfers ever occurred between medical schemes and a risk adjustment system was never put in place. In 2012, the South African Council for Medical Schemes, the regulatory body overseeing medical schemes in the country, said that it was 'highly unlikely that a risk equalisation system will be implemented in the near future.'[12]

One of the main reasons that the system was never implemented was due to a change in government policy towards the introduction of universal health insurance, through National Health Insurance (NHI). Under NHI, the future of medical schemes as they currently exist is uncertain, resulting in a move away from the social motivations for risk equalisation. In addition, some sources have noted that the demographic composition of some of the medical schemes may have made the introduction of the risk equalisation mechanism challenging from a political perspective. The absence of a risk equalisation mechanism in South Africa, in addition to the voluntary nature of the health insurance market, resulted in an incomplete regulatory environment for the introduction of social solidarity and has been identified as one of the key drivers of lack of innovation and escalating costs in the private healthcare market.[13]

The most recent developments on risk equalisation in South Africa come from the Compe i ion Com is ion's Health Market Inquiry report, which was published in September 2019.[14] The report recommends the introduction of a risk adjustment mechanism to complement and benefit the NHI. Even if a risk equalisation system is implemented successfully, the political tensions surrounding healthcare may mean that the system is constantly under scrutiny and subject to ongoing changes and proposals for reform. This is certainly the case in the US since the introduction of the ACA in 2010. This situation in the US is considered further in Illustrative Example 16.

12 Buthelezi, L. (17 January 2012). Medical risk fund on back burner. BHF. Retrieved 6 December 2019 from http://ftp.bhfglobal.com/medical-risk-fund-back-burner-17012012.

13 Ramjee, S. & Vieyra, T. (October 2014). Neither Here nor There: The South African Medical Scheme Industry in Limbo. Retrieved 6 December 2019 from https://actuarialsociety.org.za/convention/convention2014/assets/pdf/papers/2014%20ASSA%20Ramjee%20Vieyra.pdf.

14 Competition Commission (September 2019). Health Market Inquiry. Retrieved 6 December 2019 from http://www.compcom.co.za/wp-content/uploads/2014/09/HMI-Executive-Summary.pdf.

ILLUSTRATIVE EXAMPLE 16: US POLITICAL REFORM

In the US, healthcare reform is consistently on the political agenda. The ACA, signed into law on March 10, 2010, was perhaps the most significant regulatory overhaul of healthcare since the introduction of Medicare and Medicaid in 1965. Since the ACA was passed, there have been attempts to expand, repeal, partially repeal, or otherwise disable various provisions of the law. In addition, ongoing litigation over aspects of the ACA, including the funding of its risk mitigation programs, continues to present challenges.

One example of this relates to the risk corridor program, which was designed to complement risk equalisation by protecting insurers from the risk of mispricing. During each of the first three years following full implementation of community rating and other major reforms, the program created a corridor around which gains and losses would be shared between insurers and the government. The federal government did not set aside funds for the possibility that the overall corridor payments for the program would be a net cost to the government rather than a net gain. Moreover, there was conflicting guidance to insurers about the collectability of risk adjustment receipts prior to insurers setting their initial premium rates. When experience emerged in the first year, the amount of risk corridor payments owed by the government to insurers greatly exceeded the payments owed by other insurers to the government. Insurers who owed the government were required to pay 100% of the calculated risk corridor amount, while insurers who were owed funds from the government received only 12% of the calculated amount[15].

As a result, many insurers, especially smaller insurers with less capital, went out of business, and many others decided it was in their best interest to discontinue offering coverage in the individual and/or small group markets entirely. These decisions left individuals in certain regions with limited options, hindering one of the ACA's key goals o increased acces ite the temporary nature of the isk cor idor program its early failure created significant market disruption and political conflict concerning the long-term viability of the core reform of implementing community rating supported by risk equalisation.

Another key pro i ion of the ACA was an in i idual mandate', a req irement for i izens to obt in health insurance from at least one source, which was intended to promote a stable mix of healthy and sick participants in health insurance markets under community rating. The individual mandate was repealed in 2019, while the community rating remains. This development will put upward pressure on premium rates because the anticipated exit of many healthy individuals from the market is a trend for which the risk equalisation program cannot provide relief.

In addition, the government has expanded alternative health insurance options that are outside the scope of the risk equalisation program: short-term limited duration policies and association health plans[16]. These plans are not req ired to pro ide comprehen ive coverage or follow many of the ACA's other market rules and could lead to further divisions in the individual market; in particular, these products could attract healthy individuals out of the risk equalisation program, weakening its foundation.

These and other alterations to ACA have made it difficult for insurers to set rates, manage reserves, and report financials, and for regulators to sustain stable markets.

There are several new healthcare reform proposals being debated at the time of writing this report, in conjunction with the run up to the 2020 US Presidential Election, some of which aim to introduce public options or increase eligibility for public programs like Medicare and Medicaid (commonly referred to as "Me icare for All". li i ians support a ingle payer system funded fully by the federal governmen . If public programs are expanded alongside the private insurance markets, the use of risk equalisation will remain an important factor in stabilising the US healthcare system. Even if more significant reform, such as single payer system, is implemented, risk equalisation may be used to neutralise risk across healthcare providers. Therefore risk equalisation may continue to be an integral part of the U.S. healthcare system under many different paths that political reform may bring.

15 Katterman, S. (5 October 2015). Headwinds Cause 2014 Risk Corridor Funding Shortfall. Milliman Healthcare Reform Briefing Paper. Retrieved 6 December 2019 from http://us.milliman.com/insight/2015/Headwinds-cause-2014-risk-corridor-funding-shortfall.

16 Busch, F. & Karcher, J. (22 August 2018). Association Health Plans After the Final Rule. Milliman White Paper. Retrieved 6 December 2019 from http://www.milliman.com/insight/2018/Association-health-plans-after-the-final-rule/.

GENERAL IMPLEMENTATION CHALLENGES

In addition to legal and political challenges, there may be general implementation issues that arise, particularly where healthcare reform or the introduction of risk equalisation systems is based on models in operation in different countries or territories. Such issues arose in Poland when the German healthcare system was used as the basis for reform of the Polish healthcare system in the late '90s, with little success. However, a similar system was introduced in the Czech Republic in the early '90s, with a combination of private health insurance and subsequently risk equalisation, and it is still in operation today. Illustrative Example 17 looks at these countries in further detail.

ILLUSTRATIVE EXAMPLE 17: HEALTHCARE REFORM IN POLAND AND THE CZECH REPUBLIC

Successful reform of a healthcare system depends on a country's specific socioeconomic and political background and as a result it can be difficult to simply duplicate another healthcare system without allowing for country-specific factors. In the 1990s both Poland and the Czech Republic introduced healthcare reform that was based on the Bismarck model, which had operated successfully in Germany for many years.

Fundamental healthcare reform was introduced in Poland in 1999 with the introduction of a government-run insurance model, based on the Bismarck model operating in Germany. The public insurers were called 'sickness funds' and healthcare premiums were financed by employees through payroll tax deductions. In total 17 public sickness funds were established. No private sector insurance was allowed. Each sickness fund was to manage financial resources coming from insurance premiums and ensure provision of medical services for its members by contracting with providers.

However the healthcare reform faced significant political challenge. Even before the sickness funds started operating the legislation was amended over 25 times,[21] with the initial insurance premium being reduced from 12% of salary to 7.5% of salary. Significant assumptions underlying the self-financing concept of the healthcare system were compromised from the beginning (including the number of sickness funds established—too high to ensure a minimum of 4 million to 5 million members, which was considered to be required for a fund to be self-financing). Not surprisingly, shortly after their introduction, significant differences in access to and quality of services were identified between the sickness funds. Members' dissatisfaction and financial problems led to further deterioration of the system. The main issue seemed to be around transparency of funding—tracking premiums for insured lives, transferring to sickness funds and financial settlements. However, no improvements were possible at that time due to the collapse of the government coalition. Ultimately, sickness funds were replaced by a central insurance public institution, the National Health Fund (Narodowy Fundusz Zdrowia, or NFZ) in 2003, with the aim of providing equal access to medical services for all citizens.

In contrast, in the Czech Republic, healthcare reform based on the Bismarck system was successfully implemented in 1992 and still functions today, with some modifications. There are seven sickness funds currently in operation[22] (from the 27 sickness funds initially established)—one public fund, the General Health Insurance Fund (Všeobecná Zdravotní Pišťovna, or VZP) covering 57% of the market, and six private insurance companies. The insurance premium is 13.5% of salary with two-thirds covered by an employer.[23]

A key difference of the system in the Czech Republic was the introduction of private insurers. This was also considered as part of the reform in Poland, but it would have required an appropriate system to track insurance premiums and ensure transparency, which was not in place at the time. In the Czech Republic, private health insurance funds (with a legal status as independent public entities or 'not-for-profit' insurers) were introduced in 1993, a year after the health reform was implemented and the VZP started it operations. The insurance funds were allowed to offer additional benefits on top of the standard benefit package (e.g., free travel health insurance, subsidies for wellness activities) and these were used to segment the market and attract younger, healthier lives. This resulted in the public VZP retaining the older, higher-risk lives. In 1994 a very simple risk equalisation scheme was used to redistribute about 60% of collected premiums between insurers based on the age of insured lives.

21 Medexpress.pl (18 March 2019). 43 amendments in total, XX-lecie Powszechnych Ubezpieczeń Zdrowotnych w Polsce. Retrieved 6 December 2019 from http://www.medexpress.pl/xx-lecie-powszechnych-ubezpieczen-zdrowotnych-4/73234.

22 OECD (7 December 2018). Improving the Czech Health Care System. Economics Department Working Papers No. 1522. Retrieved 6 December 2019 from http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=ECO/WKP(2018)70&docLanguage=En.

23 Bankier.pl (11 August 2007). In the Czech Republic, since 1993, 18 health insurance funds have gone bankrupt, only 9 more are left. Retrieved 6 December 2019 from https://www.bankier.pl/wiadomosc/W-Czechach-od-1993-r-zbankrutowalo-18-kas-chorych-zostalo-tylko-lub-az-9-1623783.html.

The current risk equalisation system in the Czech Republic redistributed funds according to a risk-adjustment scheme based on age, gender and pharmaceutical cost group (PCG). In addition, a HCCP results in ex post compensation payments of 80% of claims above a specific threshold[24] and makes up about 10% of total transfers. The redistribution is managed through a central account that is supervised by a board of directors comprising representatives from each of the sickness funds and various government minsters. The last risk adjustment factor, PCGs, was added in January 2018 as a way to improve the health-status element of the risk-adjustment scheme. This change took over seven years to implement, from the initial proposal, partly because it transpired that chronic patients were evenly distributed among health funds, resulting in only a marginal increase in the allocation of funds to the public VZP.

While the healthcare reform in both countries was based on the same underlying model, the Bismarck system in Germany, these examples show that successful implementation of health reform depends on the specific socioeconomic and political background in the country in which the reform is taking place. The Czech Republic was able to implement a dynamic healthcare system that could respond to changes such as the introduction of private insurance funds and risk equalisation and the system was allowed to adjust to its optimal self-financing level (due to sickness funds' defaults and mergers an increase i insurance pre ium .In Poland the introduction of Bismarck-based system was less successful in part due to inadequate transparency in relation to fund transfers and the level of political compromise to the initial structure of the system (especially related to the level of insurance premium and number of sickness funds). Lack of political support led to the deconstruction of the public healthcare system, which today still does not allow private insurance companies to operate within the public sector.

24 The threshold is equal to 15 times the average annual costs per member in the entire healthcare system

5. Summary

While the concept of risk equalisation is relatively easy to understand, designing and implementing a risk equalisation system to fit into an existing healthcare system can be a complex and time-consuming process. This paper sets out some of the key considerations in designing and implementing a risk equalisation system. When choosing risk adjusters, predictive accuracy and transparency are key factors to consider. Consideration also needs to be given to the benefits to include, the calculation approach taken (prospective or retrospective), the impact on competition and efficiency and how to deal with exceptionally high claims. The technical and legal aspects of the system need to be carefully constructed in order to protect the scheme from legal challenge in the implementation phase and, where possible, from the risk of ongoing political and legal challenge.

Risk equalisation has many advantages for a healthcare system, but its primary role is to facilitate affordable access to healthcare to high risk individuals. An efficient risk equalisation system can reduce insurers incentives to risk-select, resulting in greater competition in terms of efficiency, quality of service and consumer needs. This can increase innovation in the market and ultimately result in improved patient outcomes. However, risk equalisation can face significant challenges in its implementation, including legal and political challenges, particularly due to the large transfers of funds between insurers or healthcare providers.

The effectiveness of a risk equalisation scheme needs to be monitored on an ongoing basis once it is introduced, to ensure it has created the right incentives for insurers and healthcare providers. In addition, schemes are subject to regular updates to ensure they remain efficient for the current market.

How Milliman can help

Milliman is one of the leading experts in healthcare financing and delivery. We advise clients on a wide range of issues—from assessing the impact of healthcare reform on organisations or populations to streamlining operations while advancing the quality of patient care. Our consulting work is supported by a powerful tool kit of data analytics solutions and informed by the most trusted, comprehensive set of cost guidelines in the industry.

Risk equalisation is not a pure actuarial and/or data science. It involves many stakeholders, requires a multitude of expertise and requires continuous monitoring and improvement. We combine technical and analytical excellence with policy expertise, business acumen and country-specific knowledge, and work with our clients closely to develop accurate, robust and practical risk equalisation programs. Our consultants have designed and implemented risk equalisation programs, advised governments, insurers, healthcare providers and other healthcare professionals on risk equalisation systems around the world.

If you have any questions or comments on this paper, or on any other issues affecting risk equalisation, please contact any of the consultants below or your usual Milliman consultant.

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States Seek to Improve Affordability, Expand Coverage with "Public Option" and Medicaid Buy-in Proposals

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Abstract

Issue: The 2018 election brought with it new energy in statehouses and state legislatures to improve access to insurance coverage and fill gaps in current law. During the 2019 legislative sessions, at least ten states debated "public option" or "Medicaid buy-in" programs as mechanisms to expand coverage, lower premiums, and increase the number of plan options for consumers.

Goal: Assess states' goals in pursuing public option or Medicaid buy-in programs, the variety of mechanisms proposed, and critical issues for state consideration, such as the impact of such programs on state finances, providers, and consumers of other sources of coverage, including ACA-compliant individual market and employer-group plans.

Methods: Analysis of state legislation, laws, and published reports about public option or Medicaid-buy in proposals and structured interviews with state officials, legislators, and advocates in nine states.

Findings and Conclusions: Only one state – Washington – ultimately enacted a public option bill during the 2019 state legislative session. Five other states—Colorado, Maryland, Nevada, New Mexico, and Oregon—tasked agency officials or independent commissions to study and/or develop a Medicaid buy-in or public option program. These states share common goals, such as improving the affordability of insurance, reducing the uninsured, and offering consumers more plan choices. The states also share similar political and practical challenges to enacting and implementing a public option or buy-in proposal. These include stakeholder concerns and fiscal constraints, and considerations regarding the downstream impact on ACA marketplace and employer-sponsored coverage.

Background

The Affordable Care Act (ACA) has achieved remarkable success expanding insurance coverage to more people, reducing the uninsured rate from 16.3 percent in 2010 to 8.8 percent in 2017.[1] However, in the last two years there is some evidence that those coverage gains have eroded, and approximately 27.5 million people nationwide lacked coverage throughout 2018.[2] The primary reason cited for being uninsured is the lack of an affordable coverage option.[3]

Deep ideological differences in the U.S. Congress have inhibited federal action to expand coverage beyond current levels, but the 2018 election brought with it new energy in statehouses and state legislatures to improve access to insurance and fill gaps in current law. During the 2019 legislative sessions, this energy manifested itself in several ways, including five new states with reinsurance programs, two states with a new individual mandate penalty, and state-funded premium subsidies in California.[4] Additionally, at least ten states debated "public option" or "Medicaid buy-in" programs as mechanisms to expand coverage and improve affordability.

Medicaid buy-in and public option proposals can vary widely in their design and impact. Conceptually the Medicaid buy-in would allow individuals with incomes too high to qualify for Medicaid under current eligibility rules to "buy in" to the program.[5] Some states are also considering leveraging the purchasing power of the Medicaid program to reduce provider prices and thus improve coverage affordability for people enrolled in commercial insurance. One version of this is the ACA-authorized Basic Health Plan (BHP) program. The BHP is an option for states to leverage federal premium subsidy dollars to cover low-income residents (up to 200 percent of the federal poverty level) through state-contracted plans outside the ACA marketplaces. Years before the 2019 state legislatures were considering public option or Medicaid buy-in proposals, New York and Minnesota adopted the BHP. New York and Minnesota's BHPs have been able to offer enrollees comprehensive benefits at a lower cost than private marketplace plans, largely because they pay lower rates to providers.[6] The BHP can also be a platform for states to subsidize the enrollment of certain residents who are ineligible for marketplace coverage, such as undocumented immigrants.

The public option concept envisions a state-backed health plan that would compete in the individual market with private plans.[7] However, the amount of state backing can vary. At one end of the spectrum, the state would design the benefits, set the premium rate, build the network, conduct the marketing and consumer support, and bear the full financial risk of paying claims. In other proposals, such as in Washington, the government's involvement is less, with the responsibility for plan network design, operation, and risk delegated to private insurers. While state officials are charged with developing a plan to provide additional subsidies for marketplace coverage, Washington has not committed any additional funds to subsidize plan costs for public option enrollees.

Findings

Enacting a Public Option or Medicaid Buy-in: States Share Similar Goals as well as Political, Policy Challenges

Although legislatures in at least ten states considered Medicaid buy-in or public option proposals in 2019, only six states ultimately enacted legislation to advance or study the concept. Of these, only one (Washington) authorized a program.[8] The remaining five authorized feasibility studies or recommendations to implement either a Medicaid buy-in or public option plan (see Exhibit 1).

Several other state legislatures, including in Connecticut and Minnesota, seriously considered, but ultimately did not enact public option legislation. In pursuing public option or Medicaid buy-in programs, state goals included improving affordability, increasing competition, and reducing the number of uninsured. Different goals may dictate different policy choices for the public option or buy-in plan. For example, both Washington and Colorado focus in part on reducing premiums in the individual market. Reducing premiums can help individuals who are ineligible for Medicaid or the ACA's premium subsidies find more affordable coverage. However, critics have noted that it can have the perverse effect of reducing the buying power of subsidized marketplace enrollees because the ACA's premium tax credits are pegged to premiums.[9] In another state where the primary goal is to increase competition, a "fallback" public plan solely for areas that have only one or two insurers might become an attractive policy option.

Exhibit 1. State Public Option/Medicaid Buy-in: Enacted Legislation, 2019

State	Policy Goal(s)*	Program Type	Legislative Result	Timeline
Washington	• Improve affordability • Increase competition	Public Option	State to contract with insurers to offer a plan with a network of providers paid at a government-set rate; insurers would be allowed to also offer plans at commercially negotiated rates.	Public option to be available by January, 2021
Colorado	• Improve affordability, access • Increase competition	Public Option	Recommendations	Due to legislature by November 15, 2019; Public option to be available by January, 2022
Maryland	• Improve affordability • Market stability	Medicaid buy-in	Study	Due to legislature via annual report
Nevada	• Reduce uninsured • Improve affordability • Increase competition, particularly in high-premium areas	Public Option	Study	Due to legislature in 2020
New Mexico	• Improve affordability • Reduce uninsured	Medicaid buy-in	Study	To be conducted in 2019-2020 (no deadline provided)
Oregon	• Reduce uninsured	Medicaid buy-in Public Option	Study	Due to legislature by May 1, 2020

*As described in legislative text and in interviews with state officials, legislators and stakeholders.

State Approaches

Under Washington's "Cascade Care" program, all insurers participating in the individual market will have to offer some plans with standardized benefits that, among other things, provide more pre-deductible coverage of high-value services. Private insurers that choose to offer a public option health plan must also limit the amount they pay providers and adhere to additional quality and value requirements. These insurers will operate and market their public option plans and will ultimately bear the financial risk of enrollees' health care costs. They are also permitted to continue to market plans in which they pay commercially negotiated rates to providers, which would have to compete alongside the public option plan.

Colorado's legislature gave its Medicaid and insurance agencies broad latitude to develop policy recommendations for a public option plan. Their proposal, released in November 2019, is similar to Washington's program in that it relies on private insurers to deliver the benefits and cover claims, but sets limits on their payments to hospital providers.[10] While it also would require insurers to offer standardized benefit designs, it differs from Washington's approach in key areas (see Exhibit 2).

Exhibit 2. The Washington and Colorado State Public Option Plans

Key Features	Washington	Colorado
How will the plan be offered?	The plan will be marketed through the state's health insurance marketplace and sold by private insurers that contract with the state.	Private insurers in the individual market will be required to offer the public option plan on and off-marketplace to ensure at least two insurers per county.
Who's eligible?	Those seeking individual market insurance, whether or not eligible for premium tax credits.	Those seeking individual market insurance, whether or not eligible for premium tax credits. In future years, the plans may be available to small employers. Self-funded employer plans may "opt in."
How will premiums be reduced?	Providers will be reimbursed at a maximum of 160% of Medicare rates[a] Standardized benefit design[b] State officials must study how to support state premium subsidies for people with incomes below 500 percent of the federal poverty level	Hospitals reimbursement will be capped based on a fee schedule (in development)[c] Plans must spend 85 percent of premiums on patient care Rebates from drug manufacturers or benefit managers must be passed onto policyholders Standardized benefit design[d]
When will the plans be available?	January, 2021	January, 2022

Source: 66th Legislature of Washington State, 2019 Regular Session, Ch. 364, Laws of 2019; Colorado Department of Regulatory Agencies and Department of Health Care Policy & Financing, "Final Report for Colorado's Public Option," Nov. 15, 2019.

[a] Excludes pharmacy benefits and rural hospitals. Reference pricing based on Medicare rates for "the same or similar services in the statewide aggregate." Primary care services (defined by the Washington Health Care Authority) must be reimbursed at least 135 percent of Medicare. Beginning in 2023, the Washington Health Care Authority may waive this contracting requirement if rates for the public option plan are determined to be no greater than the prior year's rates (adjusted for inflation), or if the Director of the Health Care Authority determines that the requirement prevents the insurer offering the public option plan from meeting network adequacy standards, and the carrier can attain actuarially sound premiums at least 10 percent lower than the prior plan year through different means.

[b] Public option plans will offer state-prescribed benefits and cost-sharing amounts. In addition, all insurers offering exchange plans will be required to offer at least one standard silver plan and at least one standard gold plan through the exchange beginning in January, 2021. Insurers offering any bronze exchange plans will also be required to offer at least one standard bronze plan.

[c] Colorado's public option plans would be required to reimburse hospitals based on a state-established, hospital-specific formula designed to "improve efficiency" and reduce "exorbitant prices." The draft report proposed capping hospital reimbursement at between 175 and 225 percent of the Medicare payment rate.

[d] Colorado's public option plans would be required to cover more primary and preventive care services that enrollees can access without having to meet their deductible.

Colorado's legislature will need to approve key elements of the plan, including provisions limiting the amount that participating insurers would pay hospitals and requiring that two insurers in every county offer a public option plan.[11]

New Mexico sought to adopt a Medicaid buy-in for residents who do not have access to Medicaid or Medicare, employer-sponsored insurance, or federal premium tax credits. According to a state official, the state's goal was to assist consumers who do not qualify for marketplace subsidies, including spouses and dependents deemed ineligible because of access to employer-sponsored coverage (often referred to as the "family glitch"),[12] and undocumented immigrants. Efforts foundered in the wake of a fiscal analysis projecting an annual state cost of up to $81 million per year, and advocates settled for a $132,000 appropriation to study the issue.[13,14]

Nevada is studying three possible approaches: (1) allowing individuals to buy in to its state employee health benefit plan, (2) offering a public option solely in those regions that currently lack private insurance choices and where consumers face high premiums, or (3) offering a statewide plan through a public-private partnership.[15] Maryland's study of the Medicaid buy-in is part of a broader state market stabilization strategy, and the commission's mandate includes a review of other policy proposals, including merging the individual and small-group markets, adopting a BHP, standardizing benefit designs, and supplementing federal subsidies with state dollars.[16] In Oregon, a newly created Task Force on Universal Health Care is charged with recommending the design of a "well-functioning single payer health care financing system," and the Oregon Health Authority will separately develop a plan for a Medicaid buy-in or public option program that can cover Oregon residents without current access to health care, at no net cost to the state.[17]

Easier Said Than Done: Political and Policy Challenges

- **Stakeholder concerns**

  Ultimately, to meet their goals of expanding affordable coverage to more people, states have two primary but not mutually exclusive choices. One is to tackle the primary source of high insurance costs by limiting provider reimbursement.[18] This can ignite strong opposition from politically powerful providers. For example, Colorado's proposal for a public option plan, which reduces premiums by constraints on provider prices, has drawn a strong critical reaction from the state's hospital lobby.[19] Washington's public option proposal initially proposed paying providers at 100 percent of Medicare rates, but legislators increased that limit to 160 percent of Medicare in the final bill, reducing premium savings for consumers. Policymakers cited opposition from providers who feared a cut in revenue. However, providers may still be reluctant to join the public option's network at even 160 percent of Medicare rates.[20]

  States must also grapple with resistance from insurance companies. Washington legislators, for example, reported surprise at how strong initial insurer opposition was to their bill, with one noting: "I thought that they would welcome the idea of putting some limits on the providers." Officials and media in Connecticut reported that even though insurers were "at the table" during negotiations over their public option proposal, last minute threats from Cigna to move its Hartford headquarters to a different state effectively killed the bill.[21] "That threat has a lot of power in Connecticut," said one official. "…[I]t scared off too many important or key members [of the legislature]."

  However, insurers' views do not appear to be monolithic. While some seem prepared to battle any additional amount of government involvement in health plan development or administration, state officials reported that other insurers were more flexible. For example, Washington legislators found that several insurers ultimately either supported their bill or committed not to oppose it, in part because they recognized the cost-saving potential of reduced provider rates.

- **Fiscal concerns**

  A second option is to use state money to supplement federal financial assistance under the ACA or to expand access to state public programs. However, proposals that could require state resources or put the state at financial risk face significant hurdles. For

example, a participant in Colorado's development of a public option proposal noted that the state was unable to raise any general funds due to its "Taxpayer Bill of Rights" law, which prevents the state from raising taxes without voter approval. The law effectively eliminates the ability to take on any insurance risk or improve affordability through state-funded subsidies. Similarly, Nevada collects no income tax, leaving the legislature with "very constrained revenue options" for any buy-in program. Oregon's legislature has charged the Task Force on Universal Health Care with devising a Medicaid buy-in or public option program that has "no net cost" to the state. In New Mexico, policymakers expressed an initial willingness to consider state financial support for a Medicaid buy-in, but ultimately could not agree to the price tag for covering thousands of uninsured residents including undocumented immigrants. California's new program using state funds to significantly expand premium and cost-sharing subsidies for marketplace coverage, and Massachusetts' and Vermont's supplementation of federal premium tax credits, are notable exceptions.[22]

- **Interaction with federal policy**

  Reducing the overall cost of coverage—through Medicare reference pricing or some other means—can enable the state to apply for an ACA "Section 1332" waiver from the federal government. The 1332 waiver allows a state to modify provisions of the law in order to pursue state health reform goals. If those changes result in lower premiums (and thus lower costs for the federal government due to reduced premium tax credits), the state can seek "pass through" funding and capture those savings to support coverage expansion.[23] Although Washington did not seek a 1332 waiver to support its public option plan, Colorado officials have signaled an intent to do so. However, the prospects for such a waiver being approved are uncertain. The current administration has made clear it will not look favorably upon a waiver that seeks to improve access to public coverage and rejected a prior Colorado plan to use Medicare reference pricing to help fund an individual market reinsurance program. [24, 25]

Implications of Buy-in, Public Option Plans for the Individual and Employer Plan Markets

- **The Individual Market**

  Depending on their structure, public option and Medicaid buy-in programs may have a significant impact on the stability of the ACA-compliant individual market. Key design questions include:

  - **Who is eligible for the plan? Is the goal primarily to help consumers above 400 percent of the federal poverty line (and ineligible for federal premium subsidies), or lower-income enrollees?** Will the plan be an alternative to marketplace coverage (as with the BHP and potentially a Medicaid buy-in)? States may have more leeway under federal rules to design off-marketplace programs and to target them to certain populations. However, plans available only outside the marketplace, if offered as an alternative to marketplace coverage, could negatively affect the marketplace's financial stability and reduce incentives for private insurers to participate, particularly in lower-population areas. A program designed to improve affordability for unsubsidized individuals by reducing individual market premiums (an aim of Washington's Cascade Care and Colorado's public option proposal, as well as most other public option concepts) might broaden the risk pool and promote market stability. At the same time, it could lower premium tax credits for the subsidized population, raising the risk that some lower-income enrollees might drop their coverage.
  - **How will risk be shared?** Will the plan participate in the ACA's risk adjustment program or a state reinsurance program? If a public option or Medicaid buy-in plan draws healthier individuals away from the ACA-compliant individual market, it could drive up premiums. Alternatively, it could attract individuals who are sicker on average than those in the ACA market. In both cases, the state may need to institute a risk-sharing program.

- **How will the program affect choice of private plans?** Under the ACA, private insurers' participation in the marketplace is optional. Will competition from a lower-cost, publicly backed plan discourage private insurers from offering marketplace plans? On the other hand, will a state's commitment to its market and partnership with carriers lead to greater stability and a more attractive market in which to participate?

  Notably, Washington and Colorado, which have the two most developed public option plans to date, will preserve the role of private insurers to offer plans, build provider networks, and bear the risk of paying medical claims. Indeed, stakeholders reported that a BHP option was off the table, given the risk that it would siphon enrollees away from the ACA marketplace. Washington's role (and Colorado's proposed role) are largely limited to capping provider payment rates and prescribing a standard benefit design. These states have also thus far chosen to have the public option offered through the ACA marketplace, keeping enrollees in the individual market risk pool and enabling those eligible to qualify for federal premium and cost-sharing assistance.

- **The Employer Group Market**

  Less intuitively, states will also need to think about the impact of a public option or buy-in plan on their employer group market. For example, in Washington, policymakers received projections from insurers suggesting their proposal would undermine the insurance market for small businesses. Insurers in that market opposed setting provider rates at 100 percent of the Medicare rate, arguing that the availability of a low-cost individual market option would encourage more small employers to drop their group plans and send employees to the public option plan. This would also have the effect of reducing provider revenues further. Increasing the limit to 160 percent of the Medicare rate ensured that premiums for the public option plan would be closer to those available in the small-group market, enabling these insurers to drop their initial opposition. Using Medicare as a reference price for a public option plan has also raised complaints among some employers who claim that providers will demand higher prices from employer group plan payers to make up for any lost revenue from the public option, although there is little empirical evidence to support such concerns.

Conclusion

Public option and Medicaid buy-in plans promise to leverage the power of state government to offer residents a lower-cost option for comprehensive coverage. Depending on their design, these programs have the potential to reduce a state's uninsurance rate, promote competition, and address, at least modestly, underlying health care costs. To achieve these goals, however, states face real challenges. Though payments to providers represent the biggest driver of health care costs,[26] a program that works by constraining provider prices will face strong provider opposition. Insurers have also made clear their concerns about competing with a public plan, even one designed as a public-private partnership, as in Washington and Colorado. Meanwhile, efforts that rely on state dollars to subsidize coverage may be fiscally infeasible for many states. States must also consider whether to apply for a 1332 waiver and how a public option or Medicaid buy-in plan will affect premiums and plan choices for consumers in the ACA's marketplaces, which have only recently begun to stabilize, as well as potential impacts on the employer group market. Further, continued state-level debates over these proposals must take place in the context of a 2020 presidential debate during which candidates are proposing sweeping national reforms. However, should Washington and Colorado successfully implement programs that constrain provider prices to improve affordability and preserve enrollees' access to services, they may serve as models for other states and for those contemplating national reforms.

Acknowledgments

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By Coleman Drake and David M. Anderson

Terminating Cost-Sharing Reduction Subsidy Payments: The Impact Of Marketplace Zero-Dollar Premium Plans On Enrollment

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ABSTRACT **The termination of cost-sharing reduction subsidy payments to insurers in 2017 by the administration of President Donald Trump resulted in a proliferation of Marketplace plans having zero-dollar premiums in 2018 and 2019. While it is known that lower premiums increase Marketplace enrollment, it is not clear whether a zero-price effect exists in which enrollment spikes when health insurance is free. We examined whether such an effect exists and found that increased availability of zero-dollar premium plans would have caused a 14.1 percent enrollment increase among lower-income Marketplace enrollees in 2019. If zero-dollar premium plans had not been available in 2019, our simulation results suggest that enrollment in the federally facilitated Marketplace would have decreased by roughly 200,000 enrollees. When we accounted for this zero-price effect, we found that variation in premiums above zero dollars was not associated with enrollment changes. These results suggest that efforts to insure lower-income populations should focus on making health insurance free to potential enrollees, instead of simply reducing premiums. However, increased enrollment in zero-dollar premium plans could result in increased cost sharing among Marketplace enrollees and increased federal outlays for Advance Premium Tax Credits.**

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On October 12, 2017, the administration of President Donald Trump terminated cost-sharing reduction (CSR) subsidy payments to insurers servicing the Marketplaces created by the Affordable Care Act (ACA).[1] The subsidies reduce out-of-pocket spending for qualifying Marketplace enrollees. To qualify for a subsidy, people must select a silver plan with an actuarial value approximating 70 percent and have household incomes at or below 250 percent of the federal poverty level—about $31,000 for an individual in 2019. While insurers have not been directly reimbursed for CSR subsidies, they are still legally obligated to provide them to qualifying enrollees.[2]

Forty-three state insurance commissioners responded to the CSR subsidy payment cuts by implementing a "silver loading" strategy in 2018. Under silver loading, insurers offset the loss of the subsidy payments by increasing only the premiums of silver plans instead of increasing the premiums of all plans.[3] Thus, under silver loading, premiums of nonsilver plans are unaffected by the CSR subsidy payment cuts.

Silver loading also increased the affordability of Marketplace plans for subsidized enrollees by increasing their Advance Premium Tax Credits (APTCs). These subsidies cap the premium of the benchmark silver plan as a percentage of modified adjusted gross income for qualified Marketplace enrollees (those earning 100–400 percent

of poverty). The benchmark plan is a silver plan, and thus silver loading created larger spreads between the premiums of the benchmark plan and less expensive plans.

Marketplace enrollees can purchase a zero-dollar premium plan when their premium tax credit exceeds the postsubsidy premium of at least one plan. While zero-dollar premium plans have been available to some Marketplace enrollees since 2014, the CSR subsidy payment termination dramatically increased exposure to or availability of these plans by creating larger spreads between the premiums of the benchmark plan and nonsilver plans. In 2018 a forty-year-old with an income of $25,000 could purchase a zero-dollar premium plan in 1,679 counties—up from roughly 220 counties in 2017.[4]

Consumers' decisions to purchase health insurance may be a matter of whether they can do so for free, rather than for the dollar amount that health insurance costs. The behavioral economics literature suggests that a "zero-price effect" exists that makes people regard products with a zero price as intrinsically attractive.[5] Although zero-dollar premium plans have existed for decades, the zero-price effect has received little attention. Thomas Buchmueller and Paul Feldstein identified a zero-price effect in employees' choice of group health plans.[6] Rudy Douven and coauthors identified a zero-price effect in a web-based survey and argued that zero-price effects exist in Medicare Advantage plan choice.[7] However, neither study examined whether zero-price effects influence the decision to become insured.

Douglas Keith Branham and Thomas DeLeire examined zero-dollar premium plans in the Marketplaces and found that they were frequently chosen by enrollees in 2018.[8] The Congressional Budget Office projected that the CSR subsidy payment termination would increase Marketplace enrollment by one million enrollees per year as a result of lower net premiums for subsidized buyers.[9] However, it did not appear to have considered the zero-price effect.

In this study we examined whether a zero-price effect exists in potential enrollees' decisions to become insured in the Marketplaces. We used premium and enrollment data from the federally facilitated Marketplace (HealthCare.gov) and from California's state-based Marketplace (Covered California). The elimination of CSR subsidy payments acted as a natural experiment that created large, plausibly exogenous variation in exposure to the zero-price effect within US counties over time. Including California added to the richness of our analysis because, unlike other states, California sets a premium floor of one dollar to cover abortion services. Estimates of the size of the zero-price effect indicate how 2018 and 2019 enrollments were affected by the availability of zero-dollar premium plans, as well as how much Marketplace enrollment could have increased if zero-dollar premiums plans had been more widely available.

Study Data And Methods

DATA Our primary data sources were the Centers for Medicare and Medicaid Services' Marketplace Open Enrollment Period Public Use Files and the Qualified Health Plan Landscape Files from HealthCare.gov, both for 2015–19. The enrollment data report the number of enrollees in each county-year, stratified separately by age and income groups (categorized as incomes of 100–150 percent, 151–200 percent, 201–250 percent, and 251–400 percent of poverty). The Landscape Files list the premiums of Marketplace plans in each county-year. Both data sources were restricted to the thirty-nine states that used the federally facilitated Marketplace for at least one year in the study period. We also included analogous enrollment and premium information from Covered California, which were available for 2016–19. Enrollment data for Hawaii and Kentucky were unavailable until 2016 and 2017, respectively, so excluded both states from our descriptive analyses. We excluded Alaska and Nebraska from all analyses (discussed below) because their rating areas are not defined according to counties. Finally, we excluded South Dakota from our regression analyses in 2019 because it changed its rating-area definitions.

We supplemented these data with lists of Medicaid managed care insurers and states that expanded eligibility for Medicaid from the Henry J. Kaiser Family Foundation. Our unit of analysis was the county-year, which we stratified by income group. Our final sample consisted of 12,919 county-years, representing 2,780 counties.

STUDY VARIABLES We sought to understand how Marketplace enrollment responded to both premium levels and the zero-price effect. Ideally, we would have observed individual enrollees' demographic characteristics, which would have enabled us to calculate their post–premium tax credit premiums. However, the Open Enrollment Period Public Use Files contain information on enrollment only at the county-year–income group and county-year–age group levels.

We addressed this limitation by using a two-step process to calculate the minimum premium, defined as the post-APTC premium of the lowest-cost plan for a representative enrollee in each county-year–income group. First, using premi-

Our findings suggest that making zero-dollar premium plans widely available could be a powerful tool for increasing enrollment.

um data from the Landscape Files, we calculated the post-APTC premium of the lowest-cost plan for single adults ages twenty-five, forty-five, or sixty at the midpoint of each income group (that is, with incomes of 125 percent, 175 percent, 225 percent, or 325 percent of poverty). These ages approximate the midpoints of age groups reported in the Open Enrollment Period Public Use Files (ages 18–34, 35–54, and 55–64). Second, for the midpoint of each income group, we calculated the minimum county-year premium as the average of the post-APTC premium of the lowest-cost plan available to single, nonsmoking adults ages twenty-five, forty-five, or sixty, weighted by enrollment in each age group. We provide a more detailed description of this approach in the online appendix.[10] Because we did not observe individual enrollees' demographic characteristics, it is important to note that this measure of minimum premiums is an approximation of the minimum premiums faced by enrollees in a given county-year–income group.

The percentage of enrollees exposed to the zero-price effect was calculated similarly to how we calculated minimum premiums. For each county-year–income group, we created three binary indicators for whether the minimum premium for each of the three age groups was zero. Then, we took the age group enrollment-weighted average of these binary indicators, thereby creating a continuous measure of zero-premium exposure (that is, an approximation of the percentage of enrollees within an income group with a zero-premium plan available to them) that ranged from 0 (no exposure or availability) to 1 (universal exposure or availability).

STATISTICAL ANALYSIS We estimated multivariate log-linear regression models at the county-year level for each income group to estimate the impact of monthly minimum premiums and zero-premium exposure on Marketplace enrollment. We included county fixed effects to account for time-invariant county demographics, provider market characteristics, and state regulatory standards. We included year fixed effects to capture overarching changes in the federally facilitated Marketplace over time. We controlled for insurance market characteristics that could affect enrollment, including whether the county was in a Medicaid expansion state, the number of insurers in a county, and whether a Blue Cross–affiliated or Medicaid managed care insurer was present in a county. We clustered standard errors at the rating-area level, since insurers must price their plans uniformly across rating areas.

These models relied on within-county variation in premiums and zero-premium exposure over time to identify the effects of these variables on enrollment. While they contained a robust set of control variables, it is possible that unobserved time-varying county characteristics—such as advertising from insurers or perceptions of product quality—biased our estimates.

To address both of these concerns and assign a causal interpretation to our results, we estimated instrumental variables models using Hausman instruments,[11] with variation in premiums from other counties within the same state and income group used to isolate exogenous variation in minimum premiums and zero-premium exposure free of bias from unobserved plan characteristics that could affect enrollment. We discuss this approach and its assumptions in detail in the appendix.[10]

LIMITATIONS We acknowledge that our study had three limitations. First, we did not observe individuals' enrollment decisions, only aggregated county-year–income group enrollment. We were thus able to estimate enrollees' sensitivity to premium and zero-price effects only across income groups—not within them, as would be possible with individual-level data.

Second, we did not observe substantial variation in zero-premium exposure for the group with incomes of 101–150 percent of poverty at the county-year level. That exposure has been close to 100 percent in all counties since 2015.

Third, we did not observe the uninsured or their decisions to remain uninsured. Our inferences regarding Marketplace enrollment were thus limited to observed changes in Marketplace enrollment.

Study Results

DESCRIPTIVE STATISTICS In 2015 zero-dollar premium plans were available for forty-five-year-old nonsmoking enrollees with incomes of 151–200 percent of poverty in 13.2 percent of counties, for those with incomes of 201–250 percent

of poverty in 0.1 percent of counties, and for those with incomes of 251–400 percent of poverty in no counties (exhibit 1). In 2018 the plans were available for identical enrollees in 83.1 percent, 50.3 percent, and 6.6 percent of counties, respectively. Zero-premium exposure increased slightly in 2019 across income groups, apart from a slight 1.5 percentage-point-decrease for those with incomes of 100–150 percent of poverty. In that year 98 percent of counties had 100 percent exposure for forty-five-year-old nonsmoking enrollees in the lowest income group. We observed little variation over time in exposure for this group. Exposure exhibited similar trends for twenty-five-year-old and sixty-year-old enrollees, as shown in appendix exhibit A2.[10]

Appendix exhibit A1 maps zero-premium exposure in 2016–19 by county among the group with incomes of 151–200 percent of poverty.[10] There was large geographic variation in exposure before 2018. Afterward, exposure increased to nearly 100 percent in twenty-eight of the forty sample states. Notable exclusions included Arkansas, California, Indiana, Mississippi, and New Jersey.

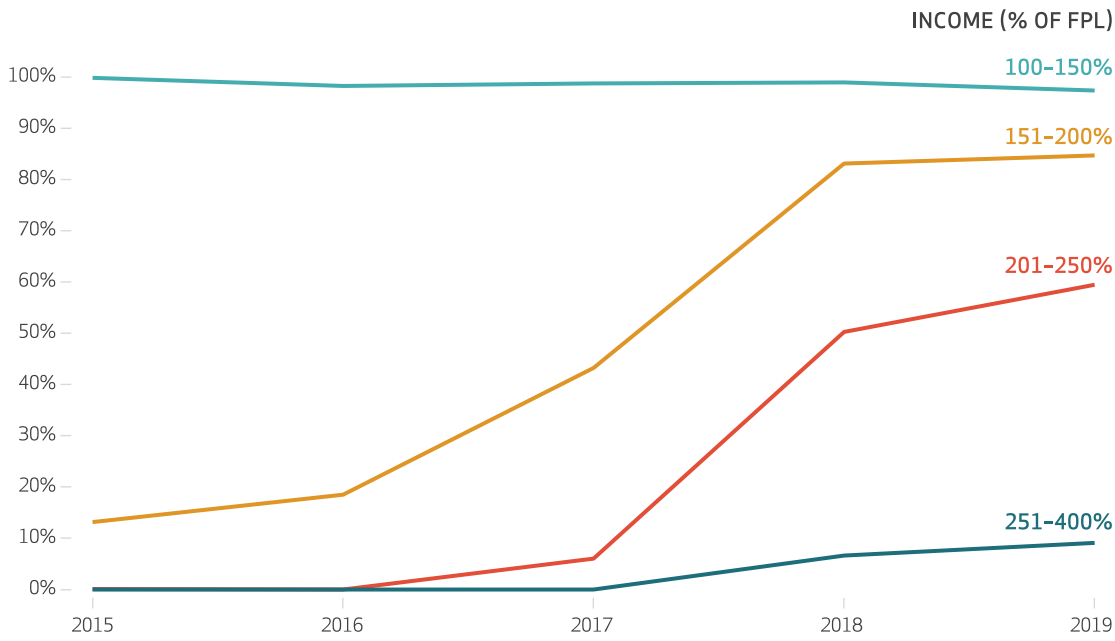
Because of the Marketplace subsidy design, minimum premiums for subsidized people decreased with age and increased with income (exhibit 2). Before 2018 primarily poorer and older enrollees were exposed to zero-dollar premium plans. Illustrating the shift, in 2018 and 2019, on average, zero-dollar premium plans became available to 69.8 percent of twenty-five-year-old enrollees in the group with incomes of 151–200 percent of poverty, 54.9 percent of forty-five-year-old enrollees in the group with incomes of 201–250 percent of poverty, and 51.8 percent of sixty-year-old enrollees in the group with incomes of 251–400 percent of poverty.

REGRESSION ANALYSIS Exhibit 3 shows the results of our instrumental variables analyses. We estimated models that did and did not control for the zero-price effect to determine whether the effect had an impact on enrollment, and whether not considering the zero-price effect might lead to incorrect conclusions about the relationship between minimum premiums and enrollment.

Coefficients represent predicted percentage changes in enrollment (after proper transformations) in response to a $100 increase in minimum premiums and increasing zero-premium exposure from 0 percent to 100 percent, respectively. Our main finding pertained to the group

EXHIBIT 1

Percent of counties in which zero-dollar premium plans were available to federally facilitated Marketplace enrollees, by income group, 2015–19



SOURCE Authors' analysis of data for 2015–19 from the Open Enrollment Period Public Use Files and Qualified Health Plan Landscape Files. **NOTES** Results were calculated for forty-five-year-old nonsmokers. Results for twenty-five-year-old and sixty-year-old nonsmokers are in online appendix exhibit A2 (see note 10 in text). Enrollees with household incomes below 100 percent or above 400 percent of the federal poverty level (FPL) do not qualify for Advance Premium Tax Credits and thus cannot obtain a zero-dollar premium plan. Hawaii, Kentucky, and California were excluded, as explained in the text.

EXHIBIT 2

Minimum monthly premiums across counties, by income and age groups of federally facilitated Marketplace enrollees, before and after cost-sharing reduction subsidy payment cuts in the Marketplace, 2015–19

Income (% of FPL)	2015–17 Minimum monthly premium ($) Mean	2015–17 Minimum monthly premium ($) SD	2015–17 % of enrollees with access to a zero-dollar premium plan	2018–19 Minimum monthly premium ($) Mean	2018–19 Minimum monthly premium ($) SD	2018–19 % of enrollees with access to a zero-dollar premium plan
25-YEAR-OLD						
100–150%	0.2	1.5	94.2	0.4	2.5	97.1
151–200%	38.4	18.3	6.2	10.3	19.9	69.8
201–250%	109.0	21.6	0.0	52.8	42.5	16.1
251–400%	197.5	37.4	0.0	193.3	56.5	0.9
45-YEAR-OLD						
100–150%	0.1	0.9	98.9	0.3	2.1	98.2
151–200%	20.5	18.9	24.9	5.4	15.1	83.9
201–250%	86.1	29.6	2.1	26.5	40.7	54.9
251–400%	227.1	30.9	0.0	149.6	76.3	7.9
60-YEAR-OLD						
100–150%	0.0	0.5	99.9	0.1	1.1	98.6
151–200%	3.1	9.3	85.3	1.7	10.0	96.6
201–250%	32.8	33.3	29.4	8.7	25.8	84.1
251–400%	166.2	55.9	1.5	54.3	80.2	51.8
AGE WEIGHTED						
100–150%	0.1	0.8	98.1	0.2	1.6	98.2
151–200%	18.6	14.4	42.1	5.0	13.0	85.6
201–250%	72.5	28.4	11.5	25.4	33.2	57.9
251–400%	197.5	34.4	0.6	121.6	69.8	23.5

SOURCE Authors' analysis of data for 2015–19 from the Open Enrollment Period Public Use Files and Qualified Health Plan Landscape Files. **NOTES** Hawaii, Kentucky, Alaska, and Nebraska were excluded, as explained in the text. All calculations are made for nonsmokers. FPL is federal poverty level. SD is standard deviation.

with incomes of 151–200 percent of poverty. When zero-premium exposure was not included in the model for this group, we found that a $100 increase in monthly minimum premiums would cause a 30.3 percent decrease in enrollment in the group. However, when zero-premium exposure was included, we found that increases in minimum premiums were not significantly asso-

EXHIBIT 3

Changes in enrollment in the federally facilitated Marketplace and Covered California resulting from a $100 increase in minimum monthly premiums or making a zero-dollar premium plan available, by enrollee income group

Covariate	Enrollment change for incomes of: 100–150% of FPL	151–200% of FPL	201–250% of FPL	251–400% of FPL
Models that did not control for zero-premium exposure				
$100 increase in minimum premium	−99.94%****	−30.30%****	−19.75%****	−18.86%****
Make a zero-dollar premium plan available	—[a]	—[a]	—[a]	—[a]
Models that did control for zero-premium exposure				
$100 increase in minimum premium	−99.98%***	−12.72%	−17.22%****	−20.47%****
Make a zero-dollar premium plan available	−12.20	14.11***	4.96	−7.85

SOURCE Authors' analysis of data for 2015–19 from the Open Enrollment Period Public Use Files and Qualified Health Plan Landscape Files, analogous enrollment and premium data from Covered California, Henry J. Kaiser Family Foundation. Status of state Medicaid expansion decisions: interactive map [Internet]. San Francisco (CA): KFF; 2019 Nov 15 [cited 2019 Dec 3]. Available from: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/, and Henry J. Kaiser Family Foundation. Medicaid managed care tracker [Internet]. San Francisco (CA): KFF; [cited 2019 Dec 3]. Available from: https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/. **NOTES** The sample includes 12,919 county-years of data for the federally facilitated Marketplace and Covered California. California was excluded in 2015 because data on enrollment during the open enrollment period are not available for that year. Hawaii, Kentucky, South Dakota, Alaska, and Nebraska were excluded in some or all years of the analysis, as explained in the text. All specifications included county-year insurance market characteristics and county and year fixed effects. All models were estimated using an instrumental variables approach. Postsubsidy premiums and zero-premium exposure were instrumented with Hausman instruments (the appendix provides details; see note 10 in text). Standard errors were clustered by rating areas. FPL is federal poverty level. [a]Zero-premium exposure was not included in these models. ***$p < 0.01$ ****$p < 0.001$

ciated with changes in enrollment. Instead, changing zero-premium exposure from 0 percent to 100 percent caused a 14.1 percent increase in enrollment in this group. These results indicate that it is not premium levels that influence enrollment for lower-income enrollees, but whether a plan with a zero-dollar premium is available.

We did not find that zero-premium exposure caused a significant change in enrollment for enrollees with incomes above 200 percent of poverty. In contrast, a $100 increase in monthly minimum premiums caused a 17.2 percent decrease in enrollment for enrollees in the group with incomes of 201–250 percent of poverty. Similarly, a $100 increase in minimum premiums caused a 20.5 percent decrease in enrollment for the group with incomes of 251–400 percent of poverty.

Our results for the lowest income group suggest that this group was extremely sensitive to minimum premiums, with a $100 increase in minimum premiums associated with a near-total decrease in enrollment. We did not detect a significant association between zero-premium exposure and enrollment for this group. We suspect, though we cannot confirm, that these findings are a result of the small number of county-years (854 of 12,919) in which zero-premium exposure was not 100 percent for this income group.

A discussion of other model coefficients and identification checks for our instrumental variables specifications are in the appendix.[10] In the appendix we also show the effects of different assumptions about income levels to explore whether our findings were driven by enrollees with lower or higher incomes.[10] Our findings suggest that sensitivity to zero-premium exposure among the group with incomes of 151–200 percent of poverty might be driven by enrollees with relatively lower incomes among this group (appendix exhibit A12).[10]

POLICY SIMULATION Using our estimates, we simulated changes in enrollment that would have occurred among the group with incomes of 151–200 percent of poverty if zero-dollar premium plans had been uniformly available in 2019. We found that enrollment for this income group, which included roughly 2.1 million enrollees in 2019, would have increased by 3.3 percent, or 60,593 enrollees, if zero-dollar premium plans had been uniformly available (appendix exhibit A13).[10] Conversely, we projected that 201,709 enrollees in the income group would not have signed up for coverage in the federally facilitated Marketplace in 2019 if zero-dollar premium plans had not been available. Thus, 2019 enrollment for the income group would have decreased 10.8 percent without zero-dollar premium plans. Total and state-specific estimates of enrollment changes with full zero-premium exposure and the elimination of zero-dollar premium plans are shown in appendix exhibit A13.[10]

Exhibit 4 illustrates the results of this simulation. Enrollment in 2019 would have increased if zero-dollar premium plans had been universally available. The largest increases would have been concentrated in cities and states where zero-dollar premium plans were least available in 2019, including the cities of Chicago, Las Vegas, and Phoenix and the states of Arkansas, Indiana, Mississippi and New Jersey. Notably, if California were to eliminate its one-dollar premium floor, we projected that 2019 enrollment among the group with incomes of 151–200 percent of poverty in California would have increased by 14.1 percent.

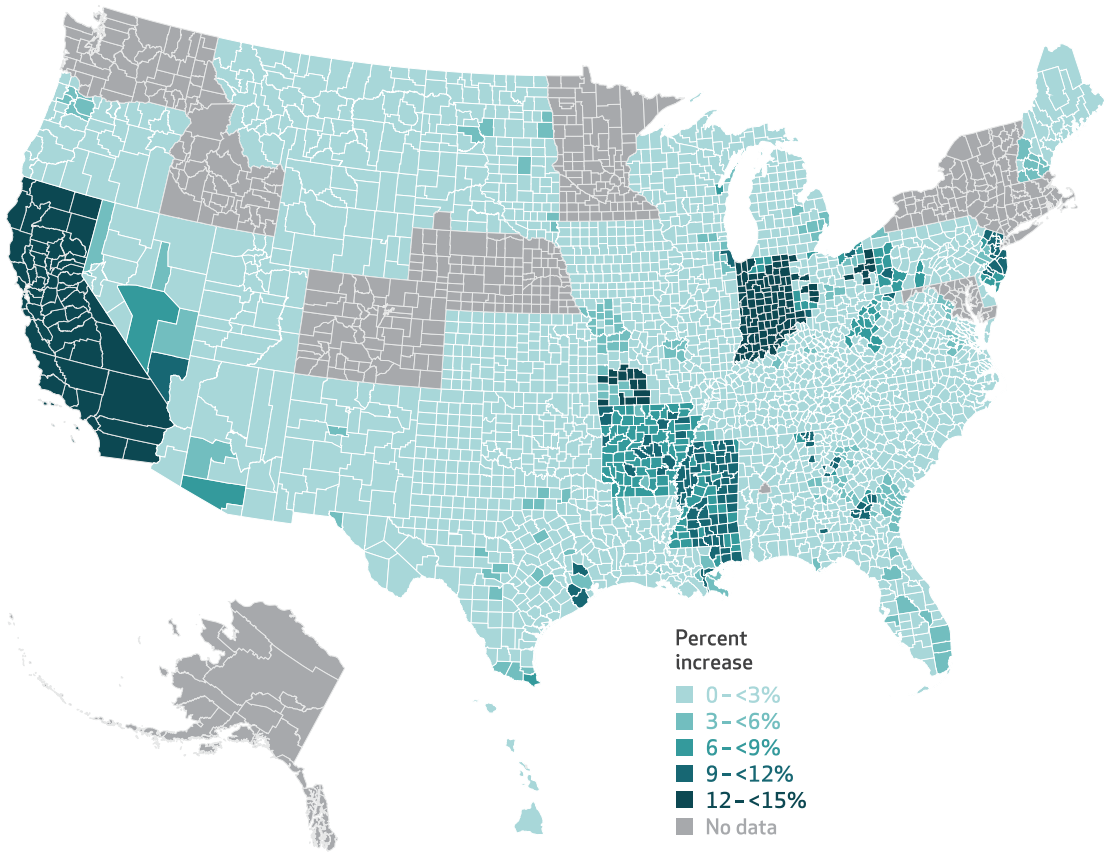
Discussion

In this article we have provided evidence of a zero-price effect on overall enrollment in the health insurance Marketplaces. We found that the availability of zero-dollar premium plans caused a 14.1 percent increase in Marketplace enrollment among enrollees with incomes of 151–200 percent of poverty. Premium levels had no effect on enrollment for this group once we controlled for the zero-price effect. Only after income exceeded 200 percent of poverty did we find a relationship between nonzero premium levels and enrollment. We did not find evidence of a zero-price effect above 200 percent of poverty. Lower-income enrollees might be more responsive to zero premiums in their decisions to purchase health insurance because this population faces more income variability and could face high compliance costs in the management of monthly premium payments.[3,12] Policy makers considering expansions of health insurance should be aware that even nominal premiums could lead to enrollment being substantially lower among low-income populations, compared to requiring no premium payments.

Zero-dollar premium plans increased Marketplace enrollment in 2018 and 2019. These plans were available in 64 percent of counties in 2019 for forty-year-old adults earning $25,000.[13] Roughly 16 percent of 2019 enrollees in the federally facilitated Marketplace chose a plan with a zero-dollar premium.[14] Despite a 300,000-person decrease in federally facilitated Marketplace enrollment in 2019,[15] we simulated that the availability of zero-dollar premium plans increased enrollment in the Marketplace by roughly 200,000 enrollees with incomes of 151–200 percent of poverty in 2019—a 10.8 percent

EXHIBIT 4

Simulated increases in enrollment resulting from the introduction in 2019 of a zero-dollar premium plan for Marketplace enrollees with incomes of 150–200 percent of the federal poverty level



SOURCE Authors' analysis of data for 2015–19 from the Open Enrollment Period Public Use Files and Qualified Health Plan Landscape Files and analogous enrollment and premium data from Covered California. **NOTES** The results are only for California and states that used the federally facilitated Marketplace. Alaska and Nebraska were excluded because their rating areas are not defined according to counties. California sets minimum premiums at one dollar.

increase in enrollment for this group. Had zero-dollar premium plans been available throughout the entire federally facilitated Marketplace and in Covered California, we simulated that 2019 enrollment would have increased by 60,000 enrollees.

Absent a reinstatement of CSR subsidy payments or large changes to the Marketplaces, zero-dollar premium plans will be a feature of the Marketplaces indefinitely. Our findings suggest that making zero-dollar premium plans widely available could be a powerful tool for increasing enrollment among potential enrollees with lower incomes, counteracting other policy changes such as decreases in enrollment outreach and the elimination of the individual mandate.

States could increase Marketplace enrollment by increasing the availability of zero-dollar premium plans. State insurance commissioners can require insurers to silver load, which adds the cost of CSR subsidy payment cuts exclusively to silver plans.[3,16] Silver loading increases the premium spread between the benchmark silver plan and bronze plans, increasing the prevalence of zero-dollar premium bronze plans.[3] Three states—Indiana, Mississippi, and West Virginia—had not silver loaded as of 2019.[17] A further step is to implement the "silver switcheroo," which loads the cost of CSR subsidy payment cuts exclusively onto on-Marketplace silver plans.[16] The silver switcheroo increases premiums spreads for on-Marketplace buyers, while holding off-Marketplace buyers harmless. Twenty-two states had not yet implemented the silver switcheroo by the end of 2019.[17]

Our results suggest that Covered California enrollment could increase by roughly 14 percent among the group with incomes of 151–200 percent of poverty if Covered California allowed its plans' postsubsidy premiums to reach zero dollars. Currently, California makes the coverage of

abortion services not eligible for federal funding mandatory.[18] (Abortion coverage is not eligible for premium tax credits under the ACA.) Thus, California requires that insurers charge one dollar per member per month to provide abortion coverage.[18] If other states included other nonessential health benefits in their required benefit packages, they would experience similar trade-offs.

New Jersey restricts cost-sharing variation within metal levels. In 2019 New Jersey bronze plans were required to have an actuarial value of 64 percent—higher than the 58.5 percent minimum allowed by federal law.[19] This regulation limited the financial exposure of existing enrollees by preventing them from selecting plans with higher cost sharing. However, it also limited the premium spread between the benchmark silver plan and bronze plans, which reduced the availability of zero-dollar premium plans in the state and thereby reduced enrollment. A trade-off thus exists between reducing enrollees' financial exposure by increasing minimum actuarial value levels and increasing insurance coverage via the zero-price effect.

State policy makers could use standardized benefit design regulations to increase zero-premium exposure. One way to do so would be to require that all silver plans have an actuarial value near 72.0 percent (the maximum allowable value for silver plans) and require each insurer to offer at least one bronze plan with an actuarial value near 58.5 percent (the minimum allowable actuarial bronze value).[19] Together, these two regulations would require that Marketplace insurers maintain large premium spreads, thereby maximizing exposure to zero-dollar premium plans. Such regulations would be mechanically similar to standardized benefit design regulations currently in use in California and New Jersey.[20]

Other approaches are possible. For example, states could selectively increase subsidies to make zero-dollar premium plans available to younger, healthier populations that otherwise would remain uninsured.[21] Alternatively, policy makers could consider implementing fixed age-income band premiums, as proposed in the 2017 American Health Care Act.[22] Insurers could design plans that would be priced at a fixed subsidy level, potentially increasing zero-premium exposure.[23] States also have the ability, through Section 1332 waivers, to reallocate federal spending on premium tax credits—including the silver load increment—to improve their individual insurance markets. For example, Iowa proposed age- and income-based subsidies to change the structure of its market.[24]

Lowering the percentage of their incomes that Marketplace enrollees are required to pay for the benchmark plan also would increase zero-premium plan exposure by reducing the premium spread necessary for that exposure. The Blue Cross Blue Shield Association recently proposed such an approach for younger Marketplace enrollees,[25] the group that has been the least exposed to zero-dollar premium plans and whose members are the most price-sensitive in their enrollment decisions.[26] This approach could be a particularly effective way to attract younger enrollees into the Marketplaces.

State policy makers could use standardized benefit design regulations to increase zero-premium exposure.

Silver loading and increased enrollment in zero-dollar premium plans could have negative consequences. First, increased subsidies resulting from silver loading have significant federal costs.[9] These increased costs could be magnified by monopolist insurers that lack incentives to price their plans competitively.[16] Second, enrollees who switched to zero-dollar premium plans could decrease their financial protection from medical expenses by switching to a plan with higher cost sharing.[8]

Conclusion

We found that the availability of zero-dollar premium plans in the ACA Marketplace had a strong effect on potential enrollees' decisions to become insured, particularly in the case of lower-income enrollees. States that do not fully benefit from the zero-price effect can take steps to make zero-dollar premium plans more widely available. In states that have not yet implemented silver loading or the silver switcheroo, these shifts would essentially be cost-free to states, insurers, and enrollees. In other states, such as California (with its abortion coverage mandate) and New Jersey (with its restrictions on cost sharing), policy makers will need to consider the trade-offs of keeping these policies vis-à-vis the enrollment gains of allowing zero-dollar premium plans. Future research should continue

to examine the role of the zero-price effect on the decision to become insured in the Marketplaces, using more granular data. It should also consider other insurance markets with zero-dollar premium plans, including Medicaid and Medicare Advantage. ■

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DATA BRIEF
JANUARY 2020

U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?

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The Commonwealth Fund

Melinda K. Abrams
Senior Vice President
The Commonwealth Fund

A 2015 Commonwealth Fund brief showed that — before the major provisions of the Affordable Care Act were introduced — the United States had worse outcomes and spent more on health care, largely because of greater use of medical technology and higher prices, compared to other high-income countries.[1] By benchmarking the performance of the U.S. health care system against other countries — and updating with new data as they become available — we can gain important insights into our strengths and weaknesses and help policymakers and delivery system leaders identify areas for improvement.

This analysis is the latest in a series of Commonwealth Fund cross-national comparisons that uses health data from the Organisation for Economic Co-operation and Development (OECD) to assess U.S. health care system spending, outcomes, risk factors and prevention, utilization, and quality, relative to 10 other high-income countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom. We also compare U.S. performance to that of the OECD average, comprising 36 high-income member countries.

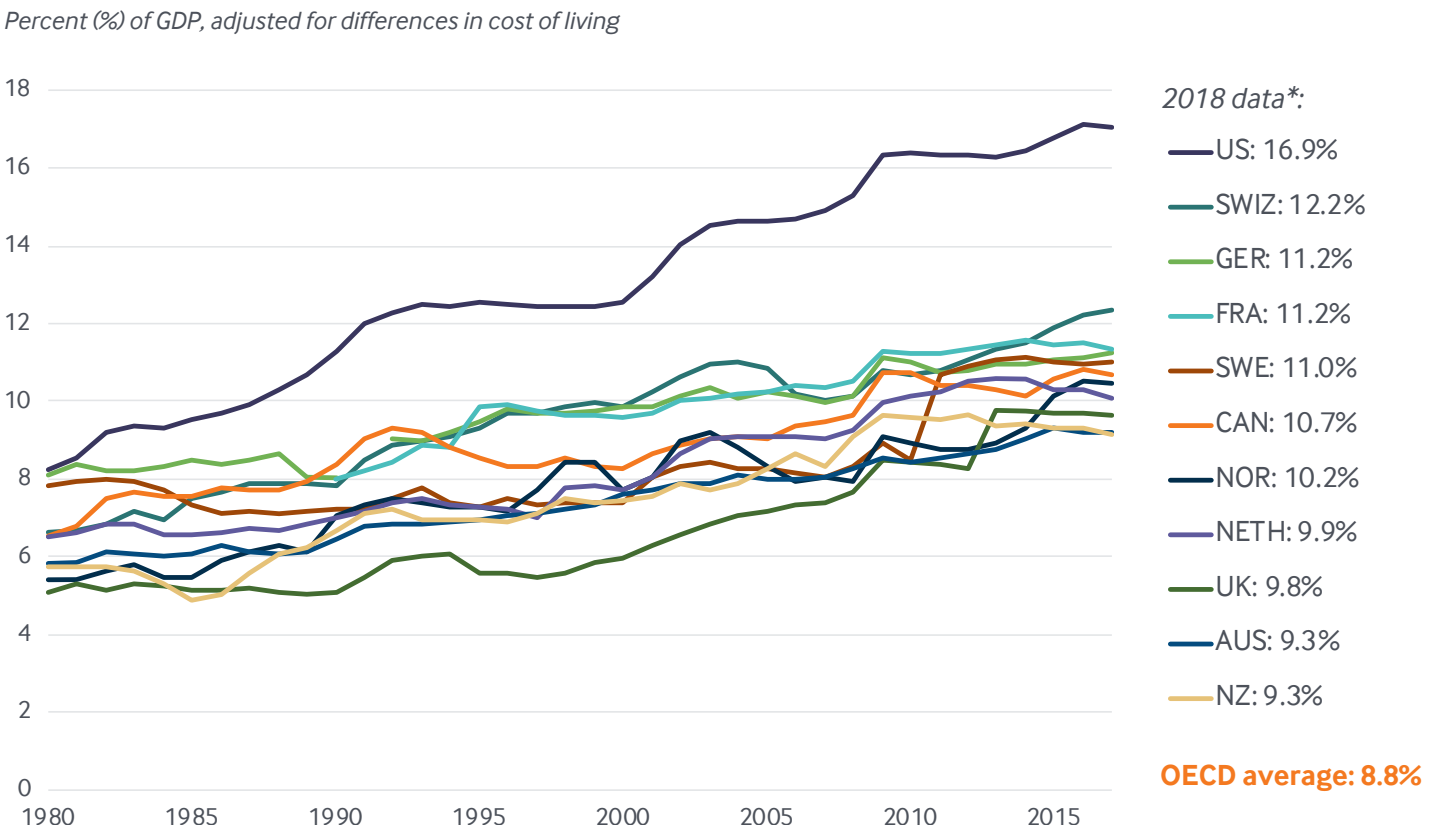
HIGHLIGHTS

- The U.S. spends more on health care as a share of the economy — nearly twice as much as the average OECD country — yet has the lowest life expectancy and highest suicide rates among the 11 nations.
- The U.S. has the highest chronic disease burden and an obesity rate that is two times higher than the OECD average.
- Americans had fewer physician visits than peers in most countries, which may be related to a low supply of physicians in the U.S.
- Americans use some expensive technologies, such as MRIs, and specialized procedures, such as hip replacements, more often than our peers.
- The U.S. outperforms its peers in terms of preventive measures — it has the one of the highest rates of breast cancer screening among women ages 50 to 69 and the second-highest rate (after the U.K.) of flu vaccinations among people age 65 and older.
- Compared to peer nations, the U.S. has among the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths.

The Commonwealth Fund

SPENDING

The U.S. Spends More on Health Care Than Any Other Country



In 2018, the U.S. spent 16.9 percent of gross domestic product (GDP) on health care, nearly twice as much as the average OECD country. The second-highest ranking country, Switzerland, spent 12.2 percent. At the other end of the spectrum, New Zealand and Australia devote only 9.3 percent, approximately half as much as the U.S. does. The share of the economy spent on health care has been steadily increasing since the 1980s for all countries because health spending growth has outpaced economic growth,[2] in part because of advances in medical technologies, rising prices in the health sector, and increased demand for services.[3]

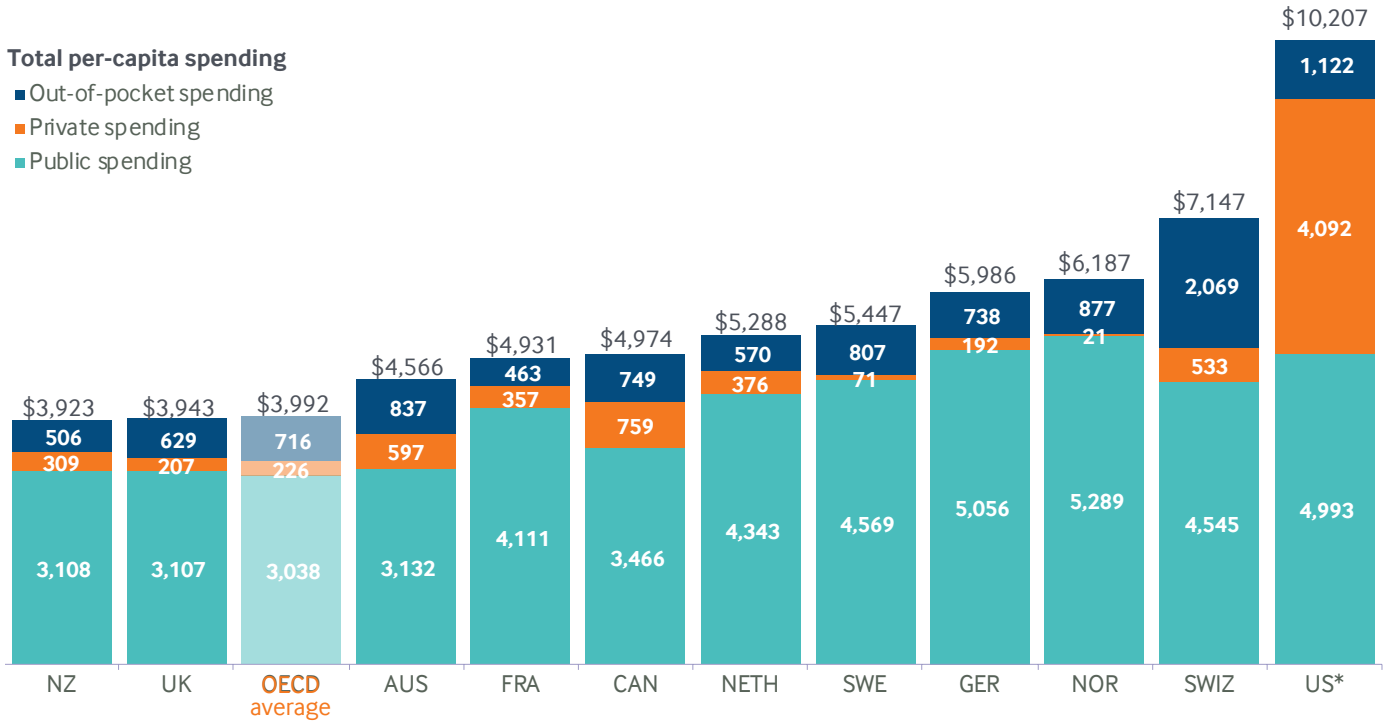
Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP = gross domestic product. OECD average reflects the average of 36 OECD member countries, including ones not shown here. * 2018 data are provisional or estimated.

Data: OECD Health Statistics 2019.

SPENDING

U.S. Public Spending Is Similar to Other Countries; Out-of-Pocket and Private Spending Are Higher Than Most

Dollars (US$), adjusted for differences in cost of living



Notes: Data reflect current expenditures on health per capita, adjusted using US$ purchasing power parities (PPPs), for 2018 or the most recent year: 2017 for FRA, SWIZ, UK, US; 2016 for AUS. Data for 2018 reflect estimated or provisional values. Numbers may not sum to total health care spending per capita because of excluding capital formation of health care providers, and some uncategorized health care spending. * For US, spending in the "Compulsory private insurance schemes" (HF122) category has been reclassified into the "Voluntary health insurance schemes" (HF21) category, given that the individual mandate to have health insurance ended in January 2019. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

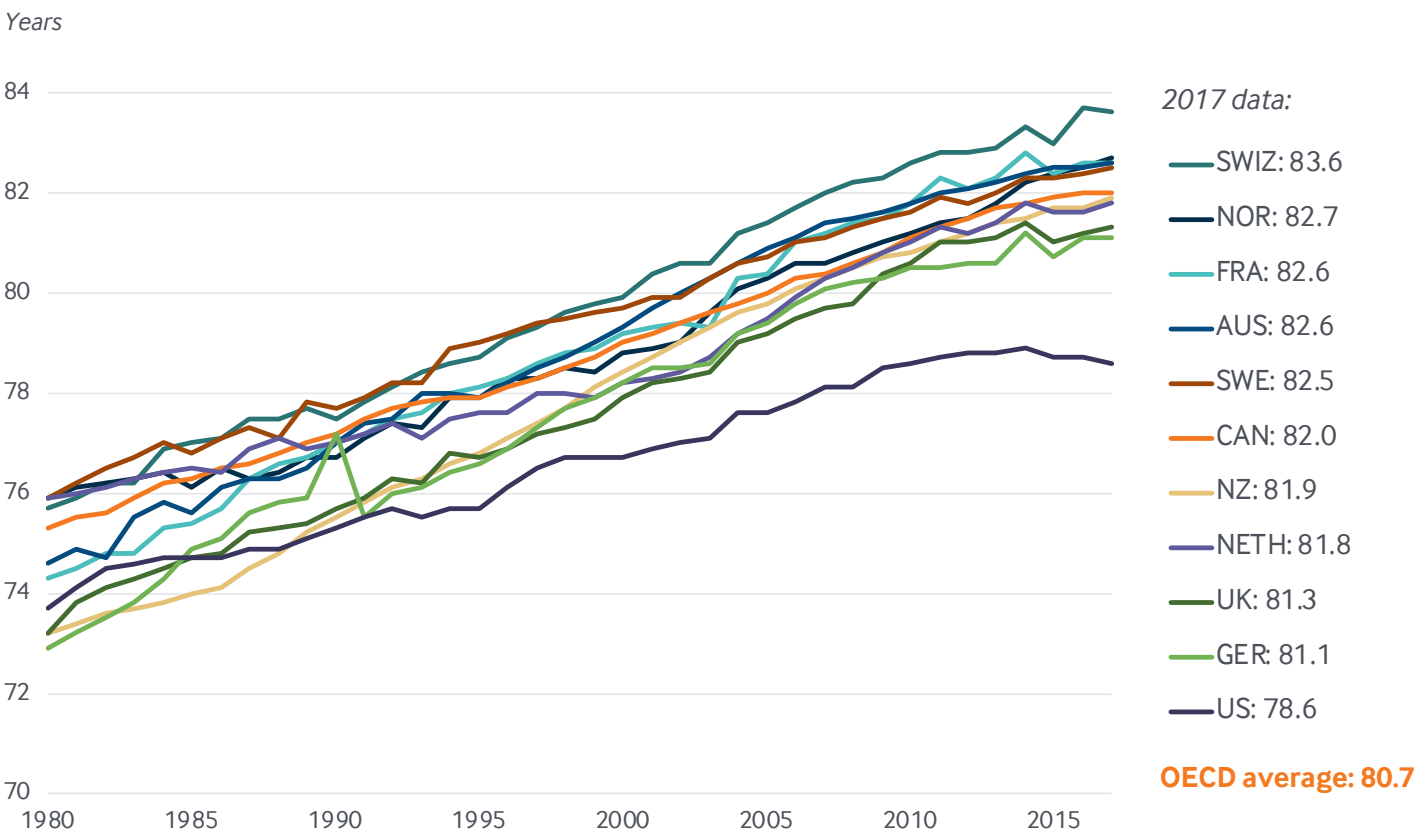
Per capita health spending in the U.S. exceeded $10,000, more than two times higher than in Australia, France, Canada, New Zealand, and the U.K. Public spending, including governmental spending, social health insurance, and compulsory private insurance, is comparable in the U.S. and many of the other nations and constitutes the largest source of health care spending.

In the U.S., per-capita spending from private sources, for instance, voluntary spending on private health insurance premiums, including employer-sponsored health insurance coverage, is higher than in any of the countries compared here. At $4,092 per capita, U.S. private spending is more than five times higher than Canada, the second-highest spender. In Sweden and Norway, private spending made up less than $100 per capita. As a share of total spending, private spending is much larger in the U.S. (40%) than in any other country (0.3%–15%).

The average U.S. resident paid $1,122 out-of-pocket for health care, which includes expenses like copayments for doctor's visits and prescription drugs or health insurance deductibles. Only the Swiss pay more; residents of France and New Zealand pay less than half of what Americans spend.

HEALTH OUTCOMES

The U.S. Has the Lowest Life Expectancy



Note: OECD average reflects the average of 36 OECD member countries, including ones not shown here.

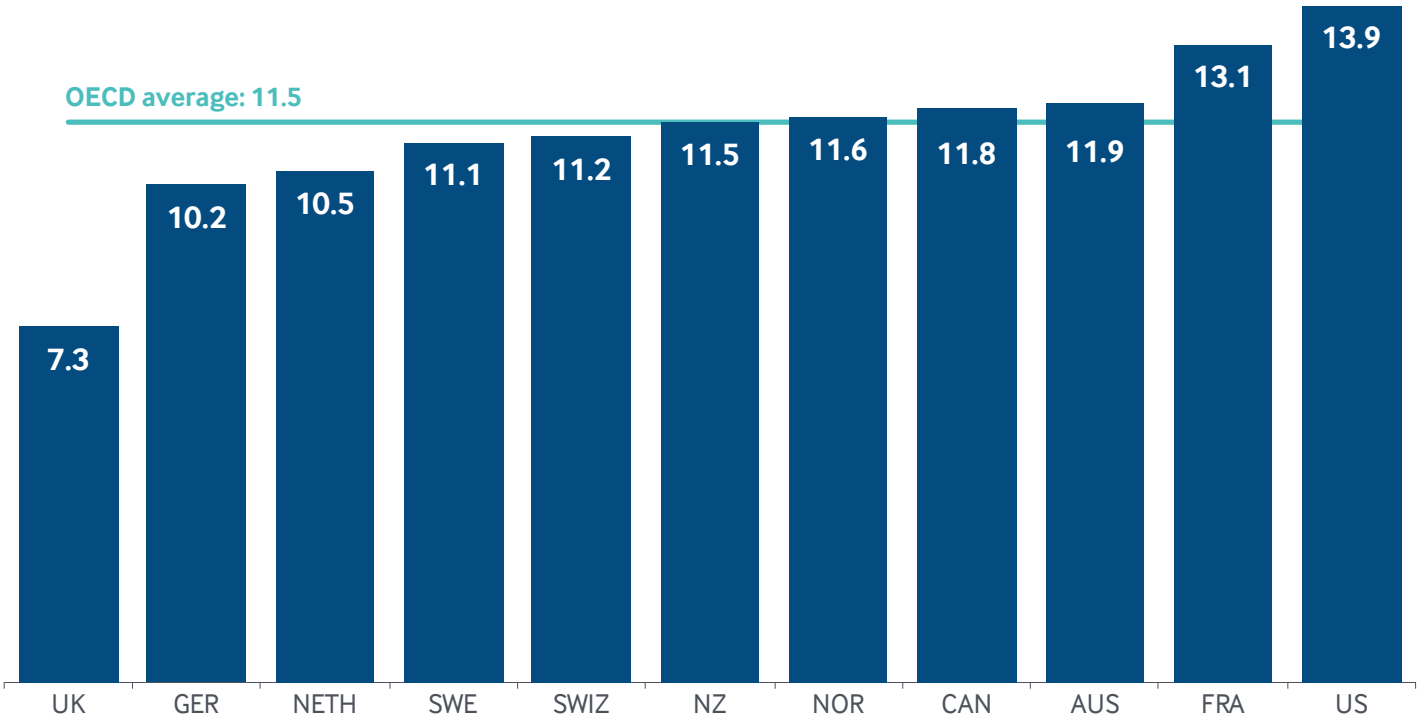
Data: OECD Health Statistics 2019.

Despite the highest spending, Americans experience worse health outcomes than their international peers. For example, life expectancy at birth in the U.S. was 78.6 years in 2017 — more than two years lower than the OECD average and five years lower than Switzerland, which has the longest lifespan. In the U.S., life expectancy masks racial and ethnic disparities. Average life expectancy among non-Hispanic black Americans (75.3 years) is 3.5 years lower than for non-Hispanic whites (78.8 years).[4] Life expectancy for Hispanic Americans (81.8 years) is higher than for whites, and similar to that in Netherlands, New Zealand and Canada.

HEALTH OUTCOMES

Suicide Rates Are the Highest in the U.S.

Deaths per 100,000 population (standardized rates)



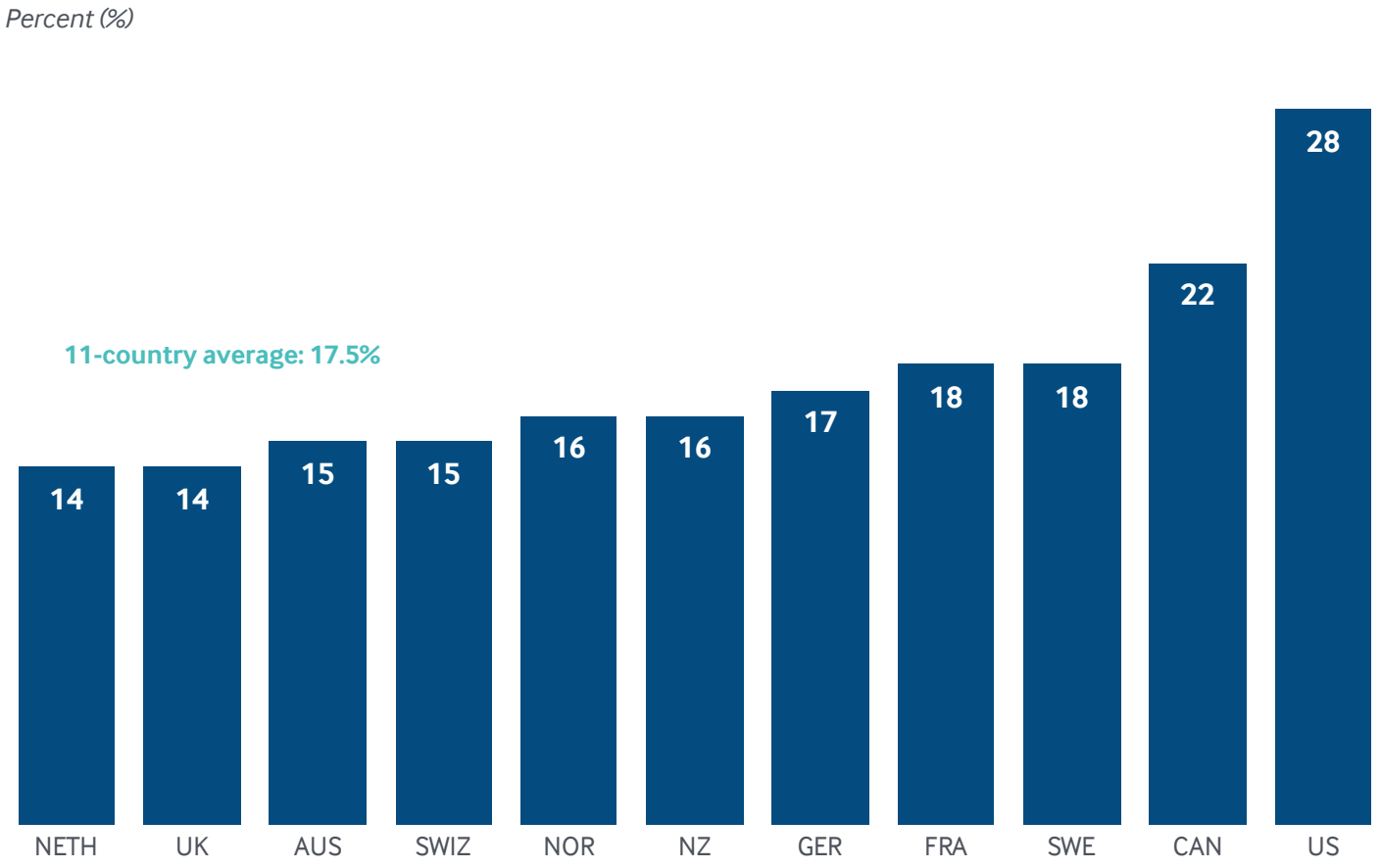
Notes: Rates reflect age- and sex-standardized rates for 2016 or latest available year: 2015 for CAN, FRA; 2014 for NZ. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

Reflecting shorter life expectancy, the U.S. has the highest suicide rate of these countries, with France a close second. Meanwhile, the U.K. has the lowest rate — half that of the U.S. Elevated suicide rates may indicate a high burden of mental illness; socioeconomic variables are also a factor.[5] The U.S. has seen an uptick in "deaths of despair" in recent years, which include suicides and deaths related to substance use, including overdoses.[6]

POPULATION HEALTH

U.S. Adults Have the Highest Chronic Disease Burden



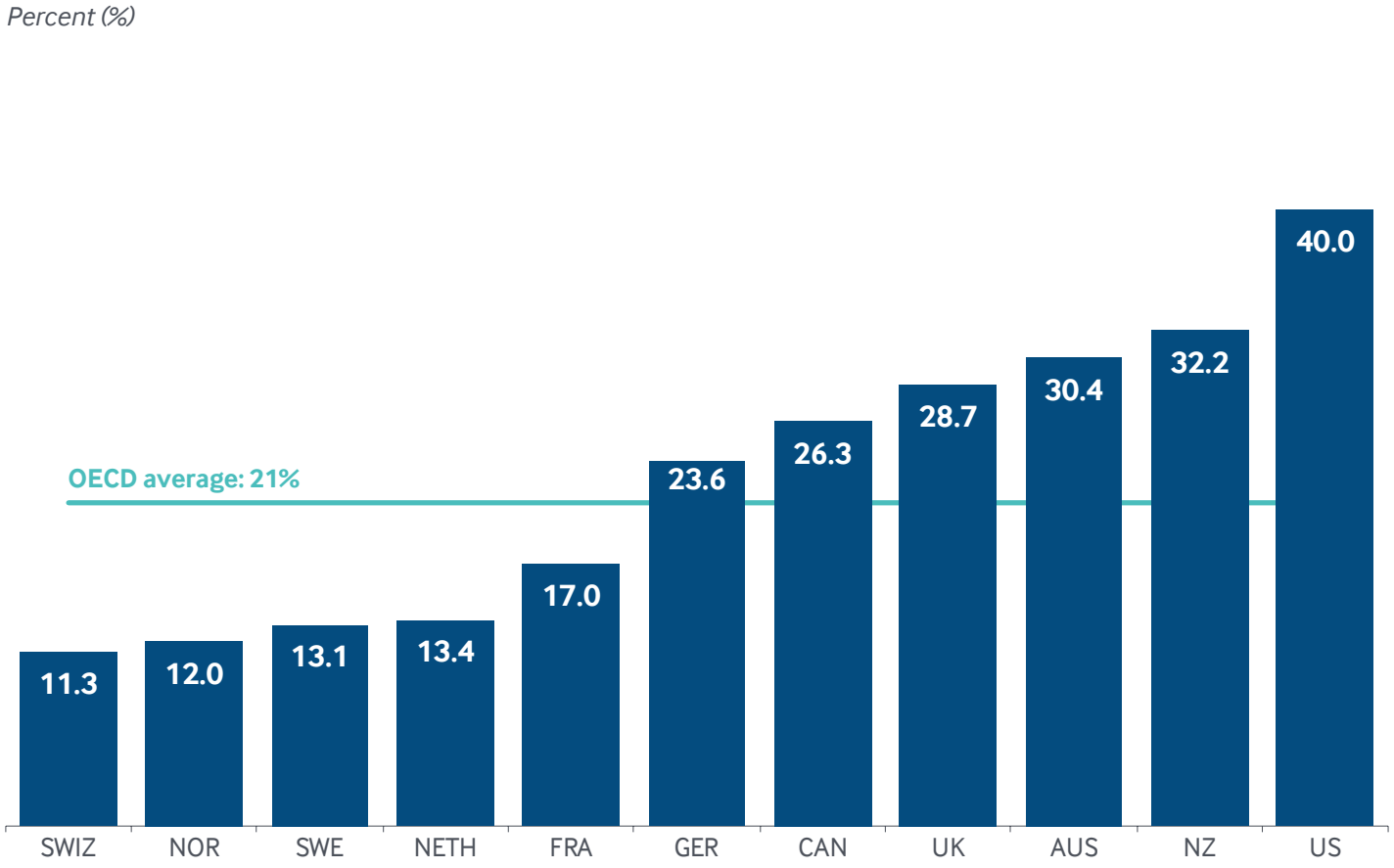
Notes: Chronic disease burden defined as adults age 18 years or older who have ever been told by a doctor that they have two or more of the following chronic conditions: joint pain or arthritis; asthma or chronic lung disease; diabetes; heart disease, including heart attack; or hypertension/high blood pressure. Average reflects 11 countries shown in the exhibit that take part in the Commonwealth Fund's International Health Policy Survey.

Data: 2016 Commonwealth Fund International Health Policy Survey.

Worse health outcomes and shorter life expectancy appear related to risk factors and disease burden. More than one-quarter of U.S. adults report they have ever been diagnosed with two or more chronic conditions such as asthma, diabetes, heart disease, or hypertension during their lifetime compared to 22 percent or less in all other countries. This rate is twice as high as in the Netherlands and the U.K.

POPULATION HEALTH

The U.S. Has the Highest Rate of Obesity



Notes: Obese defined as body-mass index of 30 kg/m² or more. Data reflect rates based on measurements of height and weight, except NETH, NOR, SWE, SWIZ, for which data are self-reported. (Self-reported rates tend to be lower than measured rates.) 2017 data for all countries except 2016 for US; 2015 for FRA, NOR; 2012 for GER. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

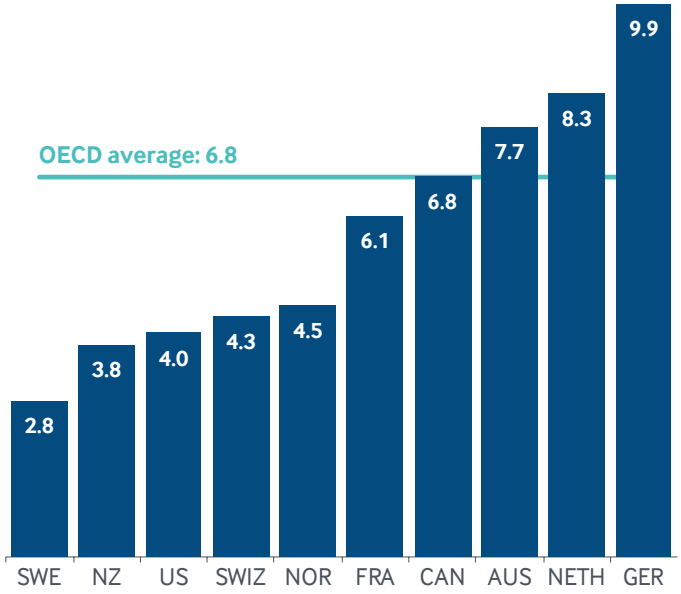
Data: OECD Health Statistics 2019.

Obesity is a key risk factor for chronic conditions such as diabetes, hypertension and other cardiovascular diseases, and cancer. The U.S. has the highest obesity rate among the countries studied — two times higher than the OECD average and approximately four times higher than in Switzerland and Norway. Overall, obesity rates were highest in English-speaking countries, all with rates of one-quarter or more of the total population. Issues that contribute to obesity include unhealthy living environments, less-regulated food and agriculture industries, and socioeconomic and behavioral factors.[7]

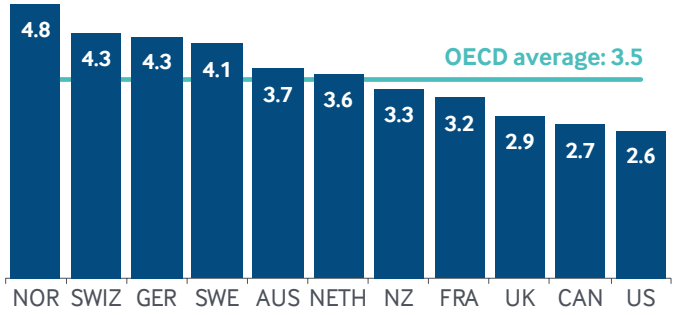
UTILIZATION

Americans Visit the Doctor Less Frequently and Have Fewer Physicians

Average physician visits per capita, 2017



Practicing physicians per 1,000 population, 2018



Despite having the highest level of health care spending, Americans had fewer physician visits than their peers in most countries. At four visits per capita per year, Americans visit the doctor at half the rate as do Germans and the Dutch. The U.S. rate was comparable to that in New Zealand, Switzerland, and Norway, but higher than in Sweden.

Less-frequent physician visits may be related to the low supply of physicians in the U.S. compared with the other countries. The U.S. has slightly more than half as many physicians as Norway, which has the highest supply.

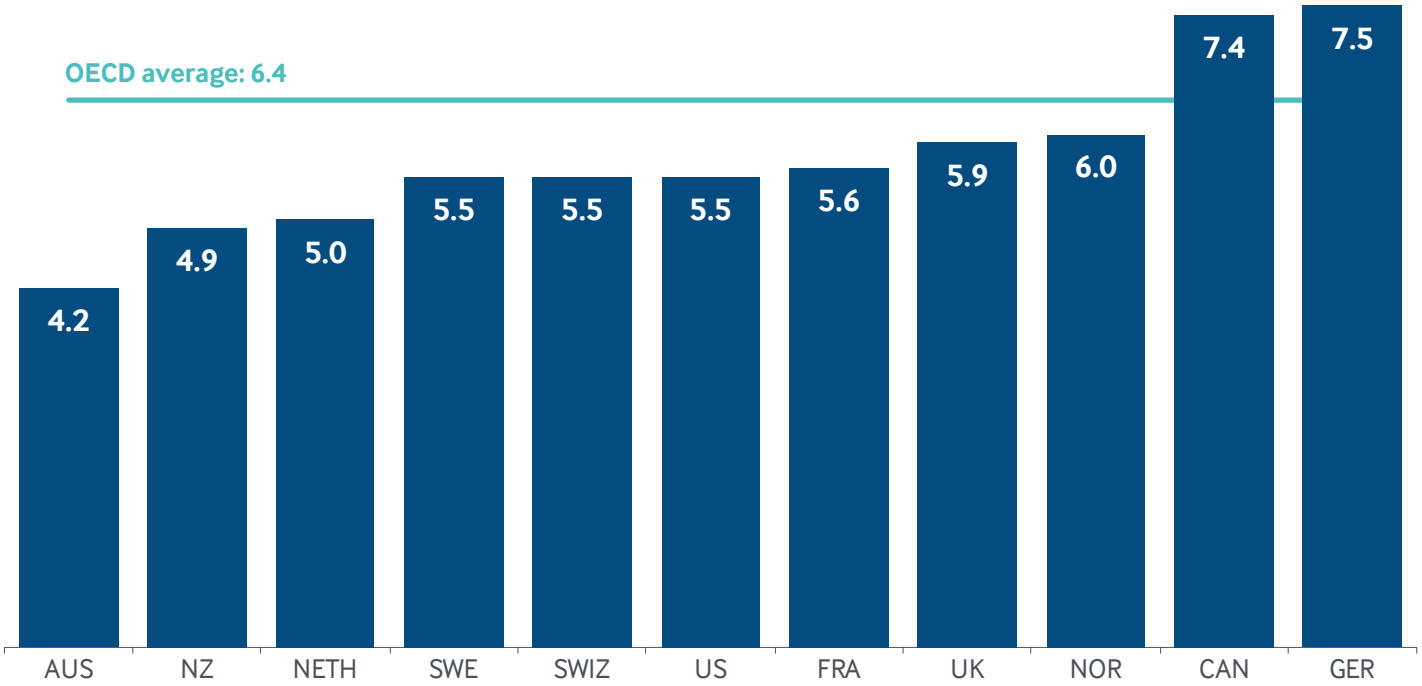
Notes: Physician visit data reflect 2017 or nearest year: 2016 for FRA, 2011 for US. No recent data for UK (since 2009). Physician supply data for 2018 or nearest year: 2017 for AUS, GER, NETH, SWIZ, US; 2016 for SWE. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

UTILIZATION

U.S. Average Hospital Stay Is Similar to That in Sweden, Switzerland, and France

Average length of stay for acute care (days)



The average length of a hospital stay in the U.S. in 2017 was 5.5 days, far lower than the OECD average and comparable to that in Sweden, Switzerland, and France. Canadians and Germans had the longest lengths of stay, while Australians had the shortest.

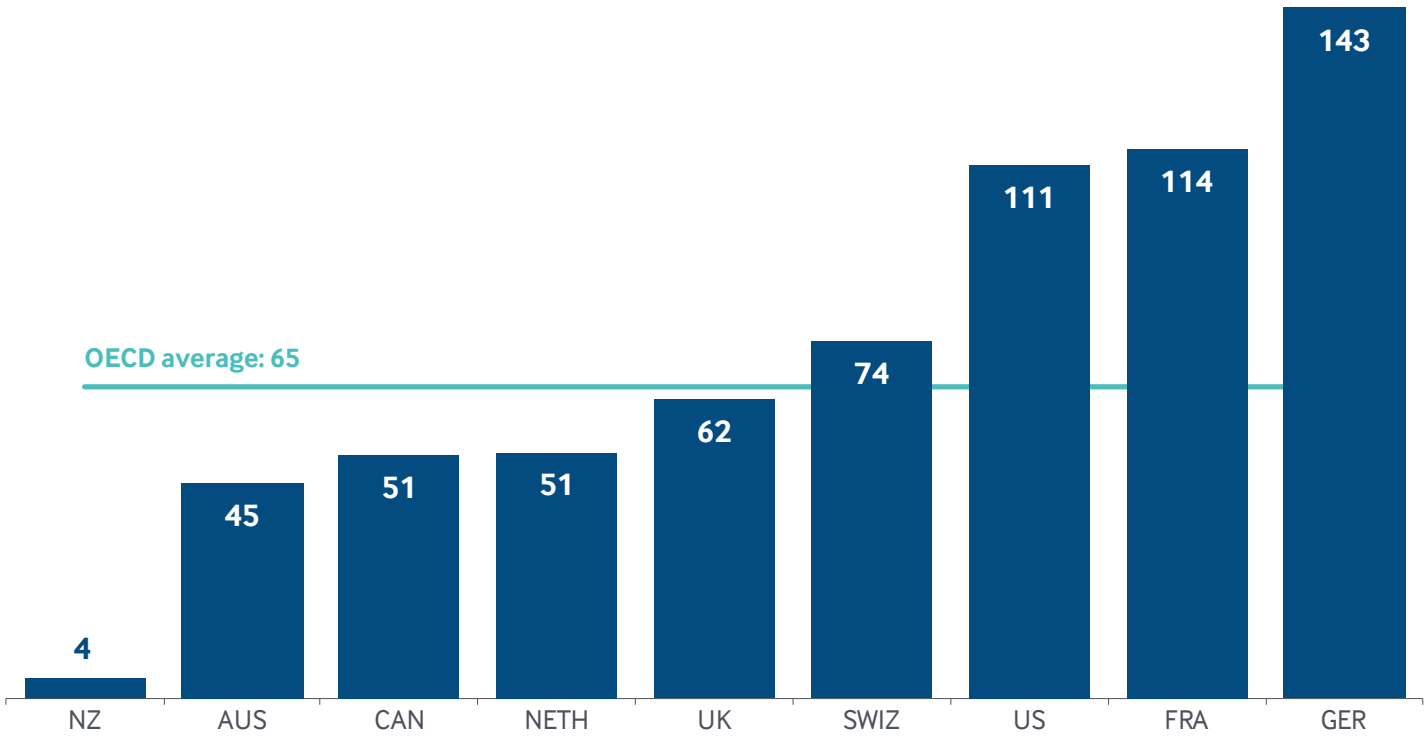
Notes: Data reflect average length of stay for curative (acute) care for physical and mental/psychiatric illnesses, or treatment of injury; diagnostic, therapeutic, and surgical procedures; and obstetric services. Excludes rehabilitative care, long-term care, and palliative care. Data for 2017 or nearest year: 2016 for AUS, FRA, NZ, US. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

UTILIZATION

The U.S. Has a High Rate of MRI Scans

Magnetic resonance imaging (MRI) scans per 1,000 population



U.S. utilization for specialized scans is higher than in most countries, nearly twice as high as the OECD average but comparable to France. Germany had an even higher magnetic resonance imaging (MRI) rate, while New Zealand's was low. Previous analyses suggest that countries with a high supply of MRI scanners also tend to have higher rates of scan utilization.[8]

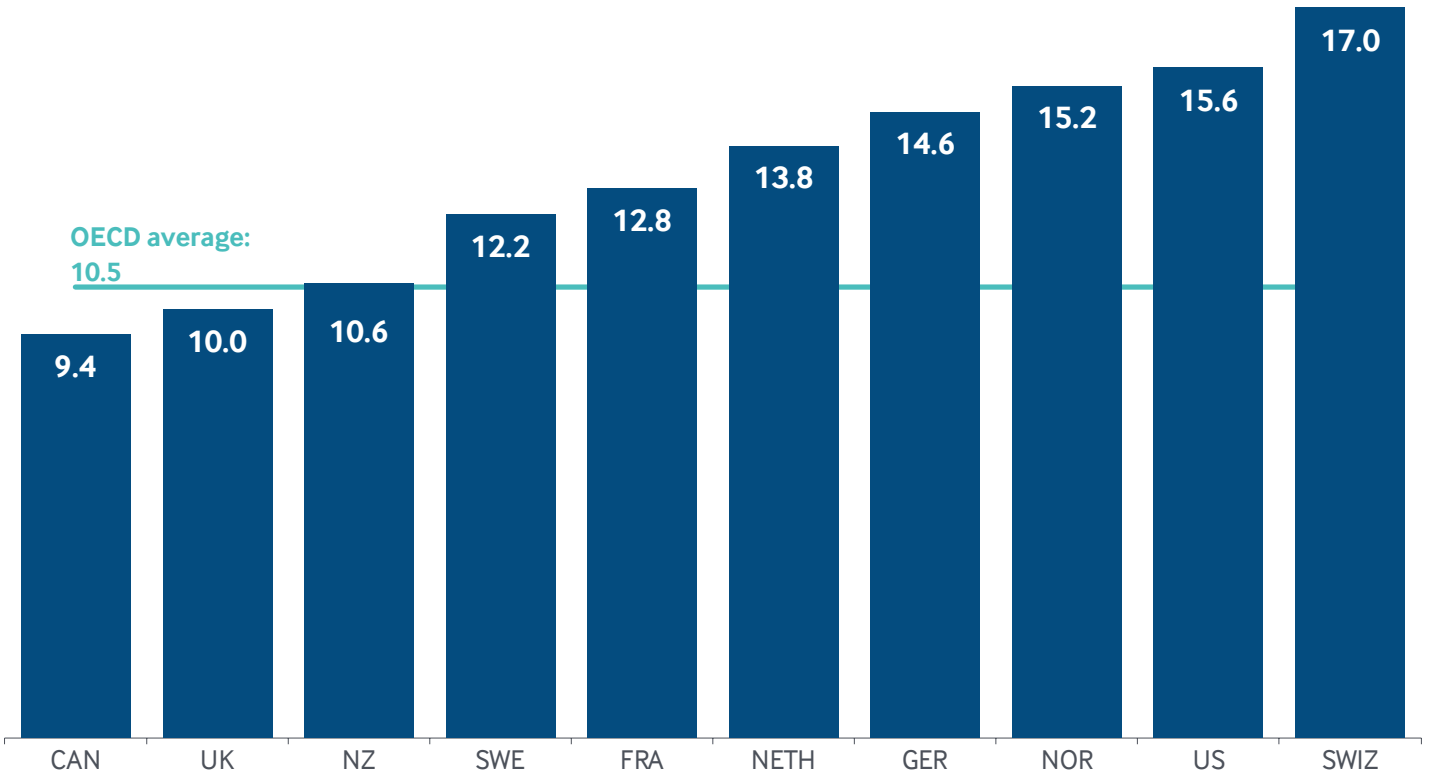
Notes: Data shown for 2017 or nearest year: 2016 for GER; 2013 for NZ. No data for NOR, SWE. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

UTILIZATION

The U.S. Performs More Hip Replacements Among Older Adults

Inpatient hip replacement procedures per 1,000 population age 65 and older



The U.S. performs some elective surgeries at a higher rate than other countries. The U.S. rate of hip replacements per 1,000 persons age 65 and older was higher than the OECD average but similar to the rate in Norway and Switzerland. Canada, the U.K., and New Zealand had the lowest rates, with rates close to the OECD average.

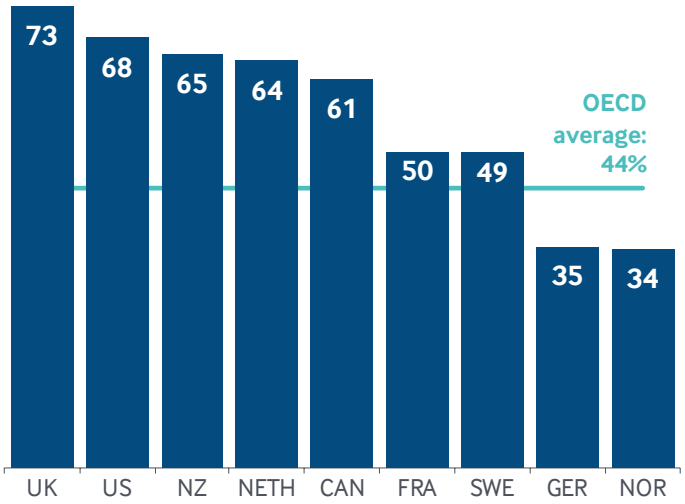
Notes: Data reflect inpatient cases only (day cases not included) for 2017 or nearest year: 2016 for NZ; 2014 for NETH; 2010 for US. No recent data for AUS. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

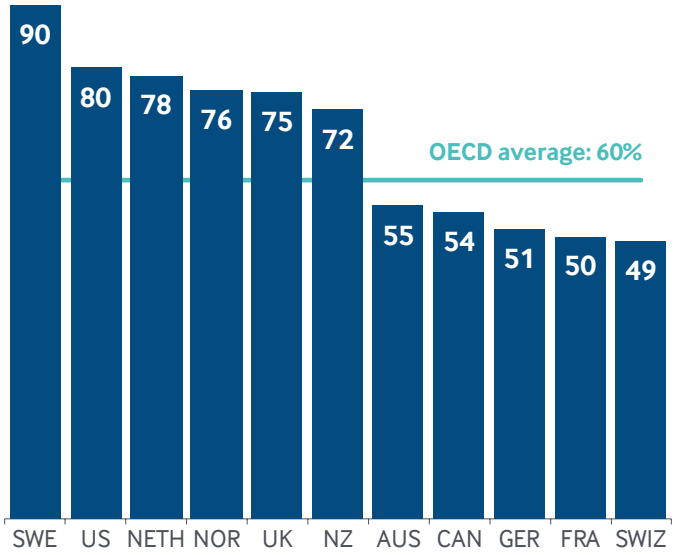
QUALITY AND CARE OUTCOMES

The U.S. Excels in Prevention Measures, Including Flu Vaccinations and Breast Cancer Screenings

Percent of adults age 65 and older immunized (%)



Percent of females ages 50–69 screened (%)



Notes: Flu immunization data reflect 2017 or nearest year: 2016 for US. No recent data available for AUS, SWIZ (since 2009/2010). Breast cancer screening data reflect 2018 or nearest year: 2017 for FRA, NOR; 2016 for AUS, GER; 2015 for CAN, NETH, US; 2014 for SWE. Programmatic data for all countries except survey data for SWE, SWIZ, US. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

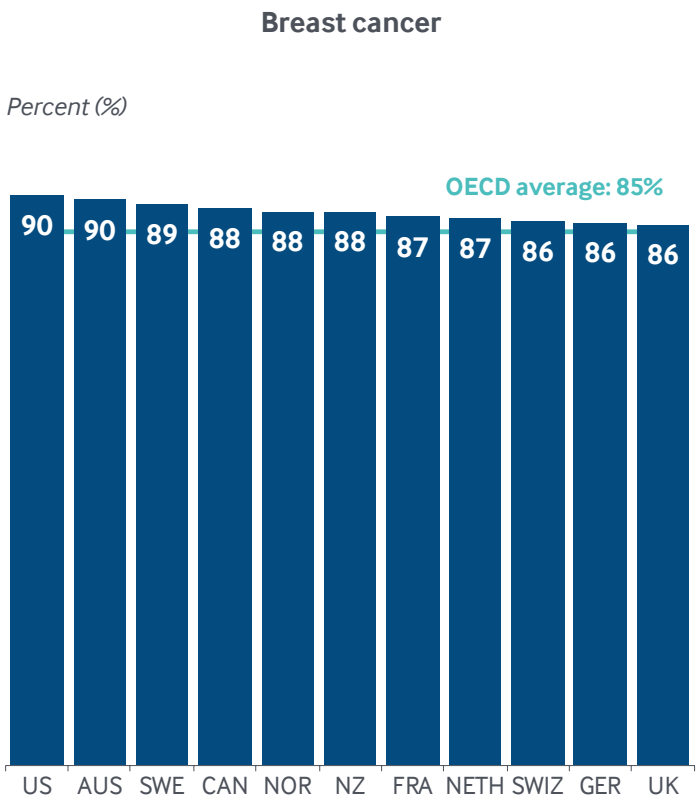
Data: OECD Health Statistics 2019.

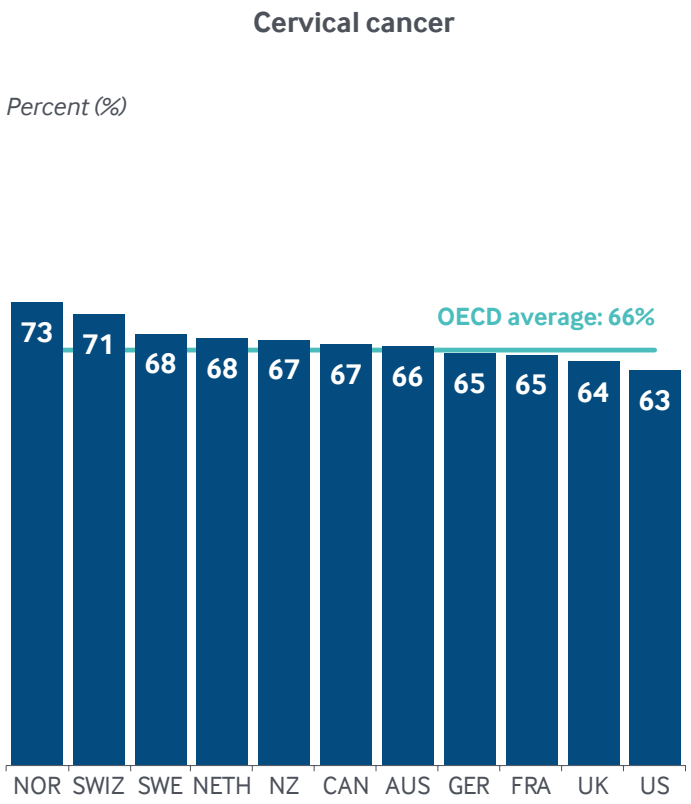
The U.S. outperforms peer nations in terms of preventive measures. In the U.S., more than two-thirds of adults 65 and older had a flu vaccine in 2016, considerably more than in the average OECD country. Only the U.K. had a higher rate than the U.S. At the lower end of the spectrum, one-third of older adults in Germany and Norway received the vaccine.

The U.S. also had one of the highest rates of women ages 50 to 69 being screened for breast cancer. The U.S. rate is considerably higher than the OECD average. In contrast, in Switzerland, France, and Germany, only half of women this age had been screened.

QUALITY AND CARE OUTCOMES

The U.S. Has the Highest Average Five-Year Survival Rate for Breast Cancer, but the Lowest for Cervical Cancer





The five-year survival rate for breast cancer is the highest in the U.S. among the 11 countries — it is more than 5 percentage points higher than the OECD average. Breast cancer survival rates in all 11 countries compared here are higher than the OECD average. This is not true for other types of cancer. For example, five-year survival for cervical cancer among U.S. women is lower than in the 10 other countries and below the OECD average.

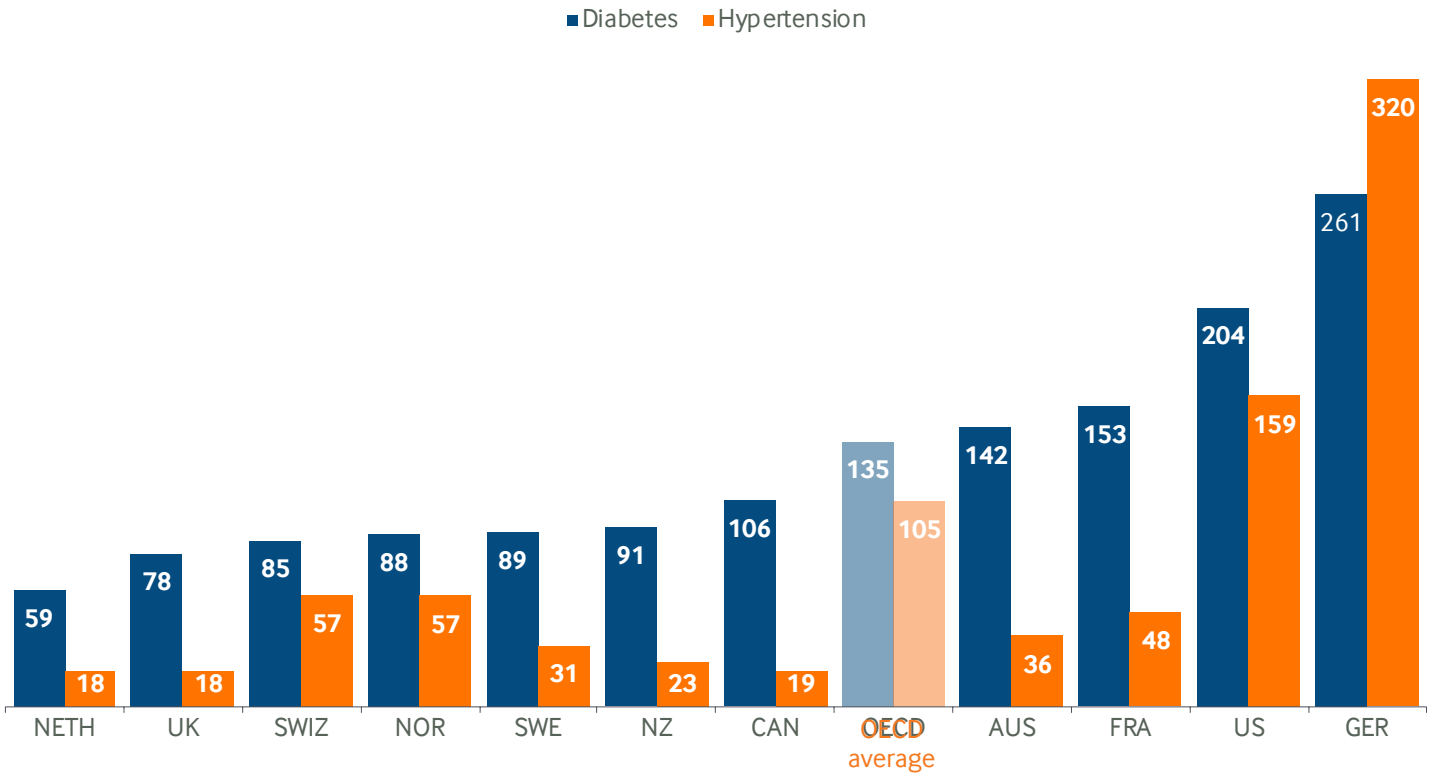
Notes: Rates reflect age-standardized survival rates for females age 15 years and older. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Data: OECD Health Statistics 2019.

QUALITY AND CARE OUTCOMES

The U.S. Has Among the Highest Rates of Hospitalizations from Preventable Causes Like Diabetes and Hypertension

Discharges per 100,000 population



Notes: Data reflect 2017 or nearest year: 2016 for AUS, NZ; 2010 for US. OECD average reflects the average of 36 OECD member countries, including ones not shown here.

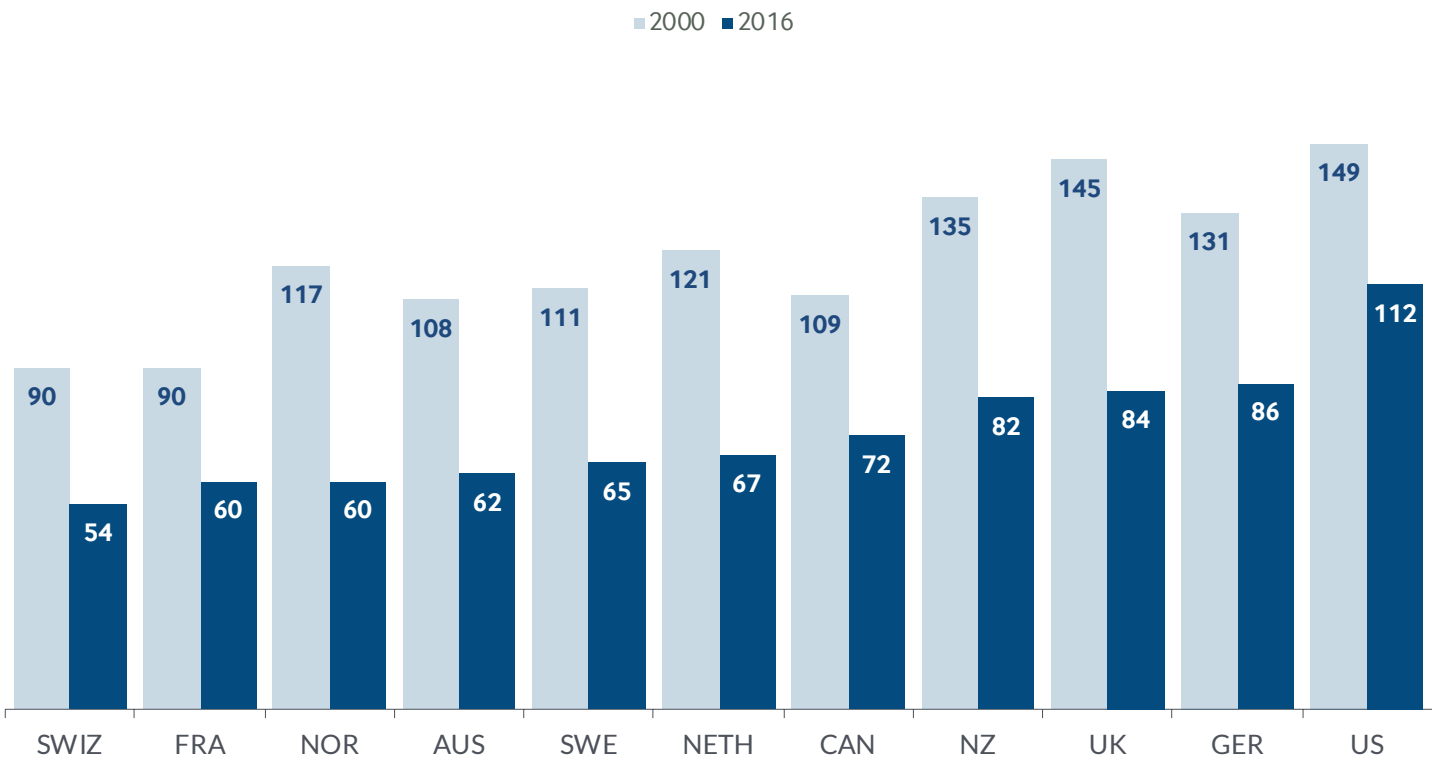
Data: OECD Health Statistics 2019.

Hospitalizations for diabetes and hypertension — which are considered ambulatory care–sensitive conditions, meaning they are considered preventable with access to better primary care[9] — were approximately 50 percent higher in the U.S. than the OECD average. Only Germany had higher rates for both conditions. The U.S. rate of hypertension-related hospitalizations was more than eightfold higher than the best-performing countries, the Netherlands, the U.K., and Canada. For diabetes hospitalizations, the U.S. rate (204/100,000) was more than threefold higher than the Netherlands, the best-performing country.

QUALITY AND CARE OUTCOMES

The U.S. Has the Highest Rate of Avoidable Deaths

Deaths per 100,000 population



Notes: Data for 2000 (except UK, 2001) and latest available (2016 for NETH, NOR, SWE, US; 2015 for AUS, CAN, FRA, GER, SWIZ, UK; 2014 for NZ). Mortality data from World Health Organization (WHO) detailed mortality files (released Dec. 2018). Population data from WHO detailed mortality files, except CAN (UN population database) and US (Human Mortality Database). Amenable causes as per list by Nolte and McKee (2004). Calculations by the European Observatory on Health Systems and Policies (2019). Age-specific rates standardized to European Standard Population, 2013.

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Premature deaths from conditions that are considered preventable with timely access to effective and quality health care,[10] including diabetes, hypertensive diseases, and certain cancers, are termed "mortality amenable to health care." This indicator is used by several countries to measure health system performance.[11] The U.S. has the highest rates of amenable mortality among the 11 countries with 112 deaths for every 100,000. It is notable that the amenable mortality rate has dropped considerably since 2000 for every country in our analysis, though less proportionately in the U.S. The U.S. rate was two times higher than in Switzerland, France, Norway, and Australia. This poor performance suggests the U.S. has worse access to primary care, prevention, and chronic disease management compared to peer nations.

CONCLUSIONS AND POLICY IMPLICATIONS

While the United States spends more on health care than any other country, we are not achieving comparable performance. We have poor health outcomes, including low life expectancy and high suicide rates, compared to our peer nations. A relatively higher chronic disease burden and incidence of obesity contribute to the problem, but the U.S. health care system is also not doing its part. Our analysis shows that the U.S. has the highest rates of avoidable mortality because of people not receiving timely, high-quality care. The findings from this analysis point to key policy implications, as well as opportunities to learn from other countries.

First, greater attention should be placed on reducing health care costs. The U.S. could look to approaches taken by other industrialized nations to contain costs,[12] including budgeting practices and using value-based pricing of new medical technologies. Approaches that aim to lower health care prices are likely to have the greatest impact, since previous research has indicated that higher prices are the primary reason why the U.S. spends more on health care than any other country.[13]

Second, our findings call for addressing risk factors for, and better management of, chronic conditions. We can start by strengthening access to care and primary care systems. Our findings show that the U.S. has a relatively lower rate of physician visits compared to other nations. This is surprising given U.S. adults' seemingly greater health needs. We do know from previous Commonwealth Fund surveys that adults in the U.S. experience greater affordability barriers to accessing physician visits, tests, and treatments.[14] Increasing access to affordable health care and strengthening primary care systems are two of the most important challenges for the U.S. health care system.[15]

Third, the U.S. should promote incentives to use effective care and disincentives to discourage less-effective care. For example, a recent analysis estimated that as much as one-quarter of total health care spending in the U.S. — between $760 billion and $935 billion annually — is wasteful.[16] Overtreatment or low-value care — medications, tests, treatments, and procedures that provide no or minimal benefit or potential harm — accounts for approximately one-tenth of this spending. The U.S. can learn from other countries; for example, our comparably high use of MRI scans and surgeries for hip replacement suggests we should assess when these interventions bring the greatest value. The global Choosing Wisely campaign promotes conversations around evidence-based care between physicians and their patients to help evaluate which tests and treatments are truly necessary and free from harm.[17]

In sum, the U.S. health care system is the most expensive in the world, but Americans continue to live relatively unhealthier and shorter lives than peers in other high-income countries. Efforts to rein in costs, improve affordability and access to needed care, coupled with greater efforts to address risk factors, are required to alleviate the problem.

HOW WE CONDUCTED THIS STUDY

This analysis used data from the 2019 release of health statistics compiled by the Organisation for Economic Co-operation and Development (OECD), which tracks and reports on a wide range of health system measures across 36 high-income countries. Data were extracted between July and August 2019. While data collected by the OECD reflect the gold standard in international comparisons, one limitation is that data may mask differences in how countries collect their health data. Full details on how indicators were defined, as well as country-level differences in definitions, are available from the OECD.[18] The 10 comparator countries included in this comparison represent those that take part in the Commonwealth Fund's annual International Health Policy Survey: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.[19]

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